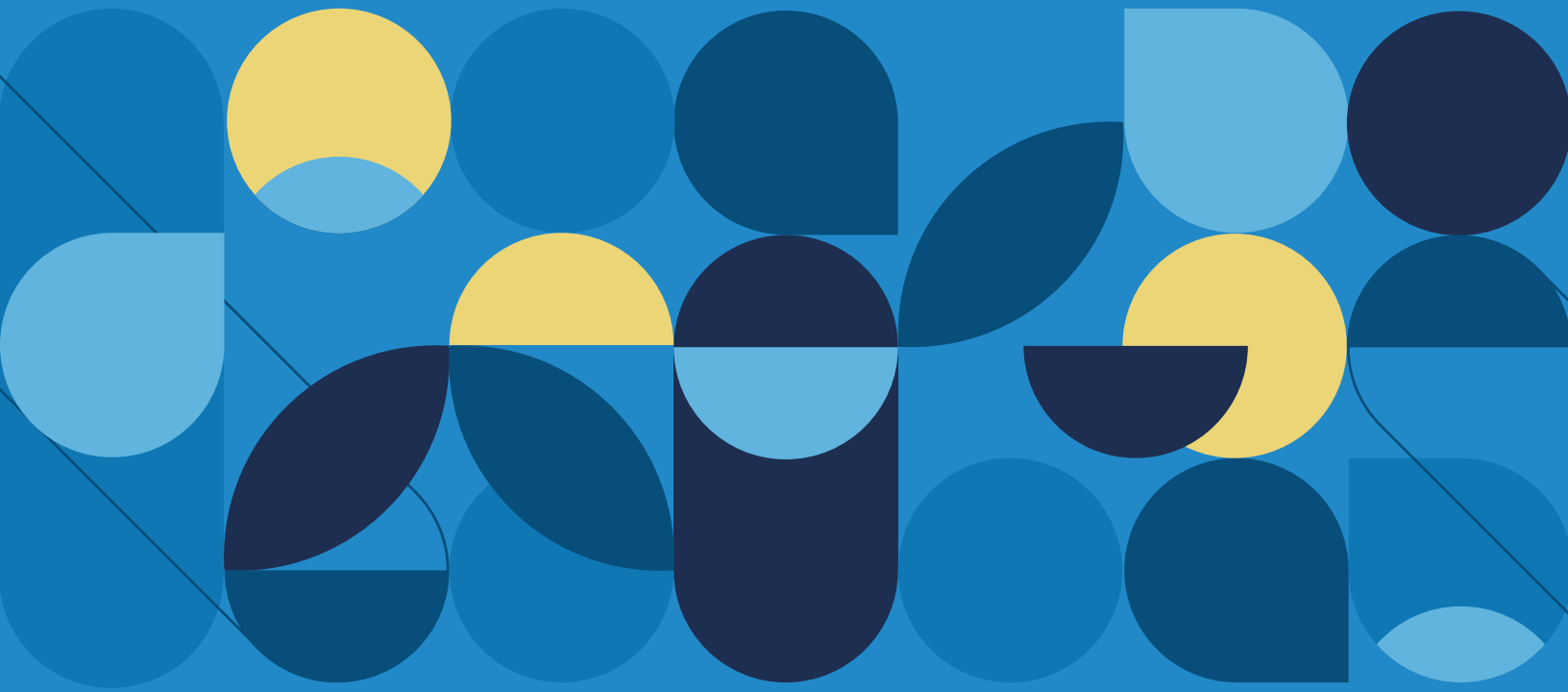
Québec Clinical Guide on Support for People Living With Opioid Use Disorder



L'Équipe de soutien clinique et organisationnel
en dépendance et itinérance

Québec

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Québec Clinical Guide on Support for People Living With Opioid Use Disorder

A publication of CIUSSS du Centre-Sud-de-l'Île-de-Montréal

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The ***Québec Clinical Guide on Support for People Living With Opioid Use Disorder*** is a production of CIUSSS du Centre-Sud-de-l'Île-de-Montréal.

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NOTES

In this document, the use of the term "nurse" is consistent with the standards of the Ordre des infirmières et infirmiers du Québec (OIIQ).

This tool was written on unceded Indigenous territories. We would like to take a moment to acknowledge the Kanien'kehá: ka Nation as custodians of the waters and lands on which ESCODI is physically located. Historically, Tiohtiá:ke / Montréal is known as a gathering place for many First Nations. Today, a diverse Indigenous population, as well as other peoples, reside here. ESCODI also has members living and working throughout Quebec. In this context, it is important for us to also recognize the territory of the 11 Indigenous Nations of Quebec. To learn more, we suggest that you consult this map with the names in the Indigenous languages of all the Indigenous communities in Quebec.

As an advocate for social justice, ESCODI recognizes the past and present consequences of colonialism. Respecting the links with the past, the present, and the future, we recognize the ongoing relationship between Indigenous peoples and other members of the Quebec community, and we encourage everyone to recognize the unceded territory they inhabit. We encourage you to learn more about the history of ancestral territories across Canada by visiting the First Nations of Quebec and Labrador Health and Social Services Commission.

ADVISORY NOTICE

This guide complements the regulatory tool published in 2020 by the Collège des médecins du Québec (CMQ), the Ordre des infirmières et infirmiers du Québec (OIIQ) and the Ordre des pharmaciens du Québec (OPQ) entitled Le traitement du trouble lié à l'utilisation d'opioïdes (TUO) (in French only).

This guide is based in part on this tool as well as on consultations with experts, professional bodies and groups representing opioid users. Its content has also been validated by a scientific committee. The guide is intended as a tool to support clinicians in their day-to-day practice.

However, this guide is not prescriptive, and its authors cannot be held responsible for the clinical practice of professionals. Clinicians are responsible for being properly qualified and trained. The care and services they provide must be based on their clinical judgment and follow the professional standards and the code of ethics to which they are subject.

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TARGET AUDIENCE

All professionals in the health and social services network may, to varying degrees, encounter opioid use disorder (OUD). This guide is intended for use by all clinicians and administrators across the continuum of health care and services.

In non-specialized care settings

Treatment for OUD can be initiated in any clinical setting (e.g., a hospital emergency department, family medicine group, detention centre, etc.). Once the person has been stabilized under treatment, it can be continued in many different general care settings. Clinicians working with someone with OUD in a non-specialized care settings will find this guide useful in their practice.

In specialized addiction care settings

The information in this guide is intended to support partner care teams specialized in the treatment of OUD (including the person in treatment, the community pharmacist, and the interdisciplinary team) as part of a collaborative, long-term approach.

EDITORIAL PREFACE

In line with the "no wrong door" approach, all professionals in the health and social services network (RSSS) may, to varying degrees, encounter opioid use disorder (OUD). There are several ways they can contribute to the continuity and quality of care and services for people with OUD, including through a referral, a diagnosis, a prescription, and enduring support.

For professionals working with these individuals over the long term, it is important to note that the treatment trajectory of someone with OUD is often compared to that of a person with a chronic illness. Applying a chronic care model implies longitudinal support and proactive treatment. The model is based on evidence-based interventions, on the creation of conditions that enable persons in treatment to be informed and competent in self-management of OUD, and on connecting them with other resources in the community who can help them achieve their goals. 1 Such individuals (and the professionals providing them with support) will experience ups and downs, periods of equilibrium and periods of complexity, breaks in treatment, and resumption of treatment, all on the journey of long-term support.

A number of challenges are commonly encountered when supporting people in treatment for OUD, including:

- OUD rarely presents alone, and persons in treatment may have complex problems related to multiple substances, mental health disorders, physical health problems, or social disadvantages;
- Persons receiving treatment for OUD may have particular needs related to their age, gender identity, sexual orientation, ethnic or cultural origin, socioeconomic status, or life experiences, which may be associated with trauma;
- Supporting persons in treatment for OUD involves difficult ethical decision-making in a context of risk mitigation (for those in treatment as well as the professionals);
- The standard practices and procedures in the health and social services network are not always well suited to the reality of persons living with OUD; and
- Persons with OUD often experience stigmatization in society as well as in the health and social services network.

Multiple challenges specific to supporting persons with OUD can be overcome (in whole or in part) by adopting a comprehensive, flexible, tailored, empathetic, and non-judgmental approach, as well as through collaborative work with other professionals and with the individuals themselves.

This guide recognizes the intersectional nature of discrimination against persons with OUD and structural stigmatization. However, the guide does not provide distinct approaches for

working with different marginalized communities. The clinical principles set out in this guide apply to people of all ethnic, cultural, and religious backgrounds; of all sexual orientations and gender identities; of all socioeconomic backgrounds; and of all ages and health conditions, without exception and without discrimination.

This guide provides tools to support clinical judgment and strategies the aim to better support people living with OUD.

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GLOSSARY

Opioid agonists

This refers to "[a]ny substance that binds to and activates mu (μ) opioid receptors, providing relief from withdrawal symptoms and cravings in people with opioid use disorder, and pain relief if used for chronic pain management. Oral opioid agonists used for treating opioid use disorder include methadone, buprenorphine, and slow-release oral morphine." [2]

Partner care team

This refers to a care team that relies on collaboration and knowledge sharing between the person in treatment and actors in the health and social services network. This relationship encourages the joint construction and pooling of knowledge to develop a shared understanding of a situation/problem and potential solutions. The partner care team may include a prescriber, a nurse or nursing assistant, a psychosocial professional, a peer support worker, and a community pharmacist. The number of caregivers on the team may grow or be reduced, depending on the level of support required. The team closely follows and supports the person receiving treatment for OUD. [3]

Essential harm reduction supplies

Essential harm reduction supplies include:

- The distribution of safer injecting and safer smoking supplies (e.g., syringe, tourniquet, crack pipe) and safer sex supplies (e.g., condoms, lubricant, etc.) and instructions on their use;
- The distribution of naloxone, and instructions on its use, to the person receiving treatment and their immediate social circle; and
- A list of available community resources, including supervised injection services when available and accessible.

Misuse

This refers to the "[u]se of medicines for purposes other than those for which they are generally prescribed. This definition includes obtaining drugs from illegitimate sources and risky consumption habits (e.g., altering the formulation, changing the route of administration or dosage, etc.)." [4] [Our translation]

Modes of opioid use

Opioids are used in a variety of ways: they can be smoked, snorted, injected, and taken by mouth, through the skin (transdermal patch), rectally, and vaginally.

Naloxone

Naloxone is an opioid antagonist that acts rapidly to temporarily reverse the effects of an opioid overdose.[5]

Opioids

This refers to "[s]ubstances commonly prescribed for pain management that bind and activate opioid receptors in the brain, suppressing the ability to feel pain. At high doses, opioids can cause euphoria, dysphoria, and respiratory depression. Opioids may be prescribed or obtained illegally, and include synthetic (e.g., fentanyl, methadone, buprenorphine), semi-synthetic (e.g., heroin, hydromorphone, oxycodone), and naturally derived (e.g., opium, morphine, codeine) classes. The term 'opiate' refers to compounds naturally derived from the opium poppy. Depending on the opioid type, formulation and individual preference, opioids are consumed via ingestion, inhalation, transdermal delivery, or subcutaneous, intramuscular, or intravenous injection."[2]

Peers

These are people with experiential knowledge who work with individuals who are living through similar experiences.[6]

Withdrawal

Withdrawal is the metabolic process by which toxic substances are eliminated from the body.[7] Withdrawal consists of a set of symptoms of varying severity that occur when the use of psychoactive substances that have been taken repeatedly—usually over a long period of time—is stopped or reduced.[8] Signs and symptoms of withdrawal include agitation, anxiety, irritability, yawning, diarrhea, abdominal cramps, pain (in the joints, muscles, bones), a craving for opioids, lacrimation, rhinorrhea, mydriasis, nausea, vomiting, piloerection, tachycardia, sweating, and tremors.[9] The Clinical Opiate Withdrawal Scale (COWS) is available in Appendix 2 of the guide published by INESSS on optimal use in OUD.

Telemedicine

This refers to the remote practice of medicine using information and communication technologies. Telemedicine is used to carry out medical procedures such as clinical assessment, diagnosis, treatment, and interpretation of diagnostic procedures. It can take place synchronously if the participants are present in real time (e.g., during a videoconference), or asynchronously if the participants are not present at the same time (e.g., during an email exchange).[10]

Opioid agonist treatment (OAT)

OAT is provided using opioid agonist medications prescribed to treat OUD. "OAT is typically provided in conjunction with provider-led counselling; long-term substance-use monitoring (e.g., regular assessment, follow-up, and urine drug tests); comprehensive preventive and primary care; and referrals to psychosocial treatment interventions, psychosocial supports, and specialist care as required. In this document, OAT refers to long-term (>6 months) treatment with an opioid agonist medication that has an evidence base for use in the treatment of opioid use disorder. 'Opioid agonist treatment (OAT)' is the preferred terminology, representing an intentional shift from the use of 'opioid substitution treatment (OST),' 'opioid maintenance treatment (OMT),' and 'opioid replacement therapy (ORT).'"[2]

Opioid use disorder (OUD)

This refers to a problematic pattern of opioid use leading to clinically significant impairment or distress that meets the DSM-5 Diagnostic Criteria for Opioid Use Disorder. OUD includes the use of synthetic and/or naturally derived opioids, whether prescribed or illegally obtained.[2]

Introduction

The Plan d'action interministériel en dépendance 2018–2028 (2018–2028 interministerial action plan on homelessness) of the Government of Québec's Ministère de la Santé et des Services sociaux indicates that opioid use has increased in recent years. The plan also reminds us how difficult it is to secure rapid access to treatment for opioid use disorder (OUD). In line with objective 4.5 of the Stratégie nationale de prévention des surdoses de substances psychoactives 2022–2025 (2022–2025 national strategy on preventing overdoses by psychoactive substances), this Québec Clinical Guide on Support for People Living With Opioid Use Disorder is intended as a tool that can be used by clinicians and managers working with persons with OUD. Our intention is to provide a tool that will promote access to integrated and adapted services. This guide reflects the prevention objectives set out in the Plan d'action interministériel en itinérance 2021–2026 (2021–2026 interministerial action plan on homelessness) by supporting improvements to the continuum of addiction services for persons experiencing homelessness. It also complements the regulatory tool published in 2020 by the Collège des médecins du Québec (CMQ), the Ordre des infirmières et infirmiers du Québec (OIIQ) and the Ordre des pharmaciens du Québec (OPQ), entitled Le traitement du trouble lié à l'utilisation d'opioïdes (TUO) (treatment of opioid use disorder [OUD]), and is a continuation of the Québec Guide to Improving Practices in the Management of Opioid Use Disorder (OUD), published in 2020 by the Équipe de soutien clinique et organisationnel en dépendance et itinérance (ESCODI).

Opioid use disorder: Background

Prevalence of OUD

The precise prevalence of OUD in Québec is not known. The most recent data, from the Canadian Alcohol and Drugs Survey, conducted in 2019, indicate that "[o]ne percent of Canadians aged 15 and older engaged in problematic use of opioid pain relievers in the past year."[11] Problematic use refers to "drugs used for purposes other than their prescribed therapeutic use."[11] Applying this **1%** rate to the Québec population **aged 15 and older,** we estimate that **73,407 people** made problematic use of opioids in 2019. Regarding OUD specifically, recent analyses show that the prevalence of OUD in British Columbia in 2017 reached 1.92% among persons aged 12 years and older.[12]

Impacts on the health and social system

Although only a small portion of the population presents with OUD, the consequences of this condition place significant pressure on health and social services, justice, youth protection, and employment services.[13] For example, in the period from January 2016 to December 2022, **36,233 hospital admissions** were recorded in Canada for **opioid poisoning.**[A,14] In addition, in 2022 alone, **35,900 emergency medical services (EMS) interventions** were recorded for overdoses potentially linked to opioids.[B,14]

Fatal overdoses

In Canada, a total of **40,642 deaths** were linked to opioid poisoning in the period from January 2016 to June 2023.[14] Accidental deaths linked to substance use have slowed the pace of life expectancy increases, particularly among men.[15] Canadian data indicate that fentanyl and its analogues are often found in substances purchased on the illicit market, unbeknownst to the people using them. Analyses performed in 2018–2019 show that **62% of samples** containing an opioid and close to **3% of samples** containing a stimulant also contained **fentanyl** or one of its analogues.[16] The presence of fentanyl, its analogues, or benzodiazepines in opioids increases the risk of overdose.[16,17] In Québec, the Institut national de santé publique (INSPQ) reports that the mortality rate attributable to opioid poisoning **trended upward** from 2000 to 2015.[18] In 2018, 424 people died due to suspected poisoning by opioids or other drugs. This number was 414 in 2019, 547 in 2020, 450 in 2021 and 541 in 2022.[19]

Delivery by injection and its consequences

People who use injection as their delivery method are at greater risk of suffering serious consequences from opioid use, namely sexually transmitted and blood-borne infections, overdoses, abscesses, cardiovascular disorders, mental health problems, suicidal risks, and post-traumatic stress disorder.[20,21] Other pulmonary, musculoskeletal, skin, and soft tissue complications are also associated with injection.[22] According to samples taken in various Canadian cities, the prevalence of injection among people with OUD varies from **57.5%**[23] to **66.9%,** on average.[24] Injection is more common among heroin users than among users of pharmaceutical-type opioids.[23,24]

Sexually transmitted and blood-borne infections

Among people with OUD, the use of contaminated injection equipment is a major source of risk for sexually transmitted and blood-borne infections (STBBI).[25] The prevalence of blood-borne infections can reach very high levels in certain samples of people with OUD. In a study by Vajdic et al. (2015),[26] **52% of patients** on admission to OAT had contracted hepatitis B virus (HBV), hepatitis C virus (HCV) or human immunodeficiency virus (HIV) in this way. Data from a large sample of people who inject drugs, surveyed by the SurvUDI network in 2017, indicate an HIV prevalence of **11.3%** and anti-HCV antibodies of **66.6%.**[27] The preva-

A Data excluding Québec.

B Data for nine provinces and territories.

lence of sexually transmitted infections such as chlamydia, gonorrhoea, and trichomoniasis is also higher among people who use drugs than in the general population.[28]

Use of other psychoactive substances

More than **90%** of people with OUD also use other substances,[29] including cannabis, cocaine, alcohol, and non-prescription drugs.[23,29]

Mental health disorders

The prevalence of mental health disorders among people with OUD is estimated at **64%**[30] according to a national survey conducted in the United States. In samples of patients admitted to OAT, this percentage can rise to over **70%**.[31–33] More specifically, a recent systematic review highlights the **high frequency of the following diagnoses** among people with OUD: depression, anxiety, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, bipolar disorder, antisocial personality disorder, and borderline personality disorder.[34]

Chronic pain

Recent studies report that between **48% and 64% of patients** in opioid agonist therapy (OAT) samples live with chronic pain.[35-39] In some people, the pain began before the OUD,[40] and OUD may develop in the context of a medical prescription[41] or self-medication.[42] In other cases, the chronic pain problem develops after the onset of the OUD.[40,41] Substance use is associated with a higher risk of accidents[42,43] and a poorer recovery in the event of injury.[43] In all cases, people suffering from a concomitant opioid use disorder and chronic pain are at risk of being under-diagnosed, insufficiently treated,[40,44–46] and stigmatized.[47]

Common sociodemographic characteristics

OUD is often associated with encounters with the criminal justice system, interpersonal problems, and unstable employment.[48] Numerous studies report that, on admission to treatment for OUD, the **majority of patients** are **men** with an average **age between 30 and 40**. Housing instability affects a significant percentage of people with OUD.[49] Conversely, **more than half (57.6%) of the people** identified in 2022 in Québec as experiencing visible **homelessness** had a substance use disorder.[50]

Many faces of OUD

In recent years, a number of studies have shown the **emergence of new profiles** of people with OUD. In particular, the problems traditionally associated with marginalized urban populations who use heroin are now seen among the **middle class populations living outside of urban centres** who use pharmaceutical-type opioids.[51] In Québec, recent studies have identified that different profiles of people have diverse service needs. This work highlights the fact that people with multiple co-morbidities and social vulnerabilities believe that it is crucial for OUD treatment services to also respond to their basic needs (e.g., food, housing). In addition, people who have developed OUD after receiving a

medical prescription for opioids to relieve their pain have stressed the importance of raising awareness of available addiction services to avoid breakdowns in service delivery.[52]

Treatment with opioid agonists: background

History of OUD treatment in Québec

In Canada, **methadone** was first used to treat OUD in 1959. The first recorded methadone treatment program dates to 1964 and was implemented in Ontario. The provision of methadone treatment continued to expand over the following decades. In 1972, there were 23 methadone treatment programs in Canada and, in 1999, an estimated 12,000 people were receiving methadone-based OAT.[53] Since then, the expansion of treatment options for OUD resulted in **buprenorphine-naloxone** being approved for use in Canada in 2007[54] at the same time that other drugs were introduced, including **slow-release oral morphine** (covered by Health Canada for OUD since 2014),[2] **injectable hydromorphone** (approved in 2019 for severe opioid use disorders), and **diacetylmorphine** (added to the federal government's List of Drugs for an Urgent Public Health Need).[55] In addition, since 2018, it is no longer necessary for a practitioner to obtain an exemption from Health Canada to prescribe methadone.[56]

In Québec, the first public OAT program using methadone was set up in 1986 at the Centre de recherche et d'aide pour narcomanes (CRAN) through support from Dr. Pierre Lauzon. CRAN is a leader in the field of OUD. This organization helped extend treatment services, developed partnerships with other institutions such as the CHUM and the Jewish General Hospital, and supported prescribers in the community.[57]

Despite the expansion of treatment options and the extension of OAT services, many persons with OUD **are still not accessing the continuum of care.**

Access to OUD treatment in Québec

The utilization rate for OUD treatment in Québec is unknown. In 2016, the utilization rate in **Montréal** was estimated at **44%.**[49] To reach a threshold comparable to those in France and Switzerland,[C] a utilization rate of 80% is a potential target. For **Québec as a whole,** data from the *Système d'information clientèle pour les services de réadaptation dépendances* (SIC-SRD) indicate that in the period from April 1, 2021 to March 31, 2022, **699 people** received an initial prescription for opioid agonist therapy (OAT) in an addiction rehabilitation centre (*Centre de réadaptation en dépendance,* CRD). As of March 31, 2022, there were 120 people on Québec's waiting list for access to a first OAT prescription in a CRD. That same year, 927 people had access to an initial professional service (e.g., from a psychosocial professional or a nurse) in a CRD. By the end of the year, there were 92 people on waiting lists for access to an initial professional service in a CRD. In 2021–2022, the average waiting time for an initial OAT prescription was **27 days,** and the median waiting time was **14 days.**

C OAT utilization was estimated at 87% in France in 201959 and in Switzerland in 2018.[60]

Effectiveness of OAT

Several studies document the **effectiveness of OAT with methadone and buprenorphine/naloxone** in terms of treatment retention, stopped or reduced illicit opioid use, reduced mortality and morbidity, and reduced risk of contracting HIV and hepatitis C among people who inject opioids.[2] Although there is currently less high-quality data available on the use of **slow-release oral morphine** for OUD treatment, the available evidence suggests that this option provides similar benefits.[2]

Several studies have also documented the effectiveness of **injectable OAT** (with diacetylmorphine or hydromorphone) in terms of retention in treatment, reduced heroin use, reduced criminalized activity and, possibly, lower mortality rates.[58]

The United Nations Office on Drugs and Crime [61] reports that, for the treatment of opioid use disorders, OAT:

Halves all-cause and drug-related mortality among people with opioid dependence

Halves HIV infection risks by reducing injecting frequency and needle-sharing

Increases linkage to, and retention on HIV antiretroviral therapy (ART) and enhances viral suppression

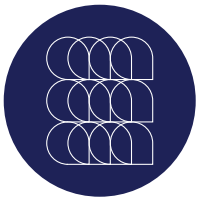
Halves the risk of HCV infection

Improves overall physical and mental health and well-being

Reduces crime and enhances social integration and functioning

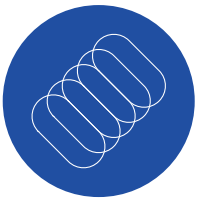
STRUCTURE OF THE QUÉBEC CLINICAL GUIDE ON SUPPORT FOR PEOPLE LIVING WITH OPIOID USE DISORDER

This guide is organized around six main themes:



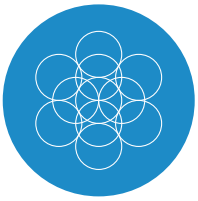
Chapter 1. Intervention philosophy

The preferred intervention philosophy proposed in Chapter 1 is based on ethical principles and values such as solidarity and benevolence, as well as clinical approaches such as harm reduction and trauma and violence-informed care. It applies to persons of all ethnic, cultural, and religious backgrounds; of all sexual orientations and gender identities; of all socioeconomic backgrounds; and of all ages and health conditions; without exception and without discrimination.



Chapter 2. Intake, safety, and an appropriate assessment

The assessment process proposed in Chapter 2 involves how the person is greeted and received, the diagnosis of their OUD, an overall assessment, and the provision of essential harm reduction supplies.



Chapter 3. Substance replacement therapy: collaborative selection and prescription

The choice of which drug to prescribe is based on a decision-making cascade that draws on the most recent scientific data as well as dialogue with the patient. Chapter 3 proposes a series of tools for making an informed choice of an OAT. It covers all the drugs that can be prescribed to treat OUD, including oral and injectable formulations, and safer supply.

Chapter 4. Essential OAT services

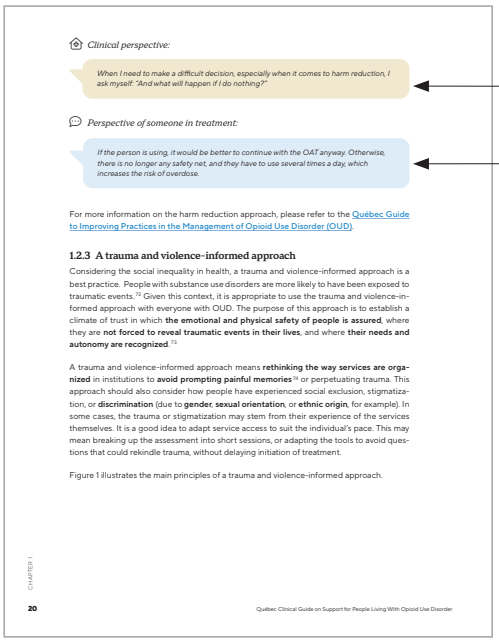
This chapter presents the types of services that can be offered to meet the individualized needs of persons with OUD, depending on the intensity of services required.

Chapter 5. Support, continuity, and the therapeutic relationship

The follow-up of a person in treatment for OUD is part of a long-term therapeutic relationship that is based on flexibility and respect for their autonomy. Chapter 5 suggests tools for providing flexible, reflective support.

Chapter 6. Professional roles and responsibilities in the organization of services

Continued follow-up for a person in treatment for OUD involves addressing multiple needs and ensuring continuity of care. Chapter 6 suggests building on collaboration, a clear division of professional roles, and responsibilities in the service organization, and skills development.



Clinical perspective:

When I need to make a difficult decision, especially when it comes to harm reduction, I ask myself: "And what will happen if I do nothing?"

Perspective of someone in treatment:

If the person is using, it would be better to continue with the OAT anyway. Otherwise, there is no longer any safety net, and they have to use several times a day, which increases the risk of overdose.

For more information on the harm reduction approach, please refer to the Québec Guide to Improving Practices in the Management of Opioid Use Disorder (OUD).

1.2.3 A trauma and violence-informed approach

Considering the social inequality in health, a trauma and violence-informed approach is a best practice. People with substance use disorders are more likely to have been exposed to traumatic events.[72] Given this context, it is appropriate to use the trauma and violence-informed approach with everyone with OUD. The purpose of this approach is to establish a climate of trust in which **the emotional and physical safety of people is assured**, where they are **not forced to reveal traumatic events in their lives**, and where **their needs and autonomy are recognized**.[73]

A trauma and violence-informed approach means **rethinking the way services are organized** in institutions to **avoid prompting painful memories**[74] or perpetuating trauma. This approach should also consider how people have experienced social exclusion, stigmatization, or **discrimination** (due to **gender**, **sexual orientation**, or **ethnic origin**, for example). In some cases, the trauma or stigmatization may stem from their experience of the services themselves. It is a good idea to adapt service access to suit the individual's pace. This may mean breaking up the assessment into short sessions, or adapting the tools to avoid questions that could rekindle trauma, without delaying initiation of treatment.

Figure 1 illustrates the main principles of a trauma and violence-informed approach.

CHAPTER 1

20

Québec Clinical Guide on Support for People Living With Opioid Use Disorder

This guide contains a series of "Perspectives" bubbles from the expert consultation process. They highlight the expertise of individuals involved in the development of the guide.

Method used to design the guide

This guide has been prepared using the following resources:

- Recent clinical guidelines in the field of OUD treatment
- Consultations with five professional orders and three professional or peer groups
- Consultations with 12 experts with lived/living experience and 17 clinical experts
- The support of a steering committee

Recent clinical guidelines

The information in this guide is based on data from recent Québec and Canadian clinical guidelines (published by the Collège des médecins du Québec, the Institut national d'excellence en santé et en services sociaux, the Canadian Research Initiative in Substance Misuse, the Équipe de soutien clinique et organisationnel en dépendance et itinérance, and the British Columbia Center on Substance Use) as well as on the contents of a course, given by the Institut national de santé publique du Québec, on an interdisciplinary collaborative approach to treating opioid use disorder *(Traitement du trouble lié à l'utilisation d'opioïdes : une approche de collaboration interdisciplinaire)*. The writing of this guide was also supported by grey literature and journal articles.

Professional orders and groups of professionals or peers

The following associations were consulted as we developed this guide; they commented on the contents and confirmed its validity: the Collège des médecins du Québec, the Ordre des pharmaciens du Québec, the Ordre des infirmières et infirmiers du Québec, the Ordre des infirmières et infirmiers auxiliaires du Québec, the Ordre des travailleurs sociaux et thérapeutes conjugaux et familiaux du Québec, the Association des intervenants en dépendance du Québec, the Association Québécoise pour la promotion de la santé des personnes utilisatrices de drogues, and Méta d'Âme. These organizations validated specific aspects of the guide in their areas of expertise.

Consultations with experts[D]

We consulted 11 people with lived/living knowledge of OUD, as well some of their family members and/or friends, to ensure that their views and experience would be represented in this guide. These experts came from four different regions of Québec.

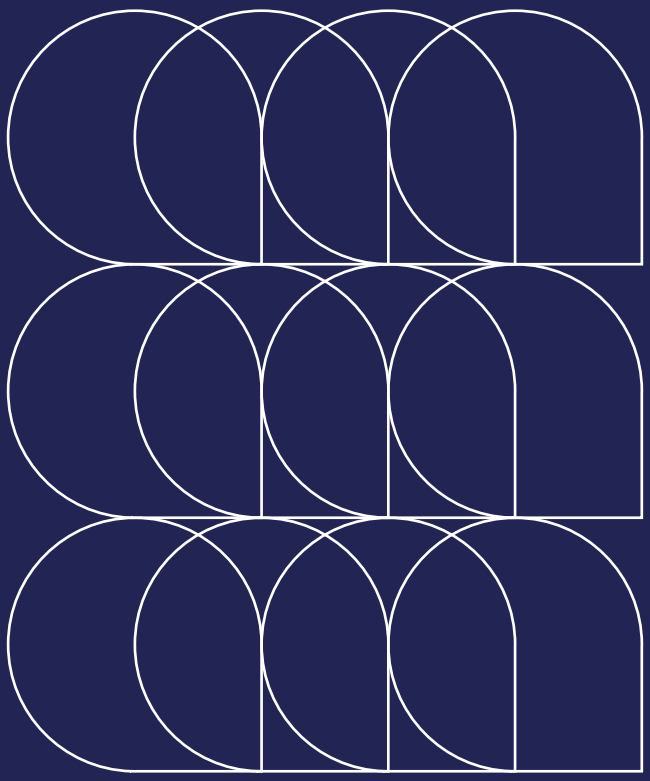
D The "Perspectives" bubbles in this guide grew out of the expert consultation process. They provide the points of view of representative individuals who have experienced OUD, their family members and friends, and expert clinicians.

Fourteen clinicians with expertise in OAT (physicians, nurses, social workers, and pharmacists) from several regions of Québec were consulted to advise and support the writing team as it developed the guide, to direct the team to relevant sources of information, and to validate the guide's content. An expert in clinical ethics was also consulted.

Steering committee

The entire process was overseen by a steering committee made up of the writing team, researchers, and a representative of the Ministère de la Santé et des Services sociaux.

CHAPTER 1



Intervention philosophy

Chapter 1. Intervention philosophy

This guide is based on an intervention philosophy that can be adapted to all contexts, care settings, and individuals. The authors recognize the intersectional nature of discrimination against persons with OUD and the structural stigmatization they face. At the same time, this guide proposes values that apply to people of all ethnic, cultural, and religious backgrounds, sexual orientations and gender identities, socio-economic backgrounds, ages, and health conditions, without exception and without discrimination. The philosophy proposed herein is particularly relevant when offering care and services to people who have been marginalized, excluded, or have experienced biopsychosocial vulnerability. Many persons with OUD have a history of trauma, and the care and services offered must avoid resurfacing or perpetuating such trauma. The proposed intervention philosophy is based on principles, ethical values, and clinical approaches. They are presented below and illustrated through examples provided by individuals who have received OAT in the past.

1.1 Ethical principles and values

The administration of care and services to persons with OUD is underpinned by principles and values such as justice and equity, integrity and dignity, solidarity, autonomy, benevolence and humility, as well as by the ethical principle of vulnerability. These principles and values are defined in the Québec Guide to Improving Practices in the Management of OUD.[3]

What does it say in the Act respecting health services and social services*?*

Support for someone living with OUD goes well beyond prescribing an OAT; it represents an opportunity to create a bond and make the person feel welcome. Recall that the ***Act respecting health services and social services*** sets out requirements for the provision of care and services: interventions must reduce mortality and morbidity, act on the determinants of health and well-being, promote the health and welfare of individuals, and "[reduce] the impact of problems which threaten the balance, fulfilment or autonomy of users." The person receiving services must "be treated… with courtesy, fairness and understanding, and with respect for his dignity, autonomy, needs and safety" and participate in their care and services. The services provided must make it possible to "[attain] comparable standards of health and welfare in the various strata of the population and in the various regions" and "ensure that services are accessible on a continuous basis." "[Respect] for the user and recognition of his rights and freedoms must inspire every act performed in his regard."[62]

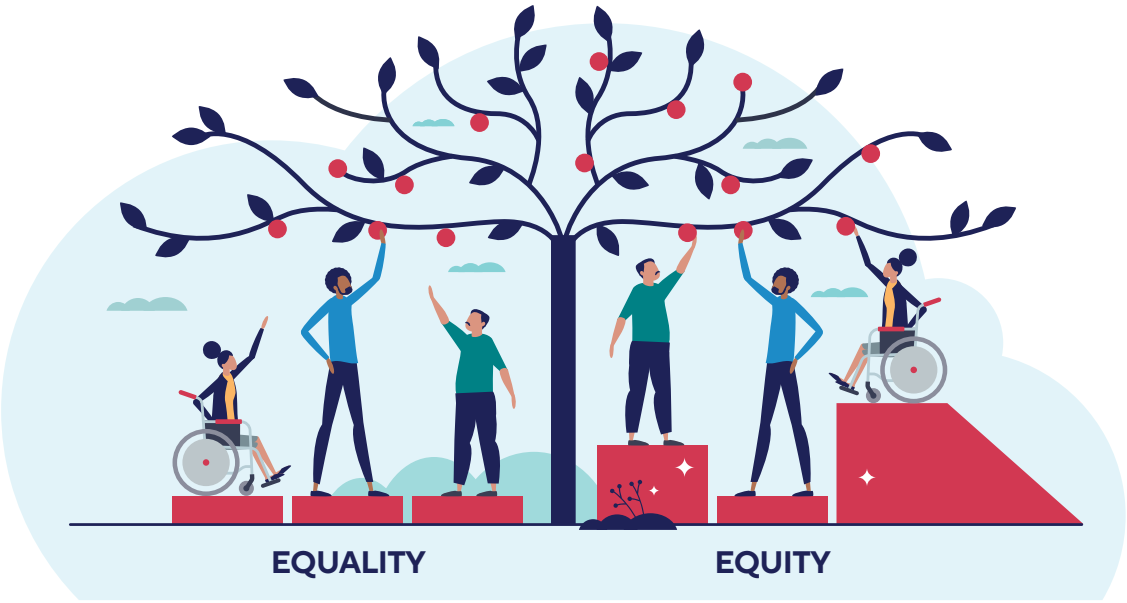
Fairness and equity

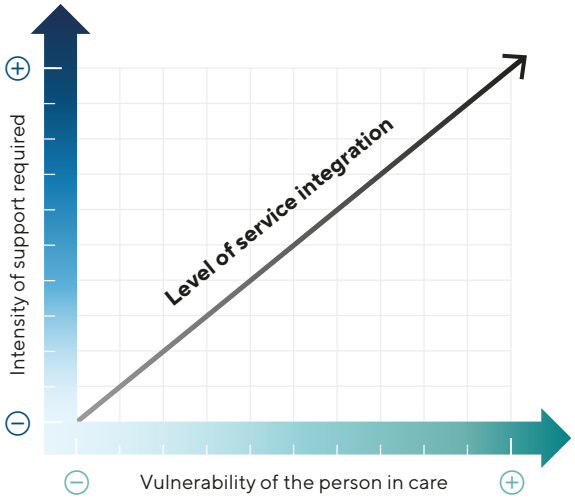
What does this mean for the provision of services to persons with OUD?

In OAT, a fair and equitable provision of services ensures that the appropriate constellation and level of services is provided to each patient, so that everyone can achieve their self-identified goals. Depending on the individual, achieving the their goals may require different means. The more vulnerable a person's situation, the more their services will need to continuous and flexible to address that individual's unique needs and goals. For example, some people are able to travel to appointments, while others do not have the necessary resources or abilities to do so (e.g., transportation, dependent children, cognitive abilities). Similarly, some people have stable housing and a telephone, while others make lack stability and resources. To provide individualized service, all people are welcomed upon arrival, and appointments are not strictly necessary. In this way, clinicians can help those individuals who do not have the same resources as others to achieve the same level of health, welfare, and functioning.

💬 *Perspective of someone receiving treatment:*

> *It's hard for people who don't have an address to access services.*





The graph on the left illustrates how the support intensity that is offered can be adjusted in response to the degree of vulnerability of someone's situation in order to achieve equity. Adopting this perspective allows people with multiple vulnerabilities and complex physical and mental health problems to receive intensive, integrated support from multidisciplinary teams and partners. These individuals may require more time and support, as well as considerable flexibility and adaptability in the form of personalized services.

Autonomy

What does this mean for the services provided to persons with OUD?

OAT should be initiated as soon as possible to relieve withdrawal symptoms and promote informed decision-making. Providing services that encourage autonomy in OAT means consulting the person, giving them the relevant information, and ensuring that they have understood the information and their rights. In this respect, clinicians can use and distribute the Opioid Use: My Treatment, My Choices. Dialogue is essential for the person and the partner care team to identify the issues and arrive at a care framework that suits all concerned. Autonomy also implies that the person has the right to take risks, based on their priorities, which are not necessarily the same as those of the care team. For this reason, the partner team provides a flexible framework and supports the person's autonomy based on their goals. Not everyone being followed by the team has the same goals, and they are not all necessarily seeking abstinence. Imposing a rigid framework would run the risk of forcing the person to be less than transparent, for fear of losing their access to care.

Perspectives of persons receiving treatment:

For persons on OAT, take-home doses can help support autonomy.

People often cut ties with their loved ones because they can't be themselves. It's important to avoid letting the same thing happen with their professionals.

It would be great if punitive measures could be removed or changed, given that we are adults who are asking for medication, just like any other patient.

Integrity and dignity

What does this mean for the services provided to persons with OUD?

Persons with OUD have the right to take risks, and the caregiver's role is to propose mitigating measures (in particular, by handing out essential harm reduction supplies and providing relevant, accurate, and up-to-date information). Providing services that promote integrity and dignity in OAT means showing respect, without judgment, so that they can be themselves. Regardless of their social status, background, or values, people are to be treated with respect. In this context, the caregiver's role is to propose various paths that are consistent with the individual's realities and wishes (while ensuring that they are feasible), and to respect and accept the decisions they make (within the applicable ethical limits).

Perspectives of persons receiving treatment:

> *The treatment contracts that people have to sign, and the way they're worded... They don't have that for other diseases. This shouldn't be. We should be received just like anyone else.*

> *I've already felt that the caregivers were thinking: "Not her again. Of course, she's taking risks, so she should have expected to find herself in this situation."*

> *The first time you walk into a doctor's office, you're walking on eggshells. You feel like you're at their mercy. You get the impression that your fate is in their hands.*

Solidarity

What does this mean for the services offered to persons with OUD?

Providing services that promote solidarity in OAT means offering the person the same care and services that you would want to receive yourself. The therapeutic relationship is a privileged one, and the bond is maintained through unconditional acceptance.

Perspective of someone in treatment:

> *Patients need to be humanized. You should think that this person could be your child, or a family member. Recovery requires respect and dignity. Try not to think of the person as just a drug addict.*

Caregiver's benevolence and humility

What does this mean for the services provided to persons with OUD?

Providing services that encourage benevolence and humility in OAT means offering people the conditions they need to be autonomous. These conditions are created by being a good listener, recognizing their experience and abilities, providing support that is adapted to their pace, refusing to take a paternalistic or directive approach, acknowledging the other

person and their needs, and adopting a gentle, warm, and humane approach. A trauma and violence-informed approach is characterized by this benevolence and humility.

Ethical principle of vulnerability

What does this mean for the service offering for persons with OUD?

A service guided by vulnerability in OUD means offering people the conditions they need to exercise their autonomy, while at the same time maintaining a back-up safety net. If someone is incapable of giving consent to care and would refuse treatment, without understanding the damaging implications of such a choice on their prognosis of survival, then compassionate interventions could be put in place to protect them. Furthermore, judgment must be exercised when implementing protective measures (e.g., Act P-38), as they can have serious consequences on the bond of trust. The *Protéger* fact sheet (in French only), produced by the *Centre de recherche de Montréal sur les inégalités sociales, les discriminations et les pratiques alternatives de citoyenneté* (CREMIS), has some suggestions for further reflection on vulnerability and aptitude.

Perspectives of persons receiving treatment:

> *You need to acknowledge that the person knows himself and his needs.*

> *You mustn't be condescending, and you have to spend some time with the person.*

1.2 Clinical approaches

1.2.1 Accounting for social inequalities in health

The Rio Political Declaration on Social Determinants of Health states that "[h]ealth inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health."[63] It should be noted that, when it comes to health literacy, 66% of Quebecers aged 16 and over have skill levels below what is considered desirable.[64] In addition, the negative consequences of opioid use are strongly associated with living in an economically disadvantaged area, where there is a concentration of stress and occupational and residential instability.[65]

"Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health."

"These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health."
(Rio Political Declaration on Social Determinants of Health, 2011)

Similarly, the structural stigmatization attached to people who use substances reflects the inequalities embedded, often unwittingly, in our society and organizations.[66] Many people with OUD are **marginalized**. **Marginalization** falls within **the social determinants of health** and can influence access to health care and treatment outcomes. In clinical practice, the **principle of equity** is applied to **reduce social inequalities and barriers to treatment**, with a goal to distribute treatment between individuals fairly and in a spirit of solidarity. There are certain obstacles that are commonly encountered by people wishing to receive treatment for OUD, including the associated costs, the treatment's availability and proximity, access to information about the treatment, the conditions of treatment (rules and restrictions), and the relationship with healthcare providers.[67]

What does this mean for OAT?

- ★ Consider the impact of social determinants and social inequalities, for example, in economic or relational terms.
- ★ Reduce barriers to access to treatment for these people (e.g., transportation, income, rigid treatment framework). In this respect, Projet Barrières (the Barriers project, in French only) has a six-step approach for reducing barriers to access and retention in OAT services (see section 5.7 for more information on barriers to treatment).
- ★ Establish a dialogue with the person so that you can work together on evaluating ways to facilitate access and retention in treatment (e.g., reminders, arrangements for volunteer transportation, arrangements for access to housing, and teleconsultations).
- ★ Provide relevant, accurate, up-to-date, and easy-to-understand information so that people can learn about their treatment and make choices based on their values and priorities.

Perspective of someone in treatment:

> *It's important for people to be able to make free and informed choices, but everyone needs to understand the advantages and disadvantages in terms of their objectives. Whether the options suit their situation.*

Applying the **equity principle** to help **reduce social inequalities in health** means taking into account people's experiences with being marginalized. With this in mind, the intervention philosophy favoured in this guide recognizes all experiences of **marginalization**—that can be linked, for example, to **gender, sexual orientation**, and **ethnic origin**—when analyzing the social determinants of health.[68]

Some people experience more obstacles related to social determinants of health. The principle of equity means considering social inequalities in health and adapting the quantity, intensity, and location of services so that everyone receiving care can achieve their self-identified goals. In this respect, the wheel of privilege and power illustrates the points of intersectional power and allows us to become more aware of the structures that perpetuate power imbalances.

Clinical perspective:

> *To show solidarity with the people who receive our services, we need to recognize that the main source of the harm they experience is the context in which we live. It is a context characterized by inequality, a housing crisis, stigmatization, an overdose crisis, the criminalization of substances... Showing solidarity also means feeling personally engaged in these social issues, and taking their impacts into account in the way we organize our services and take action.*

1.2.2 Harm reduction and the holistic vision

The harm reduction approach is based on humanism and pragmatism. Under this approach, clinical interventions are guided by a **consideration of risks and benefits** in response to a hierarchy of realistic goals identified by the person in treatment. The interventions are designed to encourage respect and **participation by the person in the treatment process**.[69,70]

The harm reduction approach helps **improve the quality of life of the person in treatment** by offering **services suited to their needs** from a **holistic perspective**. **This approach can thus reduce and prevent risks without requiring abstinence**.[3] In short, the purpose of this approach is to move the person toward their best possible biopsychosocial state at any given time, depending on their goals. Harm reduction is a dynamic and continuous process toward better overall health and well-being.

At the clinical level, the implementation of the harm reduction approach can be based on a **warm, respectful, and non-stigmatizing welcome**, the establishment of a **therapeutic alliance, respect for the person's goals**, the implementation of a **treatment plan tailored to the person's various needs** (e.g., physical, emotional, cultural),[3] and a trauma and violence-informed approach.

The concepts of **autonomy** and **dignity** also mean that the person **can choose to take certain personal risks**. As a result, clinicians are called upon to **manage risks** daily and try to achieve a **balance** between competing issues (e.g., professional responsibility, the person's autonomy and dignity, personal safety).

What does this mean for OAT?

- ★ Maintain a reciprocal and egalitarian therapeutic relationship, based on dialogue and trust, between the members of the team and the person in treatment.
- ★ Accept that the person in treatment may make choices that carry certain risks, encourage informed choices, and offer risk mitigation measures (harm reduction strategies).
- ★ Maintain the therapeutic relationship and respect the person's autonomy through dialogue.
- ★ Avoid imposing a rigid framework, which could force the person to be less than transparent out of fear of losing access to care or lead the person to abandon treatment altogether.
- ★ Offer the person various ways to reduce the risks and consequences and let them decide which one to try first.
- ★ Aim to take a series of small steps.
- ★ Accept the person as they are in their personal development trajectory.

The above recommendations speak to the "dignity of risk." An individual's dignity manifests through their ability to be autonomous. Preventing individuals from taking risks affects their dignity. The dignity of risk means allowing an individual to take a risk with the aim of improving personal growth and quality of life.[71] In terms of ethics, this approach validates risk-taking, so it can help caregivers resolve any issues around their professional and human responsibilities.

Clinical perspective:

> *When I need to make a difficult decision, especially when it comes to harm reduction, I ask myself: "And what will happen if I do nothing?"*

Perspective of someone in treatment:

> *If the person is using, it would be better to continue with the OAT anyway. Otherwise, there is no longer any safety net, and they have to use several times a day, which increases the risk of overdose.*

For more information on the harm reduction approach, please refer to the Québec Guide to Improving Practices in the Management of Opioid Use Disorder (OUD).

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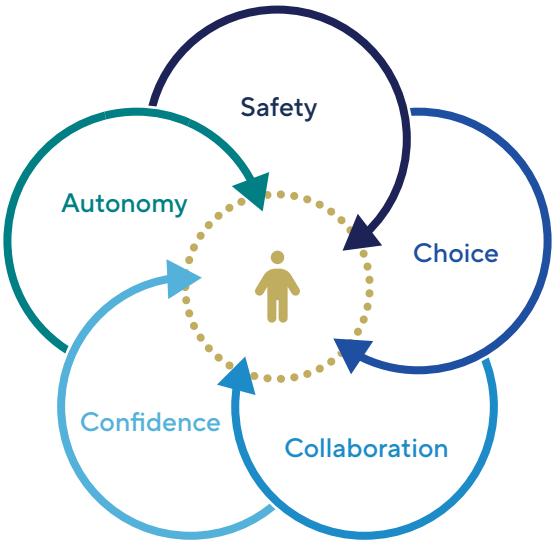
Considering the social inequality in health, a trauma and violence-informed approach is a best practice. People with substance use disorders are more likely to have been exposed to traumatic events.[72] Given this context, it is appropriate to use the trauma and violence-informed approach with everyone with OUD. The purpose of this approach is to establish a climate of trust in which **the emotional and physical safety of people is assured**, where they are **not forced to reveal traumatic events in their lives**, and where **their needs and autonomy are recognized**.[73]

A trauma and violence-informed approach means **rethinking the way services are organized** in institutions to **avoid prompting painful memories**[74] or perpetuating trauma. This approach should also consider how people have experienced social exclusion, stigmatization, or **discrimination** (due to **gender**, **sexual orientation**, or **ethnic origin**, for example). In some cases, the trauma or stigmatization may stem from their experience of the services themselves. It is a good idea to adapt service access to suit the individual's pace. This may mean breaking up the assessment into short sessions, or adapting the tools to avoid questions that could rekindle trauma, without delaying initiation of treatment.

Figure 1 illustrates the main principles of a trauma and violence-informed approach.

Figure 1. The trauma and violence-informed approach



The trauma and violence-informed approach aims to establish a climate of trust where people feel safe, where they are not forced to reveal their traumatic past, and where their needs and autonomy are recognized.[73]

What does this mean for OAT?

- ★ **Raising awareness:** The team members (e.g., clerk, secretary, attendant, nurse, social worker, pharmacist, physician) understand the various forms of trauma, their prevalence, and their impact on individuals, families, and communities.
- ★ **Emotional, physical and cultural safety:** The professionals reassure the person that they are not obliged to reveal any personal information that would make them feel uncomfortable. The individual's emotional and physical safety are paramount. This safety zone is all the more important because people who have experienced trauma or violence may quickly slip into feeling they are in danger, or they may feel that way all the time. For such individuals to access services and participate fully in their treatment, they need to feel safe and secure.
- ★ **Choice, collaboration, and trust:** Clinicians and the person in treatment work together to achieve the person's desired goals, without imposing unwanted services. Clinicians present their role simply and clearly, so that the person can direct the follow-up according to their needs and goals.
- ★ **Strengths and abilities:** Clinicians build on the person's strengths to support them toward achieving their treatment goals and to help build their self-esteem.

More detailed information on trauma and violence-informed care are available in a fact sheet provided by the Canadian Centre on Substance Abuse (available in English and French).

Other resources that clinicians may find useful in learning more about trauma and violence-informed care include:

The **Trauma-Informed Practice & the Opioid Crisis — A Discussion Guide for Health Care and Social Service Providers**, published by The Centre of Excellence for Women's Health, explains how trauma-informed practice works as a response to the opioid crisis, particularly for persons who have experienced gender-based violence;

The publication **SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach** provides a framework to support organizations in providing trauma-informed services;

Trauma-Informed Care, an online course, provides a good understanding of the principles and functions underlying a trauma-informed approach;

Traumas complexes et populations vulnérabilisées : redéfinir nos pratiques d'accompagnement (CREMIS) (complex trauma and vulnerable populations: redefining our support practices, a course in French only).

Perspectives of persons receiving treatment:

Allowing people to talk about their experiences can be therapeutic when the time is right and a relationship of trust has been established.

You don't have to tell everything in order to get treatment; that shouldn't be required.

Trauma, it's hard just thinking about it, let alone talking about it...

The first meeting is not a good time to talk about trauma. The relationship is new, and you'll leave with an open wound.

A stable team is an important part of creating a climate of trust in which trauma can be discussed.

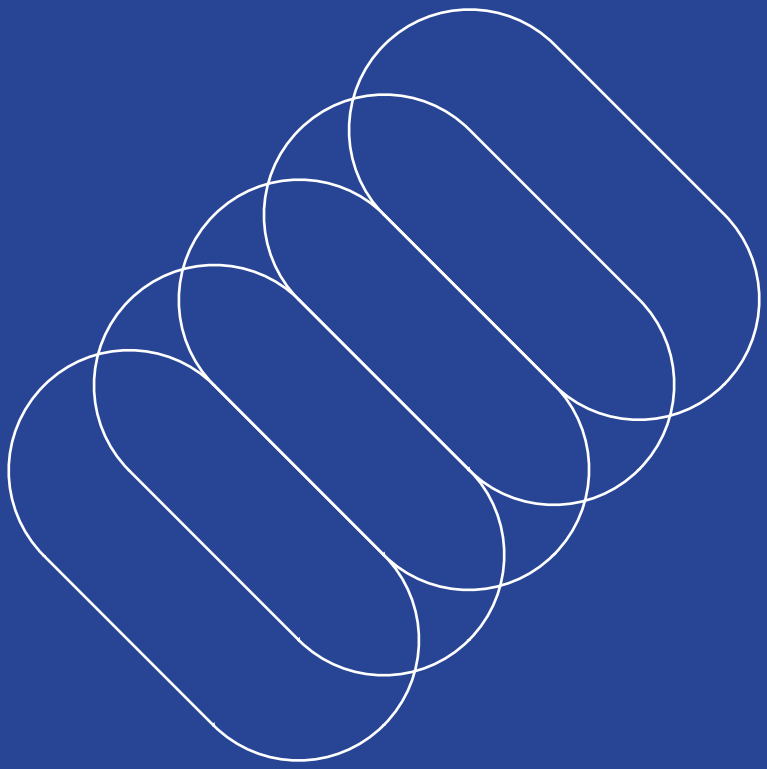
When discussing trauma with a patient, you need to make sure you have some time or else a safety net, such as another person present, to continue the discussion.

1.3 Intervention philosophy: a checklist

By applying the intervention philosophy proposed in this guide, people with OUD can be supported through appropriate and respectful services, regardless of their ethnic or cultural origin, sexual or gender identity, social status, or any other biopsychosocial characteristics, based on the following dimensions:

- **Fair and equitable services** ensure the right intensity of services for each individual, so that everyone can strive for the their desired results;
- **Respect for autonomy** consists of supporting informed decision-making by placing the person and their interests at the centre of care, giving them relevant information, and ensuring that they have understood it;
- **Respect for integrity and dignity** means receiving people with respect and without judgment, so that they can be themselves;
- **Solidarity** means offering the person the same care and services that you would wish for yourself;
- **Benevolence and humility** involve creating the conditions necessary for people to be able to exercise their autonomy (e.g., by listening, recognizing experience and abilities, respecting each person's pace, rejecting any paternalistic or directive approach, being gentle);
- Taking the **principle of vulnerability** into account means offering the person the conditions needed to exercise autonomy while maintaining a safety net in case it is needed (e.g., someone who is not capable of consenting to care);
- Accounting for the impact of **social determinants, social inequalities**, and structural stigmatization helps **reduce barriers** to access and improves treatment retention;
- The **harm reduction** approach involves prioritizing the therapeutic relationship and accepting that the person makes choices that carry risks, while promoting informed choices and risk mitigation measures; and
- A **trauma and violence-informed approach** allows the person to direct the clinical interaction based on their needs and choices, in a context characterized by trust, safety, and collaboration.

CHAPTER 2



Intake, safety, and an appropriate assessment

Chapter 2. Intake, safety, and an appropriate assessment

Someone presenting with OUD who is not receiving OAT is at high risk of overdose.[75] To ensure the safety of persons with OUD, rapid initiation of pharmacological treatment should be available. The sequence of first contact, assessment, and admission to OAT should be completed as quickly as possible, ideally on the same day as the assessment.[3] The available data on initiation of OAT in emergency departments show that the commitment rate is higher when treatment is started on the day of the initial assessment.[76] In addition, rapid access to OAT is a determining factor in the recovery process for people who would like to access to treatment for OUD.[52]

Beginning with the very first contact, the person should be warmly received by all staff members (professionals and support staff). An assessment appointment should be arranged and take place as quickly as possible, ideally on the same day for anyone in a vulnerable situation.[3] Rapid access mechanisms may be needed to ensure priority treatment for certain populations, particularly pregnant or breastfeeding person and parents of young children.[7] Clinical judgment is still required to speed up access for other populations, including people whose lives are endangered by risky behaviour (e.g., recent overdoses) and those with an unstable physical or psychiatric condition.[77]

> In Ontario, the quality standards recommend that persons with OUD should have access to treatment within at most three days.[78] Meeting this deadline depends in part on the willingness of clinicians to achieve this end, but above all on the organization of services that make such rapid treatment possible. Responsibility is therefore shared between those who have clinical power and those with organizational power, at the executive and administrative levels.

Being warmly received and gaining quick access to OAT are essential, not only on first contact, but at every request for services. In fact, **treatment interruptions during OAT are frequent**, due to many different circumstances (e.g., economic, social, and personal causes). In a chronic care model (or a long-term services model[79]), interruptions of treatment by the person receiving care should never be considered a failure or erode the therapeutic relationship. Conversely, when someone stops treatment, the barriers to retention (see Section 5.7) should be examined and reduced as much as possible to encourage a resumption of treatment. **When someone wishes to resume treatment, the time between the request and resumption of treatment should be as short as possible.**

OAT is a long-term treatment. People receiving OAT may go back and forth between resuming and ceasing active or occasional drug use. The partner care team will endeavour to adjust the follow-up and treatment to meet each individual's needs. The team will also be

available to quickly resume support after treatment has been discontinued, at the person's request.

2.1 Welcoming, listening and adapting the admission process

The *Act respecting health services and social services* stipulates that "the person requiring services is the reason for the very existence of those services" and that "the user must be treated, in every intervention, with courtesy, fairness and understanding, and with respect for his dignity, autonomy, needs and safety." [62] So when people ask for services, they should feel welcome. A warm attitude and a smile can make them want to continue along this path.

Solidarity **Benevolence** **Humility**

This first contact will have an impact on whether the treatment process continues. For this reason, the person should be welcomed and listened to as part of the admission process, and the process should be adjusted to seize every opportunity and avoid red tape. [77]

Rapid and simplified access to OAT should be adapted to the person's reality. For example, the assessment can be spread over several meetings to provide shorter appointments, where the most important aspects of initiating OAT will be prioritized. [3]

At this stage, priority should be given to carrying out the steps described in Table 1.

Table 1. Essential steps in prescribing OAT

Essential step	Clinical considerations
☑ Assess drug use	The use profile is helpful for: • Making an OUD diagnosis • Assessing an initial dose for OAT • Identifying the risks (e.g., overdoses, interactions, infections) • Suggesting risk reduction strategies
☑ Making an OUD diagnosis	The DSM-5 diagnostic criteria require that a person presents with OUD symptoms over a continuous period of at least 12 months. However, the 11th version of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) states that the diagnosis can be made if opioids are used continuously for at least three months. In the final analysis, clinical judgment is crucial when analyzing the concepts of urgency, severity, and dangerousness, and when qualifying the criteria.
☑ If possible, carry out urine screening for opioids to ensure that the person is currently taking opioids	Urine tests are particularly relevant when the prescriber has any doubts about whether the person is indeed using opioids. However, the time required to obtain the results of a urine test may lead to delays in initiating OAT. For this reason, it is important to bear in mind that any delay in initiating OAT may: • Damage the bond of trust with the person; • Increase the person's risk of vulnerability and overdose. In addition, the standard screening tests have limitations and may not detect fentanyl and its analogues (see the Health Canada Safety Alert). The tests may give false positives or false negatives.[4]
☑ Carry out a pregnancy test, if necessary	The pregnancy test should not delay the start of OAT. It should be initiated anyway, particularly if the person is pregnant.
☑ Consult the Québec Health Record (QHR) to check for drug interactions	If the person has withdrawn from the QHR, it is a good idea to discuss their reasons and the risks associated with this decision.
☑ Select an OAT in consultation with the person (based on their goals)	The Make an Informed Choice tool can be used to enter into a discussion of the advantages and disadvantages of the various OATs. The chart on the continuum of treatment options allows clinicians to engage the person in a conversation about the process and logistics involved in the induction period and the selected drug. Clinicians can consult the summary table of OUT pharmacological treatments to compare the drugs in terms of their pharmacology, contraindications, advantages, etc.
☑ Prescribe OAT	A discussion of the treatment modalities (e.g., supervised or unsupervised doses) helps ensure that they are appropriate, given the person's lifestyle, and do not interfere with their stability (e.g., employment and family responsibilities).
☑ Provide the essential harm reduction supplies	Naloxone and safer injecting, safer smoking, and safer sex supplies must be offered at each meeting and must be available on site.

Who can receive a request for services?

All professionals in the partner care team (including peers) should have the skills and competencies to:

- ★ Receive someone who comes in for help and listen to their request
- ★ Adapt the assessment and admission process to better meet the person's needs
- ★ Hand out the essential harm reduction supplies

What should be done if a waiting period forces me to postpone OAT?

- ★ Take into account the fact that without OAT, the person is at risk of overdose.
- ★ Give priority to pregnant people, parents of young children, and people in very vulnerable situations.
- ★ Check for suicidal or homicidal ideations.
- ★ Start by offering psychosocial support to anyone who is interested.
- ★ Establish practical measures to maintain contact with the person until OAT is initiated.
- ★ Provide essential harm reduction supplies:
  – Naloxone and instructions on its use
  – Drug use equipment and personal protection equipment
- ★ Teach safer injection techniques, where appropriate.
- ★ Explain to the person how fentanyl detection strips are used.
- ★ Tell the person about substance analysis services.
- ★ Provide a list of the resources available in the community, including overdose prevention centres, supervised injection services (SIS), and virtual overdose prevention services (e.g.: NORS), where applicable.

Clinical perspective:

Hospitality means welcoming people who have nowhere else to go because they are ostracized, discriminated against, excluded or uprooted. How do we ensure that patients who are often excluded from receiving other services will feel at home in our organization? Being hospitable is more than just meeting physical and medical needs: it's giving the gift of hope.

2.2 Document the person's use of psychoactive substances

During the assessment, it is important to document the person's substance use (the substances used, their quantities, and the methods of administration) to determine the risks (e.g., interactions, infections) and propose risk reduction strategies. A detailed history of the person's use of various substances (e.g., alcohol, tobacco, medication) and the related disorders, an overdose history, and a history of treatment or withdrawal will help guide the interventions and the treatment.

You can use page 3 of the addiction seriousness index *(Indice de gravité d'une toxicomanie)* or the following table to get an overview of the person's substance use:

MODALITIES / SUBSTANCES	Source (street, pharmacy, other)	Method of administration (oral, smoked, snorted, injected, other)	Frequency of use (number of days, out of 7 or 30)	Quantity	Date or time of last use	Number of years of regular use
Heroin						
Hydromorphone						
Fentanyl						
Other opioids _____						
Alcohol (standard glasses[E])						
Benzodiazepines						
Cannabis						
Amphetamines						
Methamphetamines						
Cocaine, crack						
GHB						
Other						
Notes (e.g., preferred substances):						

Table inspired by the evaluation tools of the Relais program (CRAN)

Printed version

E To convert alcoholic beverages into a standard glass format: http://aodtool.cfar.uvic.ca/en/index-stddt.html

2.3 Making an OUD diagnosis

An OUD diagnosis can be made by a physician, or a nurse practitioner specialized in mental health. It is characterized by:

- Problematic use leading to impaired functioning or significant suffering;
- A series of events (at least two) within a 12-month period. [F]

Who can make an OUD diagnosis?

A physician or nurse practitioner specialized in mental health: The diagnosis of OUD can only be made by a physician, or a nurse practitioner specialized in mental health.

According to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Society (DSM-5),[48] the symptoms that may be associated with OUD include:

- Opioids taken in larger amounts or for a longer period of time than intended;
- Unsuccessful attempts to reduce or control opioid use;
- Continued use of opioids despite interpersonal or social problems caused or exacerbated by the effects of opioids.

OUD diagnostic criteria can be found in Appendix 1 of the CMQ, OIIQ and OPQ guidelines (2020),[4] on pages 48 and 49 (in French only).

What should be done when someone presents with difficulties related to opioid use but has not received an OUD diagnosis?

When someone presents with problems related to opioid use but has not received an OUD diagnosis, primary care clinicians can ask for assistance from a team of experts. These specialist teams can then establish a collaborative working relationship with the primary care treatment team.

Through this collaboration, the experts in OAT will be able to equip primary care clinicians so that they can avoid exacerbating the problem associated with opioid use and prevent OUD.

In the case of problems related to the use of prescribed opioids, please refer to section 3.4.2

F The CMQ, OIIQ and OPQ guidelines (2020)[4] specify that the physician and the nurse practitioner specialized in mental health may determine that the person has OUD, even if the symptoms have been present for less than 12 months.

2.4 Assessing the person's needs and goals

The assessment can be split into multiple sessions to suit the person's tolerance and needs. Certain items can also be prioritized to meet the person's most pressing requests (e.g., food security, accommodations, health insurance card). "The delay between the assessment and initiation of OAT should be as short as possible, and ideally the person should be able to start the pharmacological part of their treatment on the day of the assessment."[3] The practice framework proposed in the CMQ, OIIQ and OPQ guidelines (2020)[4] (in French only) recommends assessing the items listed in Table 1. The guidelines specify that the assessment may be carried out over several sessions, and that a refusal to take part in the assessments should not prevent initiation of treatment.[4]

Table 2. Assessment components according to the CMQ, OIIQ and OPQ guidelines (2020)[4]

History

- Personal and family medical history
- Infectious disease history and immunization
- In collaboration with the pharmacist, a full medication history of prescribed and non-prescribed drugs, including an assessment of adherence, taking into account all available sources of information
- Full surgical history
- Psychiatric history, including an assessment of suicide risk
- Detailed history of use of and dependence on various drugs, in particular alcohol and tobacco, or other psychotropic medications, such as benzodiazepines:
  - history of overdoses; history of previous withdrawal or detoxification programs and results obtained; quantity used of each substance
- Current state of health
- Methods of contraception used
- Assessment of the person's social situation
- Search for contraindications to the treatment
- Potentially risky behaviour, including:
  - the sharing of drug use equipment (recent or old), unprotected sexual behaviour, assessment of the risk of overdose, use in high-risk situations (e.g., driving a motor vehicle)

Physical examination

- Basic parameters, including vital signs, height, weight, and body mass index
- General appearance, including signs of intoxication and withdrawal
- Injection sites on limbs and elsewhere
- Cardiac (murmur) and pulmonary auscultation
- Signs of liver disease
- Dental health
- Nasal septum
- Skin lesions
- Gynaecological examination, where applicable

Examples of components of the mental examination (according to relevance)

- Attitude
- Psychomotor activity
- Language
- Affect and mood (depression, elation, lability, anxiety, sadness)
- Form and content of thoughts (obsessions, phobias, aggression, delirium, suicidal ideation)
- Perceptions (illusions and hallucinations)
- Higher cognitive functions (attention, orientation, memory, judgment, concentration, self-criticism)

Paraclinical examinations (depending on risk factors and condition)

- Testing for the presence of opioids and other substances in urine
- Pregnancy test for people of childbearing age
- Complete blood count (CBC)
- Serum creatinine
- Liver function tests
- HBsAg, anti-HBs, anti-hepatitis A (IgG)—vaccination if serology does not show a protective antibody
- Anti-HCV, anti-HIV after counselling and consent, if indicated
- Screening for other STIs
- ECG when using methadone, if indicated

Tools such as the addiction seriousness index *(Indice de gravité d'une toxicomanie)* and the medical withdrawal level assessment tool *(Niveau de désintoxication : évaluation par les intervenants psychosociaux : Nip-ÉP)* can also be useful guides when conducting an assessment. However, in a trauma and violence-informed approach, the tools should be used with care to maintain the person's safety, the climate of trust, and the therapeutic

alliance. With this in mind, the assessment can be spread over several meetings, according to the person's pace.

Persons with OUD may have their own treatment goals, as well as very different ideas on what constitutes recovery. For some, recovery means access to employment, going back to school, or improved interpersonal relationships. Sometimes they think of it as abstinence, or perhaps continued drug use.[52] In all cases, the INESSS suggests documenting the individual's goals in terms of their drug use (e.g., reduced illicit use, no more opioid injections, abstinence).[9] OAT is an effective treatment for reducing opioid use and keeping people in treatment. From a public health perspective, OAT has also been shown to be an effective way to reduce crime and lower mortality rates.[2] However, each person who embarks on an OAT program may have their own personal goals and motivations.

Whether the person's goals are related to use (e.g., reducing the costs associated with using substances from the illicit market, reducing withdrawal episodes), physical health (e.g., treatment of HCV, infection prevention, pain management) or their psychosocial situation (e.g., access to housing, holding onto their employment, parental responsibilities), different professionals will be involved, to varying degrees, to provide support with an approach that is consistent with such goals.

> Taking into account the person's goals and needs can help the partner team ensure optimal sharing of professional roles and identify targets for intervention, as well as promote retention in treatment.

Support for people with OUD can be seen as an exercise in meeting basic needs,[52] particularly the following:

- Physiological needs (e.g., eating, resting)
- Safety (e.g., no threats, rights, justice, care)
- Belonging (e.g., satisfying relationships)
- Self-esteem (e.g., identity, recognition, participation, reaching their full potential)
- Freedom (e.g., autonomy, self-determination)

Le processus d'évaluation constitue une occasion d'inviter la personne à nommer ses besoins, ses attentes ainsi qu'à définir les objectifs qui lui paraissent les plus urgents ou prioritaires. Cet exercice contribue au développement, en concertation avec la personne, d'un plan d'intervention individualisé.

Who can contribute to the assessment?

Physicians and nurse practitioners can:

- ✓ Perform a physical examination (e.g., injection sites, signs of intoxication or withdrawal, nasal cavities, heart murmur, stigmata of cirrhosis, skin lesions, abscesses or cellulitis, gynaecological examination);
- ✓ Request investigations (e.g., blood tests for CBC, electrolytes, creatinine, STIs; gonorrhea, chlamydia; a gynaecological examination; screening for tuberculosis, ECG for the QT interval).

Physicians and nurse practitioners specialized in mental health can:

- ✓ Assess the presence of mental health disorders and diagnose OUD.

Physicians, nurses, and nursing assistants can:

- ✓ Document family, medical, and psychiatric histories (e.g., lung disease, liver cirrhosis, STIs, infections);
- ✓ Document needs in terms of vaccinations, sexual health (e.g., contraception), diet, and sleep;
- ✓ Obtain screening for opioids with a prescription;
- ✓ Initiate/carry out a pregnancy test*;
- ✓ Initiate/carry out screening for STIs**;
- ✓ Consult the QHR for information on drug interactions.
- ✓ Assess the risk of suicide.

Pharmacists can:

- ✓ Assess a person's physical and mental condition to ensure that the medication is being used appropriately.
- ✓ Assess the risk of suicide.

Les professionnels psychosociaux peuvent :

- ✓ Assess social functioning (social workers);
- ✓ Assess psychological functioning (psychologists);
- ✓ Assess adaptive capacity (psychoeducators).
- ✓ Assess the risk of suicide.

All the professionals on the treatment team (including the patient) can:

- ✓ Document the person's drug use and its consequences (e.g., frequency, quantity, and methods of administration of each substance, signs and symptoms upon stopping);
- ✓ Document the person's risky behaviour (e.g., injection techniques, sharing of equipment, overdoses);
- ✓ Document the person's social environment (e.g., social network, income, housing situation, RAMQ, violence, legal situation);
- ✓ Provide instructions on the use of naloxone and on safer drug use;

* Graduate and nurse technicians can initiate and carry out pregnancy tests. Nursing assistants can perform pregnancy tests according to a prescription or initiate them in certain settings.

** Graduate and nurse technicians can initiate and carry out screening for STIs. Nursing assistants can screen for STIs according to a prescription.

2.5 Making contact, assessing, and admitting: a checklist

The following steps are designed to meet the priority needs of the person requesting services and to initiate OAT as quickly as possible. The overall assessment process may be spread over several meetings after the OAT prescription has been issued to accommodate the person's pace as the therapeutic alliance develops.

Reception

A professional from the team meets with and listens to the person and adjusts the admission process to suit their personal context and tolerance (e.g., is the person unwell? In a hurry? Frightened?).

Diagnosis

The physician or nurse practitioner specialized in mental health reaches a diagnosis of OUD.

Adapted Assessment

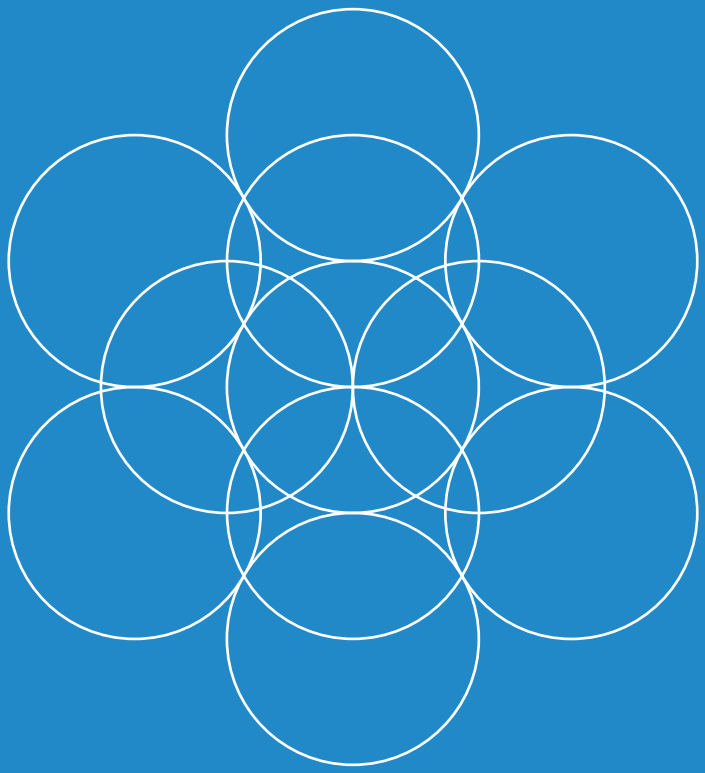
The person's immediate needs are documented. If possible, their overall situation and goals are also discussed.

Handing out essential harm reduction supplies and giving instructions on their use

Drug use equipment (plus instructions), naloxone (plus teaching), list of resources.

The initial contact is followed, as quickly as possible, by an OAT prescription. The next chapter provides considerations and decision-support tools to help persons and their prescribers make an informed choice of treatment drug.

CHAPTER 3



Substance replacement therapy: collaborative selection and prescription

Chapter 3. Substance replacement therapy: collaborative selection and prescription

Substance replacement therapy is one of the interventions offered to people with OUD. In recent years, an expanded set of treatment options for OAT has made it possible to provide better-tailored responses to the needs and goals of people seeking treatment for OUD.

3.1 Collaborative selection of a substance replacement therapy

For many people with OUD, autonomy in treatment decision-making is an important factor in a successful recovery process.[52] Several drugs and formulations can be considered, working in tandem with the person who is starting or continuing treatment. Treatment options form part of a fluid continuum, along which people can grow as individuals as their needs change. When people choose a treatment option in consultation with their partner care team, they should be informed that other treatment options (i.e., different drugs or formulations) remain available if necessary.

- The **Make an Informed Choice** tool can used to enter into a discussion of the advantages and disadvantages of the various OATs.
- The **chart on the continuum of treatment options** allows clinicians to engage the person in a conversation about the process and logistics involved in the induction period and the selected drug.
- The **OUT Pharmacological Treatment summary table** (below) enables clinicians to compare the drugs in terms of their pharmacology, pharmacokinetics, contraindications, advantages, etc.
- Appendix 1 **Common Side Effects of Opioid Agonist Treatment (OAT)** helps clinicians find solutions to reduce the impact of side effects experienced by people undergoing treatment.

Summary table of pharmacological treatments for OUD

SUMMARY TABLE OF PHARMACO-LOGICAL TREATMENTS FOR OUD	**Buprenorphine-naloxone (BUP/NAL)** *Suboxone® / (Subutex[G])* Guidance document	**Methadone** Guidance document	**Slow-Release Oral Morphine (SLOM)** *Kadian®* Guidance document	**Buprenorphine Extended-Release Injection (BUP-ER)** *Sublocade®* Guidance document
PHARMACOLOGY				
Method of use	Sublingual Oral (possible with films)	Oral	Oral	Monthly subcutaneous injection
Available formulations	 Dissolvable sublingual tablets: 2/0.5 and 8/2 mg Oral and sublingual films: 2/0.5, 4/1, 8/2, 12/3 mg	 Liquid: all doses are possible in 1mg increments Tablets: not used except in exceptional cases	 Capsules: 10, 20, 50, 100 mg	 Subcutaneous injection: 100 et 300 mg
Mu agonist effect	Partial *mu* agonist	Full *mu* agonist	Full *mu* agonist	Partial *mu* agonist
Affinity for *mu* receptors	+++	++	++	+++
RAMQ coverage	Yes	Yes	Yes Use in OAT is off label	Yes Medical exemption code number SN544[H]
Speed to reach a therapeutic dose	Fast ++ Therapeutic dose attained in 1-2 days	Slow Increase q 5-7day Therapeutic dose attained within a few weeks/months	Medium Increase q 2day Therapeutic dose attained in a few days/weeks	Fast The injection is usually initiated after 7 days of oral BUP/NAL at a therapeutic dose
Maximum starting dose	2–4 mg if COWS ≥ 8-12 Microdose method possible: see guideline	Between 1–40 mg	50–200 mg[I]	300 mg q 28day X 2 doses Then 100 mg q 28day Consider keeping the person on 300 mg q 28day if there are withdrawal symptoms at 100 mg
Maximum increases	Increases q 2-4h of 4 mg possible up to 16 mg max day 1 And 24 mg max day 2	Maximum increase of 20 mg q 5-7day	Maximum increase of 200 mg q 2day	
Maximum dose	Max dose = 24 mg (exceptionally 32 mg)	No maximum dose	No maximum dose	300 mg SC Consider decreasing the time between injections if withdrawal symptoms occur or supplement with oral BUP/NAL
Dosage	DIE, q 2day, q 3day Can be divided into BID or TID	DIE Can be divided into BID or TID	DIE	q 28day Intervals of 26 to 42 days between injections are possible

G Subutex consists of only buprenorphine, no naloxone. It must be requested through Health Canada's Special Access Program.

H For the treatment of opioid use disorder among adults clinically stabilized on buprenorphine sublingual therapy.

I Certain Canadian guidelines start with higher doses ranging from 300 mg (BCCSU) to 400 mg (MetaPhi) or even higher, based on the tolerance of the person in treatment. In such cases, the rationale should be well documented in the patient's file.

SUMMARY TABLE OF PHARMACO-LOGICAL TREATMENTS FOR OUD	**Buprenorphine-naloxone (BUP/NAL)** *Suboxone® / (Subutex)*	**Methadone**	**Slow-Release Oral Morphine (SLOM)** *Kadian®*	**Buprenorphine Extended-Release Injection (BUP-ER)** *Sublocade®*
PHARMACOLOGY (continued)				
Retitration see section 5.3 of the guide[J]	After ≥ 3 consecutive days of missed doses	After ≥ 3 consecutive days of missed doses	After ≥ 2 consecutive days of missed doses	After more than 42 days since the last injection
Unsupervised doses See the Decision Support Tool for Granting Unsupervised Doses	Greater flexibility for unsupervised doses	Slower dosing schedule for unsupervised doses The stability of diluted methadone is 14 days when kept in the fridge (and 7 days if diluted in apple juice[K])	Unsupervised doses on a case-by-case basis, according to the risks/benefits	Injection by a healthcare professional No unsupervised doses People in treatment are not authorized to have BUP-ER in their possession. It must be delivered directly to the clinic for administration
PHARMACOKINETICS				
Peak action (Tmax)	**1 h** by sublingual method **2.5 to 3 h** by oral film	**2 to 4 h** (varies between 1 to 7.5 h)	**8.5 to 10 h**	**24 h** post injection
Metabolism	CYP450 3A4 (major pathway) Glucoroconjugation UGT1A1, UGT1A3, UGT2B7	CYP 450 2B6-3A4 > 2D6 >> 2C9, 2C19, 1A2	Glucuronoconjugation (major) et CYP2D6 (minor)	First hepatic passage avoided
Half-life	24 to 42 h	8 to 59 h (24 h average)	11 to 13 h (once absorbed, however, the half-life of morphine is 2 to 4 h)	43 to 60 days
PREFERENCES AND NEEDS OF THE PERSON IN TREATMENT				
Concurrent consumption of opioids during treatment	Difficult, especially if high doses	Possible	Possible	Difficult due to probable saturation of *mu* receptors
Desire to feel sedative effects (*mu* agonist)	Not a good choice	Good choice	Good choice	Not a good choice
Concurrent consumption of alcohol (and other sedatives)	Safer	Greater danger	Greater danger	Safer
PRECAUTIONS AND CONTRAINDICATIONS				
Impact QTc	+	+++	⊘	+
Safety	Ceiling effect = low risk of overdose	Risk of sedation Risk of overdose, particularly during the start and end of treatment	Risk of sedation Risk of overdose, particularly during the start and end of treatment	Ceiling effect = low risk of overdose

J Québec clinical guideline for supporting people living with opioid use disorder.

K Refer to product monographs for more details on stability data and recommended dilutant brands.

SUMMARY TABLE OF PHARMACO-LOGICAL TREATMENTS FOR OUD	**Buprenorphine-naloxone (BUP/NAL)** *Suboxone® / (Subutex)*	**Methadone**	**Slow-Release Oral Morphine (SLOM)** *Kadian®*	**Buprenorphine Extended-Release Injection (BUP-ER)** *Sublocade®*
PRECAUTIONS AND CONTRAINDICATIONS (continued)				
Medication interactions	Minimal clinically significant interactions See BCCSU table	Multiple See BCCSU table	Moderate See appendix 5	Minimal clinically significant interactions See appendix 4
Common side effects	▸ Similar to methadone but less common ▸ Headaches in the first days ▸ Risk of induced withdrawal	▸ Increased sweating ▸ Constipation ▸ Hypogonadism and decreased libido ▸ Weight gain ▸ Nausea ▸ Drowsiness	Similar to opioids in general: ▸ Constipation ▸ Nausea, vomiting ▸ Indigestion, abdominal pains ▸ Urinary retention ▸ Drowsiness, dizziness ▸ Diaphoresis ▸ Etc.	▸ Similar to BUP/NAL tablets plus injection site side effects (pain, itchiness, induration, etc.)
Liver failure	See summary table			
▸ Child A	✓	✓	✓	✓
▸ Child B	⚠	✓	⚠	✗
▸ Child C	✗	⚠	⚠	✗
Renal failure (ClCr in ml/min)	< 30 ml/min : ⚠	< 10 ml/min : ⚠	30-60 ml/min : ⚠ Administer 50% – 75% of initial dose 15-30 ml/min : ⚠ Administer 25% – 50% of initial dose < 15 ml/min : ✗	✓
Pregnancy/ breastfeeding	✓	✓	⚠ Cf appendix 7	✗
Breastfeeding	✓	✓	⚠ Cf appendix 7	✗
Contraindications	Overall, the OAT contraindications are similar between molecules: ▸ Hypersensitivity to the active ingredients or to one of the non-medicinal ingredients ▸ Respiratory depression/failure, asthma with severe bronchospasms, severe COPD, pulmonary heart disease ▸ Gastrointestinal obstructions (including paralytic ileus) ▸ Currently taking or have taken in the past 14 days a monoamine-oxidase inhibitor (MAOI) ▸ CNS depression or significant acute intoxication by a central nervous system depressant (opioid, alcohol, benzodiazepine, etc.) ▸ Delirium tremens, seizures, intracranial hypertension, brain trauma			

Légend: ✓ Safe; ⚠ Use with Caution; ⚠ High Risk; ✗ Not Recommended.

The main opioid agonist drugs available in Québec are buprenorphine-naloxone (as a film or tablet), extended-release buprenorphine, methadone, and slow-release oral morphine.

For people who are stabilized on buprenorphine-naloxone sublingual, a transfer to extended-release injectable buprenorphine may be considered to reduce the number of trips to the pharmacy or in response to the individual's preferences.

For people who continue to inject opioids, who are at high risk of overdose, and whose mental, physical or psychosocial condition is deteriorating, treatment with injectable opioid agonists (iOATs) may also be considered.[58] This highly structured treatment with injectable hydromorphone or diacetylmorphine is self-administered two or three times per day, under clinical supervision.[L]

For people who continue to use opioids, safer supply aims to "replace psychoactive substances purchased on the illicit market with pharmaceutical substances of known and stable content. This practice, emerging in Canada, is being implemented from a public health perspective to reduce the harm associated with psychoactive substance use and prevent sometimes fatal overdoses. It is not primarily intended as a treatment for a substance use disorder."[80] In this context, short-acting opioids may be prescribed to complement or replace OAT.[80,81] The use of a safer supply can also present an opportunity to develop a therapeutic relationship with someone who is no longer has any ties with the health and social services network.

When choosing a treatment option, respect for the person's autonomy means supporting them as they make an informed decision about their treatment. All options must be presented and discussed with the person, who needs to be given complete information about the advantages and disadvantages of each option.

> « Prescribers writing prescriptions must comply with federal legislation and regulations, as well as with the ***Règlement sur les normes relatives aux ordonnances faites par un médecin***, which has been derived from the Medical Act. Particular attention must be paid to the transmission of methadone and buprenorphine-naloxone prescriptions, and even more specifically to SROM morphine prescriptions. When morphine is prescribed as part of an OAT, it is important to specify this on the prescription." [Our translation]
>
> **CMQ, OIIQ and OPQ guidelines (2020)[4]**

L It should be noted that at the time of publication of this guide, this type of treatment is not available in Québec.

Suggested questions for collaborative consideration of treatment options:

- Do you plan to continue using opioids during treatment?
- What other medical conditions do you have? Describe your medical history.
- How can taking the medication be integrated into your daily routine, in terms of your work schedule, family responsibilities, proximity to the pharmacy, and ability to get around?
- What side effects would be acceptable to you, and which would not?
- Have you already tried any other treatments?
- Do you have any concerns about certain treatments?

Perspectives of persons receiving treatment:

It's important for professionals to provide all the information and present the issues around each treatment option. For example, even safer supply can have some disadvantages.

You mustn't think for someone else. For example, by believing that someone will be encouraged to use drugs if offered certain treatment options that are compatible with parallel use.

It's important to have choices, but the person needs to understand the advantages and disadvantages in terms of their goals; how the options suit the person's situation and where they don't.

I want a doctor who knows his stuff and can present me options.

Suggested questions to support the partner care team's deliberation on the choice of a therapy and delivery method:

- What clinical characteristics could influence the decision in terms of efficacy or safety?
  - Pregnancy, a desire to be pregnant, or breast-feeding
  - Chronic or acute pain
  - Hepatic and renal insufficiency
  - Existence of contraindications
  - QTc interval
  - Other prescribed medications
  - Other substances used
  - Other
- What psychosocial characteristics might influence the decision in terms of managing daily life?
  - Job and work schedule
  - Parental responsibilities
  - Mobility and proximity
  - Travel and transportation
  - Social support
  - Residential stability
  - Cognitive impairment
  - Foreseeable incarceration
  - Insurance coverage
  - Other

3.2 Prescribing a drug therapy

Prescribing a drug therapy in the context of OUD is a **flexible and iterative process**. **Regular re-assessments of the prescription** allow the person to **move along the continuum of pharmacological options** as their needs change.

Who can initiate or adjust an OAT prescription?

- ★ **Physicians and nurse practitioners specialized in mental health (NPSMHs)** can initiate an OAT.[4]
- ★ **Nurse practitioners specialized in primary care (NPSPCs)** can prescribe an OAT and adjust the prescription if the diagnosis and treatment plan have been established by an NPSMH or a physician.[M]
- ★ **Pharmacists, NPSMHs, NPSPCs** and **physicians** may adjust the dose (up or down) and **extend** an existing OAT prescription.[N]
- ★ **No special permit or exemption is required to prescribe an OAT.**[4]

When and where can OAT be prescribed?

- ★ Every opportunity should be taken to offer and initiate OAT. For example, it can be started in a walk-in clinic, in a hospital emergency department, during a hospitalization, or by teleconsultation under certain conditions (in French only).
- ★ A single means of transmitting the prescription must be used (e.g., by fax or hand delivery).[4]
- ★ Prescribers who are unable to follow up on the OAT after initiating it must transfer the person to the most suitable place for follow-up in their region, 3 depending on the intensity of service required for that person (e.g., an addiction rehabilitation centre). Prescribers who are able to provide follow-up in primary care can receive support from a specialist team, particularly in psychosocial matters. Working closely with the new care context is necessary to avoid a disruption of services.

M "Note that the pharmacological treatment plan does not need to specify in detail the name of the molecule, the starting dose and possible adjustments. The prescriber, i.e., the professional who made the diagnosis, may leave a certain amount of latitude to the specialized nurse practitioner (SNP), who will monitor the patient by including the procedures selected in the treatment plan, in accordance with recognized practice guidelines (e.g., the molecule selected to start, any change of molecule, adjustments made in accordance with a particular practice guideline, etc.). The SNP can then monitor the patient in accordance with the established treatment plan. Note that an SNP can independently determine the non-pharmacological treatment plan."[82] [Translation]

N The measure allowing pharmacists to adjust and extend an OAT (Bill 31) is temporary. The exemption runs until September 30, 2026. Certain conditions apply to pharmacists. See the guide Optimisation du rôle du pharmacien communautaire auprès des personnes en situation de précarité (in French only).

Decision-making tool to support treatment selection

- This tool is designed to support patients in choosing their OAT molecule. It principally addresses logistical aspects.
- If you are a prescriber and desire more information on OAT, please refer to the Summary Table of Pharmacological Treatments for OUD.
- The indicated doses are only examples. Dosages must be determined by individualized clinical evaluation.

OAT

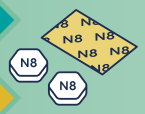
Methadone (to drink, mixed with juice)

Day 1	Day 6	Day 11	Day...
1 à 40 mg →	+ 20 mg max →	+ 20 mg max →	...

Number of days to reach a therapeutic dose ?

Switch: withdrawal or microdosing

Buprenorphine-naloxone (sublingual tablet or film)



Induction standard (with withdrawal)

Day 1	Day 2	Therapeutic dose
4 mg + 4 mg + 4 mg + 4 mg →	16 mg + 4 mg + ... →	attained in 24-48h

Microdosing (without withdrawal)

Day 1	Day 2	Day 3	Therapeutic dose
0.5 mg →	0.5 mg (2X/day) →	1 mg (2X/day) →	attained in 7-14 days

(injection)

8 à 32 mg

Injection 1X per month (stomach)

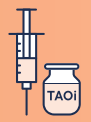
Switch: withdrawal or microdosing

Slow-Release Oral Morphine (pellets in water or applesauce)

Day 1	Day 3 and +	Day 5	Day...
Between 30 to 60 mg (up to 200 mg)* →	Increase dose 50-100 mg/48 hours (according to symptoms) →	Increase dose →	...

Number of days to reach a therapeutic dose ?

Hydromorphone ou Diacetylmorphine (injection)



Day 1	Day 2	Day...
Dose 1	Dose 1 +increase	...
Dose 2 +increase →	Dose 2 +increase →	
Dose 3 +increase	Dose 3 +increase	

Number of days to reach a therapeutic dose ?

Harm Reduction

Safer Supply →

Usually co-prescribed with methadone or slow-release oral morphine

*Certain prescribers, based on their clinical experience, sometimes start at 300mg or higher for their patients with very high tolerance. Reference: British Columbia Centre on Substance Use, BC Ministry of Health, and BC Ministry of Mental Health and Addictions. A Guideline for the Clinical Management of Opioid Use Disorder. Published November 2023. Available at: https://www.bccsu.ca/opioid-use-disorder/

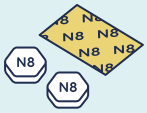
3.3 Prescription support tools

Several tools are available to support clinicians as they prescribe OAT. The Guide d'usage optimal de l'INESSS for OUD[9] (in French only) provides clear guidelines on the pharmacological aspects of induction and maintenance with methadone and buprenorphine-naloxone. The *Équipe de soutien clinique et organisationnel en dépendance et itinérance* (ESCODI) provides clinical tools to help prescribers with the pharmacological considerations relevant to slow-release oral morphine,[83] extended-release buprenorphine,[84] the buprenorphine-naloxone microdosing induction technique,[85] and safer supply[80] options. The Guide d'information et d'orientation pour une offre de TAO injectable au Québec[49] (in French only) and the CRISM National Injectable Opioid Agonist Treatment Guidelines[2] set out the induction and maintenance protocols for prescribing hydromorphone and injectable diacetylmorphine. Lastly, the CMQ, OIIQ and OPQ guidelines (2020)[4] (in French only) present the regulatory and ethical frameworks specific to physicians, pharmacists, and nurses in the context of OAT.

3.3.1 Buprenorphine-naloxone sublingual tablets and films

TOOLKIT

Buprenorphine-naloxone sublingual tablets and films
(covered by RAMQ)



PRESCRIBING

- Traitement par agonistes opioïdes (INESSS) (in French only)
- Gabarit d'ordonnance pour la buprénorphine-naloxone (CCSMTL) (in French only)
- Guide to Using the Buprenorphine-Naloxone Microdosing Method in OAT (ESCODI)
- Opioid Use: My Treatment, My Choices (ESCODI)

TRAINING

- Traitement du trouble lié à l'utilisation d'opioïdes : une approche de collaboration interdisciplinaire (Formation INSPQ) (in French only)

INFORMATION FOR PERSONS IN TREATMENT

- Make an Informed Choice (ESCODI)
- Frequently Asked Questions—Buprenorphine-naloxone (ESCODI)
- Frequently Asked Questions—Buprenorphine-Naloxone (Suboxone®) Microdosing Induction (ESCODI)

3.3.2 Methadone

TOOLKIT

Methadone
(covered by RAMQ)

PRESCRIBING

- Traitement par agonistes opioïdes (INESSS) (in French only)
- Gabarit d'ordonnance pour la méthadone (CCSMTL) (in French only)
- Drug Interactions (BCCSU)
- Opioid Use: My Treatment, My Choices (ESCODI)

TRAINING

- Traitement du trouble lié à l'utilisation d'opioïdes : une approche de collaboration interdisciplinaire (Formation INSPQ) (in French only)

INFORMATION FOR PERSONS IN TREATMENT

- Make an Informed Choice (ESCODI)
- Frequently Asked Questions – Methadone (ESCODI)

Note : Methadone tablets are not generally used in OUD, with some rare exceptions (e.g., for travel).

3.3.3 Slow-release oral morphine

TOOLKIT

Slow-release oral morphine
(covered by RAMQ)

PRESCRIBING

- A Guide to Using Slow-Release Oral Morphine (Kadian®) in Opioid Agonist Therapy (OAT) (ESCODI)
- Pharmaceutical Prescription—Slow-Release Oral Morphine (Kadian®) (ESCODI)
- Opioid Use: My Treatment, My Choices (ESCODI)

TRAINING

- Traitement du trouble lié à l'utilisation d'opioïdes : une approche de collaboration interdisciplinaire (Formation INSPQ) (in French only)
- La morphine à libération lente uniquotidienne (Kadian) : Un incontournable dans le traitement du trouble lié à l'utilisation d'opioïdes (ESCODI et CPMD) (recording of a webinar, in French only)

INFORMATION FOR PERSONS IN TREATMENT

- Make an Informed Choice (ESCODI)
- Frequently Asked Questions—Slow-Release Oral Morphine (Kadian®) (ESCODI)

3.3.4 Extended-release buprenorphine

TOOLKIT

Extended-release buprenorphine
(RAMQ exception medication for patients with a therapeutic indication)

PRESCRIBING

- A Guide to Using Extended-Release Buprenorphine (Sublocade®) in Opioid Agonist Therapy (OAT) (ESCODI)
- Pharmaceutical Prescription—extended-release buprenorphine (Sublocade®) (ESCODI)
- Opioid Use: My Treatment, My Choices (ESCODI)

TRAINING

- Mandatory training from the company
- Mise à jour sur les nouvelles formulations de buprénorphine (CPMD) (webinar in French only)
- Video on the steps in performing an injection of extended-release buprenorphine (ESCODI, en collaboration avec le CHUM) (in French with English subtitles)

INFORMATION FOR PERSONS IN TREATMENT

- Make an Informed Choice (ESCODI)
- Frequently Asked Questions—Extended-release buprenorphine (Sublocade®) (ESCODI)

3.3.5 Hydromorphone and injectable diacetylmorphine

TOOLKIT

Hydromorphone (covered by RAMQ)
and injectable diacetylmorphine
(process for urgent public health needs)

PRESCRIBING

- Guide d'information et d'orientation pour une offre de TAOi au Québec (Perreault et al.) (in French only)
- iOAT guidelines (CRISM)
- Guidance for Injectable Opioid Agonist Treatment (BCCSU)
- Clinical Tools (CCSMTL) (in French only)

TRAINING

- An observation period is recommended.

INFORMATION FOR PERSONS IN TREATMENT

- Sample operation and consent form (CCSMTL) (in French only)

3.3.6 Safer supply (substance replacement therapy)

TOOLKIT

Safer supply

PRESCRIBING
- Substance replacement therapy (ESCODI)
- The opioid crisis—safer supply (CMQ) (in French only)

TRAINING
- Safer supply—Information sheet for pharmacists (ESCODI)

INFORMATION FOR PERSONS IN TREATMENT
- Safer supply consent forms (ESCODI)

3.3.7 Naloxone

TOOLKIT

Naloxone

PRESCRIBING
- Find a Resource That Can Provide Naloxone (MSSS)

TRAINING
- L'administration de la naloxone pour inverser les effets d'une surdose d'opioïdes (Formation de l'INSPQ sur l'ENA – ID 2388) (in French only)

INFORMATION FOR PERSONS IN TREATMENT
- PROFAN training on how to deal with overdoses (profan@aidq.org; 514 910-1880)
- Possible Opioid Overdose: What to do—Nasal administration of naloxone (MSSS)
  - Video: Nasal administration of naloxone (INSPQ)
- Possible Opioid Overdose: What to do—Administration of naloxone by injection (MSSS)
  - Video: Administration of naloxone by injection (INSPQ)

3.4 Adapting substance replacement therapy to specific needs and complex problems

Situations that may require special attention in substance replacement therapy include chronic or acute pain, pregnancy, mental health co-morbidities, end of life, and advanced age.

> Interdisciplinary collaboration is always necessary when dealing with special needs and complex problems.

3.4.1 Pain in persons with OUD

People who are simultaneously in treatment for an opioid use disorder and coping with pain face numerous challenges, including an increased tolerance of opioids and the concomitant mental health disorders. Additionally, they may encounter lack of insurance coverage for certain therapeutic options, such as cognitive behavioural therapy and physiotherapy. Furthermore, there is no consensus on the best therapeutic approaches for managing pain in persons with opioid use disorders.[86]

3.4.1.1 Chronic pain

Concomitant chronic pain and opioid use involves multiple interrelated physical, psychological, and social dimensions. Optimal management should address these various dimensions through an interdisciplinary, multimodal approach that may involve:

- Treatment with opioid agonists,
- A prudent mix of other drugs, where necessary,
- Psychotherapy, or
- Other non-pharmacological interventions, such as physiotherapy.[87]

More specifically, a recent systematic review[88] highlights the effectiveness of:

- Methadone and buprenorphine-naloxone in terms of analgesia and relapse prevention,
- Mindfulness, in terms of reducing stress and cravings, and
- Cognitive-behavioural therapy aimed at stopping the use of non-prescribed substances.

Slow-release oral morphine (SROM) may also help reduce the intensity of chronic pain in persons with OUD and chronic pain.[89]

Other strategies may be considered, such as splitting doses of OAT[O] and consulting a pain expert.[90]

O The CMQ, OPQ, and OIIQ guidelines (2020) suggest splitting doses in exceptional situations only, documenting the reason behind this choice, and communicating it to the pharmacist.

Perspective of someone in treatment:

My life has been marked by physical pain. When a professional tells me that it's impossible to help me manage my pain because I'm on methadone, I find that humiliating and frustrating. It really damages the therapeutic relationship.

TOOLKIT

Chronic pain in people on OAT

- Formation Discutons douleur, parlons dépendance (CMQ) (in French only)
- National Practice Guideline for the Use of Medications for the Treatment of Opioid Use Disorder (ASAM, 2020)
- Traitement du trouble lié à l'utilisation d'opioïdes : une approche de collaboration interdisciplinaire (INSPQ) (in French only)
- Opioid agonist therapy: A synthesis of Canadian Guidelines for treating OUD (CAMH)
- Treatment considerations for co-occurring chronic pain and opioid use disorder
- Centre d'expertise en gestion de la douleur chronique (CEGDC) of the RUISSS at Université de Montréal :
  - Expert opinion (in French only): Family physicians can discuss the treatment of a specific patient and the various treatment modes with an expert.

Work with partners

An integrated treatment plan can be developed jointly by the OAT prescriber and a pain specialist (e.g., a pain clinic). In addition, many pain clinics offer advice to professionals over the phone.

3.4.1.2 Acute pain

For patients with OUD who experience acute pain, "[n]on-opioid pharmacotherapies such as acetaminophen, NSAIDs, and anticonvulsants for neuropathic pain, and specialist interventions such as nerve blocks if available, should always be trialled, but where there is severe acute pain or a significant traumatic injury, opioid analgesics are likely going to be required."[91]

For patients on buprenorphine-naloxone, acute pain management is a challenge due to the high affinity of buprenorphine at mu receptors (see the figure from Gudin and Fudin, 2020).[92] In the context of pain relief, another opioid with high affinity may be added (e.g., hydromorphone), and buprenorphine doses may be split or reduced.[91] It may be necessary

to consult a specialist.[91] The Mayo Clinic's decision algorithm[93] can also be consulted to support treatment decisions.

The treatment for acute pain is combined with OAT for patients on methadone or SROM. However, methadone should not be combined with oxycodone, due to its interaction with CYP450.[94]

TOOLKIT

Acute pain in people on OAT

- Buprenorphine webinar—Perioperative management and acute pain (in French only) (CPMD, 2022)
- Guidance Document on the Management of Substance Use in Acute Care (CRISM Prairies, 2020, p. 38)

Work with partners

An integrated treatment plan can be developed jointly by the OAT prescriber and a pain specialist (e.g., an anaesthetist), particularly for people taking buprenorphine-naloxone.

3.4.2 Opioid use disorder with prescribed opioids and misuse

Opioid drugs prescribed to manage pain can lead to iatrogenic dependence. Between 8% and 12% of patients treated for chronic pain have an opioid use disorder.[95] To prevent OUD, current guidance suggests that: the treatment of pain be regularly reassessed (pain, functional status, quality of life, sleep, mood, side effects, inappropriate behaviour); the opioid prescription be structured; and the person in treatment be supported.[77] Attention must also be paid to withdrawal-related risks in a person who may suddenly be without an opioid prescription, including the risk of illicit opioid use and overdose.

The table of factors and behaviours suggestive of opioid misuse (in French only), published by INESSS,[9] can be used to identify indications of misuse or a disorder related to prescription opioids. These include using opioid drugs in ways other than as prescribed (e.g., injecting oral tablets or increasing one's doses) or obtaining opioids from several sources (friends, street dealers, multiple prescribers). In all cases, naloxone should be given to the person, their family, and their friends to reduce overdose risk.

Persons who develop a disorder related to the use of prescribed opioids may be unfamiliar with the available addiction services. Personalized support can be key in their recovery process by ensuring continuity between pain and addiction services.[52]

What should be done when there are indications of misuse or dependence with prescribed opioids?

- ★ Structure the prescriptions: use a single long-acting drug (consider a transfer to buprenorphine-naloxone, where appropriate) and avoid as-needed dosing (PRN) wherever possible.
- ★ Work with the person to establish a management plan: e.g., prescribe for short periods, fax the prescription directly to the pharmacy, establish a clear plan with the person and the pharmacist on behaviour that does not align with goals, do not provide advance prescriptions, and make an appointment to reassess the person on the same day that the prescription ends.
- ★ Pay attention to the risks involved in withdrawal and explain them to the person.
- ★ Provide take-home naloxone and explain its use to the person and their family and friends.
- ★ Offer psychosocial support.
- ★ Suggest the Alerte program, as required.

TOOLKIT

Prescribed opioid use disorder

- Information video: **Difficult withdrawal from opioids: How can you tell?** (in French only)
- Information video: **Difficult withdrawal from opioids: How to deal with an unindicated demand for opioids?** (in French only)
- **Course on talking about pain and addiction** (CMQ) (in French only)
- Table of **Factors and behaviours suggestive of opioid misuse** (in French only)
- **Use of opioid medications for chronic pain** (FMOQ, 2021) (in French only) (can be accessed only by FMOQ members)
- **Proper use of opioids** (Le *Médecin du Québec,* 2016) (in French only)

Work with partners

An integrated treatment plan can be developed jointly by an opioid-prescribing physician, a pharmacist, and a pain specialist/addiction specialist to provide coordinated interventions and avoid the development of an OUD.

Perspectives of persons receiving treatment:

> *Professionals need to establish a clear framework within which they should encourage autonomy and information sharing, without punishing or lecturing.*

> *It is important for me to have someone who explains the issues without being paternalistic—so that we can draw up the framework together.*

3.4.3 OAT during pregnancy or breastfeeding

The United Nations Office on Drugs and Crime[61] points out that "[a]ll women have a right to high-quality perinatal care. However, women who use opioids and who are pregnant or a parent find themselves highly stigmatized, with negative impacts on their access to care. OAT service providers should receive all patients unconditionally. An OAT using methadone or buprenorphine is safe in pregnancy [121], and pregnant women who are dependent on opioids should be encouraged to use OAT and supported. Pregnant women who use drugs should have access to comprehensive and integrated services for prevention of mother-to-child transmission of HIV, HBV and syphilis [...]."[61]

The United Nations Office on Drugs and Crime [61] lists the following conditions that should be in place to ensure quality OAT services during pregnancy and breastfeeding:

"Support pregnant patients to mobilize relevant support structures and medical and social support as appropriate for their pregnancy and their OAT."

"Ensure local guidelines follow evidence-based practice."

"Clinicians should ensure doses are adjusted based on the patient's experience while pregnant, including options for split doses."

"Apply principles of trauma-informed care to perinatal services."

"Counsel and support mothers around the safety of breastfeeding while on OAT."

"Counsel patients about increased risk of overdose during pregnancy from use of illicit opioids."

"Counsel patients about the risks of detoxification."

"In the case of an opioid overdose during pregnancy, the benefits of providing naloxone outweigh the risks."

"Ensure evidence-based management of infant withdrawal syndrome."

United Nations Office on Drugs and Crime (2022) [61]

Pregnancy

Buprenorphine-naloxone and methadone are recommended for the treatment of OUD in pregnant patients. Once someone is stable on treatment, changes in OAT are not recommended, as they would adversely affect clinical stability.[9] "[c] ontinuation of treatment with slow-release oral morphine (SROM) is recommended when the person was already stable on this medication prior to pregnancy. [...] induction with SROM during pregnancy should be considered when methadone or buprenorphine-naloxone treatments [INESSS, 2021] are ineffective, contraindicated or unacceptable" (see detailed information in the A Guide to Using Slow-Release Oral Morphine [Kadian®] in Opioid Agonist Therapy).[83] Induction with extended-release buprenorphine is not recommended during pregnancy. Continuation of extended-release buprenorphine treatment following the discovery of pregnancy should be based on an assessment of the associated benefits and risks (see detailed information in A Guide to Using Extended-Release Buprenorphine [Sublocade®] in Opioid Agonist Therapy).[84]

Consulting an experienced colleague should also be considered.[9] For example, providers in Quebec can contact the Centre IMAGe du CHU Sainte-Justine, the Rond-Point group, or the CHUM (514 890-8000, ext. 27244).

> Pregnant women with OUD should be given priority access to OAT. It is recognized that a relapse leads to a significant increase in the risk of and fetal maternal mortality and morbidity. [...] [translation]
>
> **Guidelines of the CMQ, the OIIQ and the OPQ (2020)[4]**

> "The selection of the appropriate OAT agent during pregnancy should be considered on a case-by-case basis with the guidance of a specialist and in collaboration with the patient, with appropriate monitoring and follow-up."
>
> **CRISM Guidelines (2018)[2]**

> "Buprenorphine/naloxone is somewhat less likely than methadone to require significant dose changes during pregnancy, since its extended half-life renders changes in maternal blood volume less concerning. However, studies on buprenorphine treatment during pregnancy report that, in some cases, a slight increase (0.5 – 3.3 mg) in the mean dose during pregnancy may be required based on clinical judgment."
>
> **British Columbia Centre on Substance Use (2018)[96]**

> "For some pregnant patients on methadone, the acceleration of maternal metabolism in the course of pregnancy may require an increase in daily dose to address emergent withdrawal symptoms and prevent fetal stress, particularly in the second or third trimesters. [...]If needed, gradual dose increases can be made by increments of 5 mg to 10 mg. Due to the increased hepatic metabolism of methadone in pregnancy, split dosing may be considered to prevent withdrawal symptoms."
>
> **British Columbia Centre on Substance Use (2018)[96]**

Breastfeeding

Breastfeeding is generally compatible with OAT, unless there are contraindications. The parents should be offered support in this decision so that they can weigh the risks and benefits of breastfeeding in their situation.[90] More specifically, breastfeeding is encouraged in people treated with methadone or buprenorphine-naloxone when they are not using illicit substances. To learn more about the risks associated with breastfeeding for pregnant people treated with extended-release buprenorphine or slow-release oral morphine, see A Guide to Using Extended-Release Buprenorphine (Sublocade®) in Opioid Agonist Therapy[84] and A Guide to Using Slow-Release Oral Morphine (Kadian®) in Opioid Agonist Therapy.[83]

Immediate medical attention is required if the baby shows signs of unusual drowsiness, limpness, or difficulty breathing.[97,98] If the OAT dosage is increased in a breastfeeding parent, it is recommended that the child be monitored for signs of unusual drowsiness. If the OAT dosage is reduced (or if breast-feeding is suddenly interrupted), it is recommended to watch for signs of irritability in the child, as well as weight loss or diarrhea (withdrawal symptoms).

Summary table. Pregnancy and breast-feeding on OAT

	Pregnancy	Breastfeeding
Buprenorphine-naloxone in sublingual tablets or film 	**Continuation** or **initiation** of buprenorphine-naloxone is **compatible** with pregnancy in persons with OUD.	**Continuation** or **initiation** of buprenorphine-naloxone is **compatible** with breastfeeding in persons with OUD. Breastfeeding is **encouraged**.
Extended-release buprenorphine (ERB) 	Initiation is not recommended. **Continuation** of ERB in someone who is pregnant must be **assessed based on the risks** and benefits.	Initiation is not recommended. **Continuation** of ERB in someone who is breastfeeding must be **assessed based on the risks** and benefits.
Methadone 	**Continuation** or **initiation** of methadone treatment is **compatible** with pregnancy in someone with OUD.	**Continuation** or **initiation** of methadone is **compatible** with breastfeeding in someone with OUD. Breastfeeding is **encouraged**.
Slow-release oral morphine (SROM) 	**Initiation** should be **weighed against the risks** and benefits. **Continuation** of SROM is **compatible** with pregnancy in someone pregnant who is **already stabilized on SROM**.	Breastfeeding in a person stabilized on SROM must be **assessed based on the risks** and benefits.

TOOLKIT

OAT during pregnancy or breastfeeding

- Centre IMAGe du CHU Sainte-Justine (Info-Médicaments en Allaitement et Grossesse) – Centre d'information réservé aux professionnels de la santé : 514 345-2333
- Le Rond-Point (Centre d'expertise périnatal et familial en toxicomanie)
  2135 Alexandre-DeSève Street, Room KR-1203 Montréal, Québec
  Telephone: 438 386-4050
- CHUM, Neonatology Department, Obstetrics and Gynecology Department
- 1051 Sanguinet Street, Montréal, Québec H2X 0C1
  Telephone: 514 890-8000, ext. 27244
- National Injectable Opioid Agonist Treatment for Opioid Use Disorder (CRISM)
- A Guide to Using Extended-Release Buprenorphine (Sublocade®) in Opioid Agonist Therapy (ESCODI)
- A Guide for Using Slow-Release Oral Morphine (Kadian®) in Opioid Agonist Therapy (ESCODI)
- Treatment of Opioid Use Disorder During Pregnancy (BCCSU)

Work with partners

An integrated treatment plan can be developed jointly by the OAT prescriber and the perinatal care team. Collaborative practices in perinatal services and OUD contribute to healthier pregnancies, healthier children, and a greater likelihood of keeping families together and safe.[99]

Clinical perspectives:

It is important to inform the pregnant person of the risk of neonatal withdrawal syndrome, or refer them to a neonatal expert for counselling.

OAT is not synonymous with a referral to the DYP. As in any context, stability and the risks to the child must be assessed. Stable OAT can be a protective factor.

3.4.4 OAT in people being treated for a mental health disorder

Several studies conducted on samples of persons with OUD suggest that the prevalence of mental health disorders in this population may be as high as around 75%.[49] It is important for prescribers to assess the risks of potential interactions between the medications being used to treat mental health disorders and OAT.[100]

> "Mental health disorders can complicate OAT. Patients presenting with OUD should have access to mental health services as well as psychosocial support services. Those with a severe mental health disorder may require the services of a clinician who is able to treat both the OUD and the psychiatric co-morbidity."
>
> **SAMHSA (2021)[101]**

> "Assessment of the mental disorder is therefore essential and must be carried out by an authorized professional.
>
> "The use of CNS depressants such as benzodiazepines in patients with OAT is associated with a higher risk of overdose. These risks must be assessed by the prescriber to ensure that the concomitant use of these drugs is indicated and safe." [Translation]
>
> **Guidelines of the CMQ, the OIIQ and the OPQ (2020)[4]**

TOOLKIT

OAT in people receiving treatment for a mental health disorder

- ECHO® program for concomitant disorders—CHUM (in French only)
- ECHO TC ADULTE 2022-2023 | Educational videos (in French only)
- Centre d'expertise et de collaboration en troubles concomitants (in French only)

Work with partners

An integrated treatment plan can be developed jointly by the OAT prescriber and a team specialized in mental health. Collaboration between mental health, addiction, and primary care professionals leads to greater patient satisfaction and better treatment outcomes.[102]

3.4.5 OAT in the elderly

The main consideration when prescribing an OAT to an elderly person is identifying a safe dose. Induction doses should be lower than the base doses used for younger adults. The Canadian Coalition for Seniors' Mental Health guidelines (2020) suggest reducing initial doses by 25% to 50% and then increasing them slowly, using the lowest possible maintenance dose and regularly monitoring the person to detect problems that could be linked to sleep apnea, sedation, cognitive problems, and falls.[103] In addition, particular attention should be paid to the comorbidities that are more common in the elderly, such as liver, respiratory, and cognitive disorders.

TOOLKIT

OAT in the elderly

- Canadian Guidelines on Opioid Use Disorder Among Older Adults by the Canadian Coalition for Seniors' Mental Health
- Treating Substance Use Disorder in Older Adults (SAMHSA)
- Les TUS chez les personnes âgées (CPMD) (in French only)

Work with partners

An integrated treatment plan can be developed jointly by the partner care team, the pharmacist, and the CIUSSS Soutien à l'autonomie des personnes âgées (SAPA) team, including the geriatrician.

3.4.6 OAT in palliative care

For persons with OUD, pain relief in palliative care involves assessing the risks and benefits of opioids as part of an individualized and holistic approach.[104] As when initiating OAT with anyone, the choice of treatment is a joint and informed decision by the partner care team, including the person. *Palliative Care and OAT* (2019)[105] lists the considerations that should be considered, including higher doses, issues around switching to a parenteral route when oral intake is no longer possible, the potential need for a transfer from buprenorphine-naloxone to a pure agonist, the need for a multidisciplinary approach, and the risks of diversion.

TOOLKIT

OAT in palliative care

- Palliative Care and OAT (Victorian Opioid Management ECHO, 2019)
- Supporting People Who Use Substances in Acute Care Settings During the COVID-19 Pandemic (CRISM)

Work with partners

An integrated treatment plan can be developed jointly by the OAT prescriber and the palliative care team.

3.5 Requests for withdrawal and end of treatment

"Due to the associated risk of treatment drop-out, relapse, overdose, morbidity, and mortality, withdrawal management should never be recommended for persons with OUD. When a request for withdrawal management is received, the care team should have a comprehensive discussion with the person."

"[T]he person may still wish to begin opioid tapering despite contraindications [...] The care team should then introduce an opioid agonist according to standard initiation methods [...]. The opioid agonist molecule should be introduced to allow the person to attain a comfort dose and to enable them to experience a stable period. Then, if the person still wants to opioid taper, the agonist molecule doses may be gradually decreased. This decrease should take place over at least 30 days, but should ideally be spread over a longer period. At all of these stages, the person should be reassessed frequently and immediately switched to a maintenance treatment if they so desire."

Excerpts from the Québec Guide to Improving Practices in the Management of Opioid Use Disorder (2020) [3]

Long-term maintenance of OAT is recommended, and there are risks involved in stopping prematurely. When someone wants to begin a slow taper from OAT, the clinician must support them to make an informed decision and ensure that the process is safe. Treatment can be resumed at any time if the person feels the need. [4] At each stage in the treatment transition, the patient should be offered psychosocial support.

In summary, the following is recommended for patients wishing to begin a withdrawal from OAT:

- Discuss the risks with the patient [90]
- Spread the taper over several months, or even years [2,90]
- Increase the frequency of contact during the process [90]
- Manage withdrawal symptoms by slowing down the reduction in opioid doses or by using clonidine, loperamide, or dimenhydrinate [90]
- Provide long-term follow-up, [2] and consider the possibility of resuming OAT if necessary [90]

The Québec Guide to Improving Practices in the Management of Opioid Use Disorder (OUD) [3] provides a series of tools designed to support informed decision-making for people who request a slow taper.

TOOLKIT

Requests for withdrawal

- Québec Guide to Improving Practices in the Management of Opioid Use Disorder (OUD) (ESCODI)
- Making an Informed Choice Regarding Opioid Addiction (Appendix 2) (ESCODI)
- List of Items to be Addressed When People Who Use Opioids Request Withdrawal Management (Appendix 3) (ESCODI)
- Consent Form Associated with a Withdrawal Management Request Linked to an Opioid Use Disorder (Appendix 4) (ESCODI)
- Conditions to Reduce the Risks Associated With Withdrawal Management (Appendix 5) (ESCODI)

Work with partners

An integrated treatment plan can be developed jointly by the OAT prescriber, the family physician, and the pharmacist to provide coordinated services that will meet the individual's needs.

3.6 Choosing and prescribing substance replacement therapy: a checklist

The purpose of the following steps is to help you work with the person being monitored to select and prescribe a substance replacement therapy that will meet their needs.

Choose a substance replacement therapy in collaboration with the person

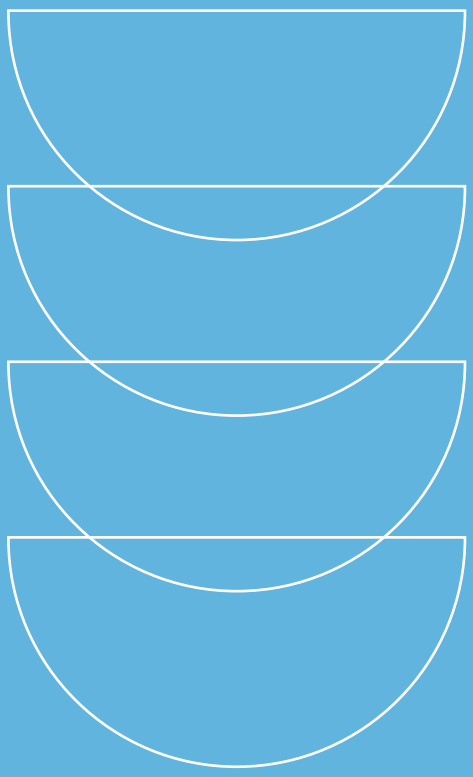
Present the therapeutic options and their characteristics. Take into account the person's goals, needs, characteristics, and preferences.

Prescribe a substance replacement therapy

If necessary, adapt the substance replacement to the person's specific needs and complex problems.

If necessary, adjust the treatment by exploring the continuum of therapeutic possibilities.

CHAPTER 4



Essential OAT services

Chapter 4. Essential OAT services

Persons with OUD may have multiple needs related to their mental health, physical health, psychosocial situation, etc. For this reason, supporting a person living with OUD goes well beyond prescribing OAT. It often requires collaboration with numerous institutional and community partners.

4.1 Baskets of services for persons with OUD

People in treatment for OUD should have access to a minimum basket of services (Figure 2). Not everything in the basket is universally required for everyone with OUD, but the full array should be easily accessible on site for those who want it.

All care settings that are likely to interact with people with OUD should be able to offer essential harm reduction supplies (e.g., safer injecting, safer smoking, and safer sex supplies, naloxone and a list of the resources available in the community) as well as instructions on how to use them. Care settings should also be able to direct people, on a personalized basis, to relevant resources, tools, or services.

To support clinicians and managers in implementing baskets of services designed to meet the multiple needs of people in treatment, a detailed toolkit (in French only) is available on website of the Équipe de soutien organisationnel en dépendance et itinérance.

Who offers the minimum basket of services?

★ Everything in the minimum basket of services can be provided on site by the OAT prescriber and his or her team.

Figure 2. Minimum basket of services for teams supporting persons with OUD*

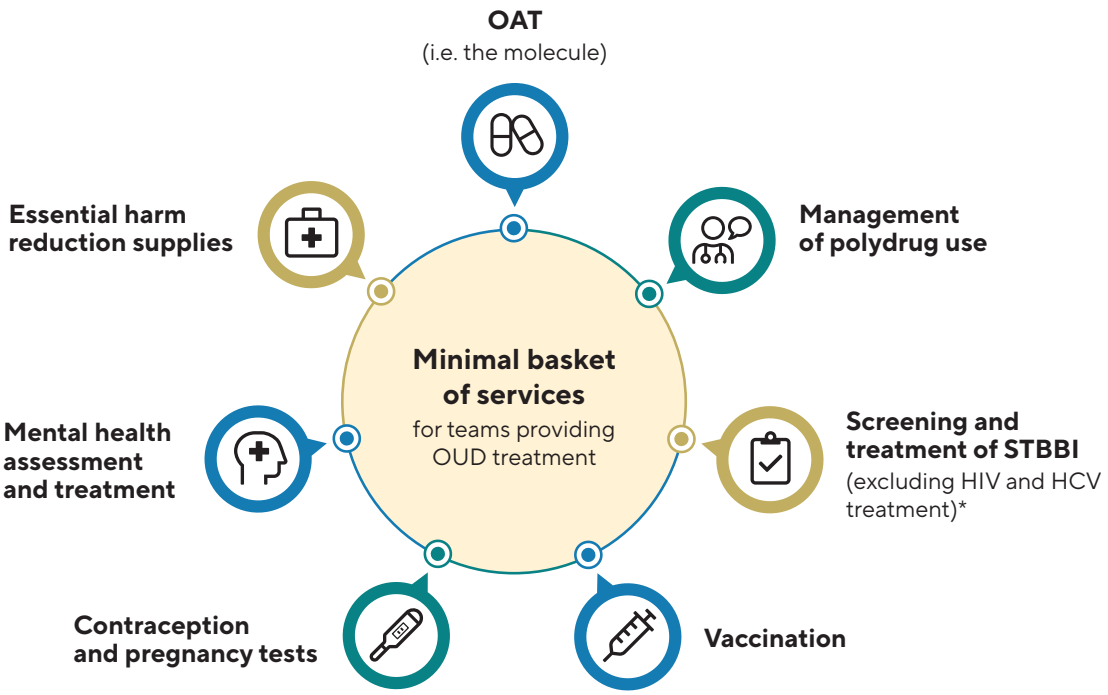


*Figure from the Québec Guide to Improving Practices in the Management of Opioid Use Disorder[3]

The expanded basket of services (Figure 3) is recommended to meet other needs commonly faced by persons with OUD, particularly those in more vulnerable situations. Facilitated access to the following services, either on site or through formalized collaborations, is recommended: drawing blood samples, meeting basic needs such as housing and food, education on reduced-risk drug use, HCV and HIV treatment, as well as HIV pre- and post-exposure prophylaxis and outreach services (i.e., services that are available as close as possible to the population).

Who offers the expanded basket of services?

- ★ Some parts of the expanded basket of services can be provided on-site by the partner care team.
- ★ All other services can be obtained by the person being monitored with the help and support of their team. For example, a member of the team can accompany the person or refer them to community organizations in the area, harm reduction sites, and clinics that are specialized in HCV and HIV treatment.

Figure 3. Expanded basket of services for teams supporting persons with OUD*

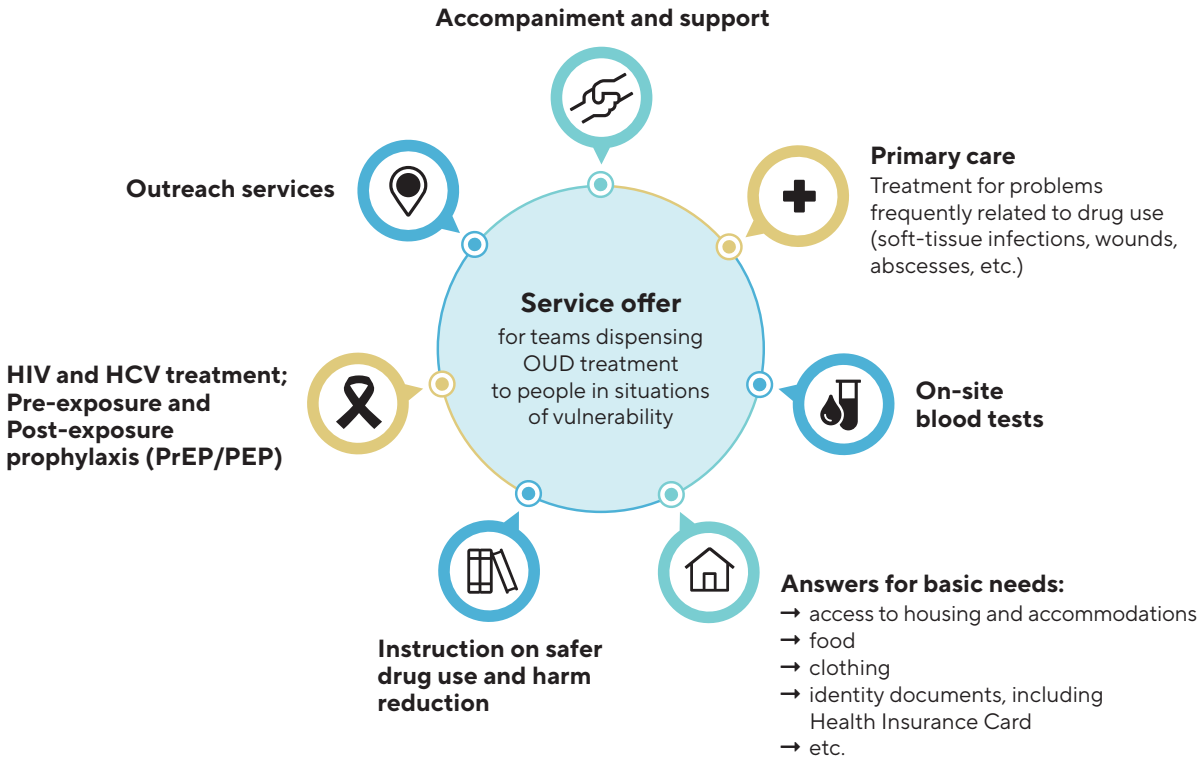


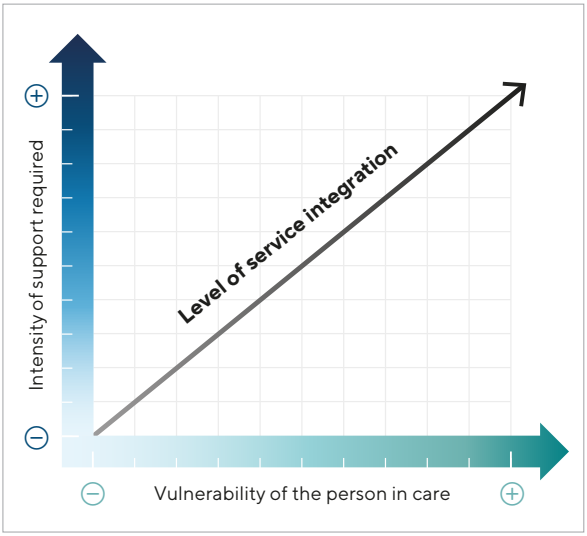
*Figure from the Québec Guide to Improving Practices in the Management of Opioid Use Disorder[3]

Furthermore, the more vulnerable a person's apparent biopsychosocial situation, the more important it is to have fully integrated care and services that are provided at one site if possible (i.e., the minimum basket and the expanded basket).

Depending on the nature and extent of a person's needs, different service options may be more or less appropriate (see Chart 1). All care settings (including emergency departments and prisons) should be able to offer a level of services adapted to the individual's needs.

In short, persons with OUD may also have numerous mental, physical, and psychosocial comorbidities. A varied and flexible range of services, administered by a partner care team, is required to meet the needs associated with these comorbidities.

Chart 1. Level of service integration



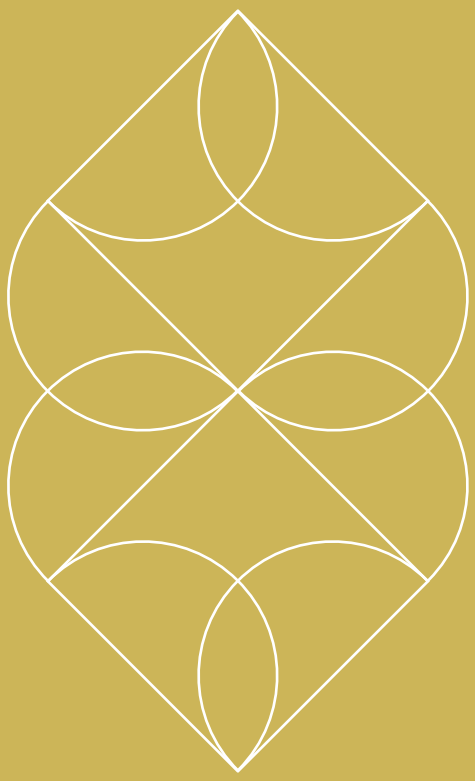
4.2 Collaboration with institutional and community partners

To offer a comprehensive range of services and a holistic approach to persons in treatment, it is necessary to establish processes and protocols for fluid collaboration between care teams and regional pharmacies, community organizations, addiction recovery housing, hospitals, police services, employment assistance services, primary care services, mobile services, housing resources, correctional services, and psychiatric teams.

With the agreement of the person in treatment, an individualized service plan can be developed by several partners in response to complex needs.

To promote a better understanding of the resources and partners that are likely to intervene with people who use opioids, knowledge transfer activities (e.g., cross-training) and collaboration forums can be established to bring together the various organizations involved.

CHAPTER 5



Support, continuity, and the therapeutic relationship

Chapter 5. Support, continuity, and the therapeutic relationship

5.1 Building and maintaining the therapeutic relationship

Many studies have shown that the quality of the therapeutic relationship between the clinician and the person in treatment influences the effectiveness of physical and psychological treatments.[106] The attitude adopted by their professionals is a determining variable in the recovery process of persons with OUD. Empathy, kindness, and trust are favourable to recovery, whereas judging the person and lacking respect are unfavourable.[52]

A high quality therapeutic alliance involves a shared understanding of the goals of treatment and the actions required to achieve them, the creation of a bond between the clinician and the patient, and the clinician's empathy toward the person.[106,107] People in treatment speak of the importance of feeling understood, accepted, and supported.[108]

At the clinical level, several strategies have been proposed to strengthen the therapeutic alliance, including open and active communication, investing time to build trust, supporting the person toward the achievement of their goals, adopting an individualized approach, collaboration, and a holistic perspective.[108]

The following strategies are suggested on the website of the American Psychological Association[109]:

- Fostering mutuality (the professional and the person in treatment as equal partners) and collaboration (e.g., working together to define treatment goals)
- Being flexible and responsive
- Using feedback
- Repairing therapeutic ruptures (e.g., recognize and discuss any misunderstandings)
- Dealing with negative emotions (e.g., practising introspection and avoiding countertransference)

Perspective of someone in treatment:

> *When I see my doctor, I get the feeling that she doesn't just want to "sort things out." I feel that she really wants to know how I'm doing. The treatment she gives me isn't perfect, but that's OK, because I feel she's doing her best.*

Clinical perspective:

> *When a person is doing well, that's a good time to develop the therapeutic alliance. We make jokes and nurture the relationship. Afterwards, if the person falls into another crisis, the door is open to intervene, because we've already worked on this.*

5.2 Understanding the risks and benefits of treatment for OUD

OAT promotes retention in treatment, cessation or reduction of illicit opioid use, reduced mortality and morbidity, and reduced risk of contracting HIV and hepatitis C for people who inject opioids.[2]

OAT also comes with certain risks, and balancing the risks and benefits is essential to therapeutic follow-up for people in OAT. In general, clinicians must deal with three main categories of risk:

- Risks of overdose
- Risks of diversion of the prescribed OAT
- Risks of serious side effects

When someone begins OAT, certain factors can contribute to the risk of overdose, including unsupervised use, continued use of illicit opioids, and the use of alcohol and benzodiazepines.[110]

Historically, three measures have been put in place to reduce the risk of overdose or diversion:

- Urine tests, to document the substances used by the person,
- Supervised daily use of the prescribed OAT, to prevent diversion or misuse, and
- Enrolment in the Alerte program, to prevent misuse and diversion of pharmaceutical opioids.

These practices can have undesirable effects for some people in terms of treatment retention, social integration,111 and the quality of the therapeutic relationship.[112] **Exercise care with these measures, based on an individual assessment of the risks and benefits for each person**.

It should also be noted that, **at the time of this writing**, urine tests no longer necessarily detect all the new substances contaminating products sold on the illicit market.[P] In addition, the Alerte program has also become less useful since the introduction of the Québec Health Record.

P Health Canada Safety Alert

"All in all, there is not, nor will there ever be, a world so tightly controlled that we will achieve zero risk. In fact, [...] there are certain risks that we have to run in order to ward off others." [Our translation]

Couturier and Belzile (2018)[113]

Perspective of someone in treatment:

I expect the people involved to be intelligent, have good judgment and exercise care. That they won't treat every patient with a one-size-fits-all approach.

5.2.1 Balancing the risks and benefits of the safety measures in OAT

From a therapeutic alliance perspective, the risks of overdose are discussed openly with people so that they can make informed choices about treatment and their use of psychoactive substances (see Section 1.2.2 on harm reduction). For urine tests, unsupervised doses, and the Alerte program, maintaining the therapeutic alliance between the person and the health care providers appears to be fundamental to navigating the potential risks and benefits of each measure.

Clinical perspective:

When I have the impression that someone isn't telling me the truth, I tell myself that there's always something real behind the lie: fear, shame, suffering. This is how I stay receptive to what they're saying.

Perspectives of persons receiving treatment:

In order for the team to help me stay wary of the risk of overdose, I need to be able to tell the truth, without fear of being punished or getting a lecture. The professionals have to be able to hear the truth and work with it.

For me, urine tests are pointless because I'm open about my use. But I understand that professionals have often been lied to, and they're worried. But that doesn't help build a relationship of trust, especially if it's done in a punitive or paternalistic way.

5.2.2 Urine tests—precautions

Managing overdose risk is part of a harm reduction approach, the purpose of which is **to reduce and prevent the risks associated with substance use during OAT**. Urine screening tests represent one tool that can provide people with information and help them manage the risks associated with the use of potentially contaminated substances.

The CMQ, OPQ and OIIQ guidelines (in French only) stress that urine tests should not be used in a punitive manner, "for example by directly associating them with the number of unsupervised doses."[4] [Our translation] These Guidelines, published in 2020, do not recommend frequent and regular use of urine tests. They suggest avoiding measures whose use implies a punitive intent. They state that [our translation]:

- "The person in treatment has the right to refuse to take the test."[4]
- "Directly supervised urine testing runs counter to respect for patient privacy."[4]
- "The patient also has the right to be informed in advance when a test will be requested."[4]
- "Most people should not require frequent and regular testing during treatment."[4]
- "The community pharmacy is not a suitable place to collect or store urine samples."[4]

Lastly, it is important to note that urine tests have limitations. The various urine tests do not systematically detect all types of substances. In addition, they can produce false positives and false negatives.[4]

5.2.3 The Alerte program

The Alerte program (in French only) matches patients with a single prescriber and sends alerts if false or falsified prescriptions are detected.[114] The program can be used to prevent the risk of overdose or diversion among people with multiple prescribers or pharmacies.[9]

To avoid stigmatizing people on OAT, caution should be exercised when implementing this safety measure, and it should only be considered if the physician has significant doubts about the person's use of prescribed drugs.[3]

> "The Alerte program matches patients with a pharmacy to facilitate monitoring of their drug therapy. [...] A patient's refusal to enrol in the Alerte program is not a valid reason for delaying the initiation or continuation of treatment."[4] [Our translation]
>
> **CMQ, OIIQ and OPQ guidelines (2020)[4]**

5.2.4 Unsupervised doses

The purpose of unsupervised dosing is to improve autonomy, quality of life, and treatment adherence and retention. Granting unsupervised doses nevertheless represents a dilemma for many clinicians. Reference guides and guidelines indicate that clinicians should use their clinical judgment to assess the risks and benefits associated with unsupervised dosing.[4,90] The CMQ, OPQ and OIIQ guidelines[4] (in French only) state that the prescriber's decision to use unsupervised doses must be justified in the patient record and that, as a result of the flexibility introduced during the COVID-19 pandemic, pharmacists may also dispense unsupervised doses until further notice (see the clinical tool on optimizing the role played by community pharmacists with people in vulnerable situations [in French only]). It is recommended that the prescriber be informed of community pharmacists' dispensing capabilties.

In the case of bottled methadone, consideration must also be given to the stability of the solution (based on the product monograph and the diluent used to prepare the bottles—in general, the period of maximum stability is 14 days when the solution is kept refrigerated and 7 days if the methadone has been diluted in apple juice[Q]).

The benefits of unsupervised doses include improved quality of life and social involvement.[90]

The risks associated with unsupervised doses include intoxication of a family member who has access to the opioid agonist, diversion to the illicit market, non-adherence to treatment, and environmental threats (e.g., theft of doses).[90]

Perspectives of persons receiving treatment:

People can be transparent if they feel that the information they share is received with a constructive attitude of working together to manage the risks.

Going to the pharmacy every day can encourage use when the pharmacy's business hours don't mesh with other obligations. For other people, the daily routine may be beneficial for a while. When all is said and done, you need to get to know the person and see what matters to them.

When I go to the pharmacy, my pharmacist gives me lots of advice about the interactions between substances and medication, and the precautions I need to take. I feel that he really cares about me. He never looks down on me, or with disdain, as others have in the past.

Q Refer to product monographs for more details on stability data and recommended dilutant brands.

"The granting of unsupervised doses forms part of the treatment plan after the prescriber has analyzed the benefits and risks associated with taking doses home. The prescriber's clinical judgment remains key to the decision on unsupervised dosing. Pharmacists may also decide not to dispense one or more unsupervised doses if they believe that this poses a danger to the patient or the community, and ask the patient to come back to the pharmacy to take them. The pharmacist should inform the prescriber of this decision as soon as possible. Obtaining unsupervised doses depends on the patient's ability to manage his or her medication, i.e., on the stability of his or her functioning." [Our translation]

CMQ, OIIQ and OPQ guidelines (2020)[4]

To support professionals' clinical judgment on whether or not to grant of unsupervised doses, the Decision Support Tool for Granting Unsupervised Doses provides a summary of the risks and benefits associated with unsupervised doses, as well as a series of questions to be discussed between the partner care team and the person in treatment.

Some examples of questions to support clinical reasoning

- **What are the potential benefits of unsupervised dosing?**
  Less spent on travelling and expenses, social and professional integration, adherence to treatment, autonomy, self-esteem, the feeling of returning to a normal life, etc.
- **What are the potential risks?**
  Intoxication, overdose, diversion, etc.
- **How will this person ensure their own safety?**
  By understanding of the risks, through stability under treatment, their mental state, etc.
- **How is this person able to ensure the safety of the community?**
  Through safe storage, residential stability, etc.

For more information: Decision Support Tool for Granting Unsupervised Doses

Clinical perspective:

When I feel like saying "No" to a patient, I like to ask myself, "Am I really helping the person in front of me? Or am I taking care of my own fears?"

5.2.5 Intervening in the event of severe intoxication or overdose

Supporting people with OUD may involve intervening in the event of severe intoxication or an overdose of opioids or other substances. To learn how to recognize and respond to intoxications and overdoses, all professionals involved should consult the tool entitled Knowing How to Recognize and Respond to a Severe Intoxication or Overdose Related to Psychoactive Substance Abuse or Alcohol Withdrawal.

The following tools may also be useful to professionals:

- **Group prescription for naloxone** (CCSMTL) (in French only)
- **Initiating the administration of naloxone (Narcan®) to reverse opioid-related respiratory depression in an institutional setting** (CCSMTL) (in French only)
- **Group prescriptions: video presentations** (CCSMTL) (in French only)
- **Tools to facilitate access to and administration of naloxone** (INSPQ) (in French only)

Urine samples from people who have undergone an overdose can be sent to the Centre de toxicologie du Québec (CTQ) to contribute to drug epidemiological investigations. The procedure can be found on the INSPQ website.

5.3 Dealing with missed doses and no-shows

> "In the course of treatment, patients may miss one or more days of treatment, whether intentionally or not. Tolerance to opioids can decline rapidly when medication is interrupted, especially if the patient is not taking other opioids, making him or her even more vulnerable to intoxication." [Our translation]
>
> **CMQ, OIIQ and OPQ guidelines (2020)[4]**

Protocols for managing missed doses can be found in the appendices to the CMQ, OPQ and OIIQ guidelines[4] (in French only) to support prescribers treating patients who may have a reduced tolerance to opioids.

Since the adoption of Bill 31, pharmacists can also play an important role in avoiding treatment interruptions due to missed doses. The clinical tool Optimisation du rôle du pharmacien communautaire auprès des personnes en situation de précarité[115] (in French only) describes how pharmacists can make adjustments to OAT.

Questions to support clinical reasoning on OAT redosing following missed doses

- To what extent has opioid tolerance decreased since the last dose of OAT?
  - Has the person used opioids every day?
  - Has the person been incarcerated or hospitalized, and therefore had less access to opioids?
- What is the risk of overdosing on the drug used to redose the OAT?
  - Is the person redosing from a pure mu agonist, such as methadone or slow-release oral morphine, or a partial agonist, such as buprenorphine-naloxone?

Numerous barriers can hinder adherence to OAT, including rigid treatment requirements,[111] residential instability, lack of transportation, mental health problems, use of other substances,[116] and lack of childcare.[117] When faced with a person in treatment who has repeatedly missed appointments, the service provider should collaboratively analyze the barriers that are hindering their access to care (see the tool for thinking about and identifying barriers to access and retention) (in French only).

An open, non-judgmental dialogue enables professionals and patients to identify the resources that could help them adhere to all components of treatment.

Perspective of someone in treatment:

The first thing is really to LISTEN to people when they say something. If someone tells you they don't have transportation, or that they don't have a babysitter, it's probably true!

"Access to OUD-related services should be possible in proximity to the living environments of people who wish to obtain treatment. In cases where services may not be offered throughout the territory, remote care, such as telemedicine, should be put in place. In addition, outreach services should be established for people who are more isolated or who experience difficulties approaching health care institutions."

Québec Guide to Improving Practices in the Management of Opioid Use Disorder (2020)[3]

Here are some examples of questions to ask a patient who misses doses or appointments:

- Are there any services that could be put in place or resources that could be mobilized to make it easier for you to attend appointments?
- Are there ways we could adjust the appointment schedule to make it easier for you to attend?
- Are there any barriers to treatment that you would like to discuss?
- How can we work together to achieve your treatment goals?

5.4 Teleconsultation

When distance from the healthcare team is an obstacle, the provider may want to consider telemedicine (more specifically, teleconsultation). Teleconsultation can also be used to facilitate retention in treatment for people who have family or socio-professional responsibilities, or who do not have a vehicle or access to public transit.

TELEMEDICINE

The remote practice of medicine using information and communication technologies. Telemedicine is used for medical procedures such as clinical assessment, diagnosis, treatment and interpretation of additional procedures. It can take place synchronously, if the participants are present in real time (e.g., during a videoconference), or asynchronously, if the participants are not present at the same time (e.g., through an email exchange). [Our translation]

Definition provided by the CMQ (2021) [10]

Important: Further information on the conditions under which telemedicine is practised is available on the website of the Collège des médecins du Québec (in French only)

As for prescribing OAT in a teleconsultation, the Collège des médecins du Québec[118] says the following [our translation][R]:

Prescribing opioid agonists

- A physician may renew a prescription or reinstate a therapy for a patient by teleconsultation if the medication history can be confirmed through the medical record or the QHR, the physician considers this justified by the patient's condition, and the previous therapy was well tolerated.[118]
- Initiation of treatment with opioid agonists (OAT) is authorized in emergency situations when the physician considers that delaying the start of therapy would result in a risk for the patient and the conditions listed below are met.[118]

Required conditions for initiating OAT by teleconsultation

- The patient has been referred to the physician by a practitioner who is experienced in working with this population (e.g., a nurse, psychologist, social worker, or practitioner from a treatment or harm reduction centre). This practitioner contacted the physician who is carrying out the teleconsultation.[118]
- The physician has obtained all the relevant information[*] in the patient's history, and a mental examination appropriate to the situation has been carried out [by the physician or by another authorized professional].[118]
- The physician considers that a physical examination is not necessary or that it can be carried out at a later date, in due course. An examination by a nurse could replace the physician's examination if the physician believes that the set of tests carried out by the nurse is sufficient at this time. However, in circumstances where a physical examination by a physician is deemed necessary to initiate OAT, an agonist cannot be prescribed, and the physician will need to see the patient in person to complete an assessment.[118]
- The physician has everything needed to make a diagnosis or a relevant differential diagnosis.[118]
- The physician chooses the safest treatment in the circumstances, and assesses the risks of toxicity, overdose and diversion of opioids, in relation to the treatment itself.[118]
- The physicians shall ensure that the patient receives the follow-up required by their condition, either by teleconsultation or in person, while collaborating with the existing multidisciplinary team. Physicians shall ensure that the required laboratory tests and, if necessary, an electrocardiogram (ECG), are carried out in a timely manner. As stated in the recently published guidelines on this subject, the professionals shall agree on a treatment plan that is tailored to the patient's reality and needs, while seeking the best balance in terms of managing the benefits and risks. In this time of pandemic, physicians must also weigh the risk of COVID-19 contamination.[118]
- The quality of patient care provided by the physician complies with the relevant standards.[118]

* According to the guidelines on the treatment of opioid use disorders (OUD) published in 2020 by the Collège des médecins du Québec, the Ordre des pharmaciens du Québec and the Ordre des infirmières et infirmiers du Québec, a full clinical assessment should be carried out, if possible, at the start of treatment, and entered in the patient record, in accordance with current regulations. Depending on the situation, it may be advisable to complete the assessment during subsequent visits and prioritize a rapid start to treatment.[118]

R The CMQ points out that this relaxation of the teleconsultation rules is valid only during the COVID-19 pandemic. The pandemic period corresponds to the duration of the health emergency decreed by the provincial government on March 13, 2020. It will end when the decree is lifted.[118]

5.5 Managing conflicts between professionals and patients in treatment

To manage conflicts, the Canadian Medical Protective Association suggests strategies for listening to, communicating with, and managing the expectations of people in treatment.

In the event of conflict, peers can mediate between the patient and the treatment team.[119]

It is also important to remember that the *Act respecting health services and social services* stipulates the following: "Every person is entitled to choose the professional or the institution from whom or which he wishes to receive health services or social services."[62] It also states: "Every person whose life or bodily integrity is endangered is entitled to receive the care required by his condition. Every institution shall, where requested, ensure that such care is provided."[62]

Perspectives of persons receiving treatment:

When there is friction between a clinician and a patient, support from a peer or a neutral street worker can help calm things down.

When a clinician and a patient have a conflictual and difficult relationship, why not try changing clinicians?

Clinical perspective:

Clinical supervision and co-intervention can serve as tools for dealing with conflicts.

5.6 Ending or suspending the therapeutic relationship

Unfortunately, clinical issues may arise for professionals and teams treating OUD. Situations of physical or verbal violence may lead professionals to ask themselves whether they have reasonable grounds for terminating a patient's treatment, either temporarily or permanently. There is no simple answer to this question, as each situation is unique. However, there are several steps that can be taken beforehand to prevent crises that could lead to suspended care or an expulsion. The article *Prévenir la violence dans le milieu médical – comment réagiriez-vous face à un patient violent?*[120] (in French only), published in *Le Médecin du Québec*, is an excellent guide on how to think about and implement preventive measures. The CMQ, OIIQ and OPQ guidelines[4] (in French only) underscore how interrupting treatment should be a last resort. Physicians who are considering terminating a therapeutic relationship can call on the services of the Canadian Protective Medical Association to assist them in the early stages of the process. They can also contact the CMQ's advisory services.

In other cases, it may be the person in treatment who asks for a change of physician or care provider. In this respect, the *Act respecting health services and social services* stipulates the following: "Every person is entitled to choose the professional or the institution from whom or which he wishes to receive health services or social services."[62] In cases where it is difficult to meet this request (e.g., a lack of specialized professional staff or repeated requests for frequent changes), professionals can refer to sections 5.1 (on the therapeutic relationship) and 5.5 (on conflict management) of this document on how to openly welcome the request and support the search for solutions.

Clinical perspective:

When it becomes necessary to impose a limit on a patient's access to the clinic, the team sits down for some in-depth discussions and looks for ways to ensure continuity in this person's medical care.

5.7 Avoiding breaks in treatment

For people in treatment, continuity of care between professionals, disciplines, and institutions is a key factor in the recovery process.[52]

5.7.1 Hospitalization, detention, and incarceration

When a person is hospitalized, detained, or incarcerated, OAT should be continued without interruption (it is no longer necessary to obtain an exemption to prescribe OAT, including in hospital settings). Similarly, it is essential to ensure continuity of OAT when a person is discharged from hospital or prison.[9,78] A checklist for organizing a transfer can be found in Appendix 2. Persons leaving prison are at increased risk for an overdose.[121]

N.B.: It is important to bear in mind that drugs administered in a hospital setting and in certain prison settings do not appear in the QHR.

It is recommended that professionals working in hospitals and prisons contact the person's treatment team to ensure continuity of treatment. Whenever possible, discharges from hospital or prison should be prepared jointly by the partner care teams, to avoid a disruption of services.

Persons who have begun an OAT in hospital or prison should be referred to an addiction rehabilitation centre (CRD) when they leave to promote treatment continuation.

Collaboration and coordination between institutional and community professionals can avoid breaks in the continuity of care.[4,90] The *Act respecting health services and social ser-*

vices states that an institution must "ensure that its services are provided in continuity and complementarity with those provided by the other institutions and resources of the region, and that such services are organized in a way that reflects the needs of the population it serves."[62]

The CMQ, OIIQ and OPQ guidelines[4] (in French only) state that when someone on OAT leaves prison, the prescriber must contact the community pharmacist chosen by the patient to provide the prescription, make the patient aware of the risks of overdose, encourage the patient to continue on the OAT, provide the patient with naloxone, and liaise with community workers to ensure drug coverage.

Perspective of someone in treatment:

> *We could have a card, to keep in our wallet, with one or two **working** phone numbers to contact members of our treatment team. This would help us put our various professionals in touch with each other.*

Remember...

- Since 2018, prescribers no longer need an exemption to prescribe an OAT in Canada.
- Need support in how to prescribe an OAT? The Équipe de soutien clinique et organisationnel en dépendance et itinérance is available to answer your questions: escodi.ccsmtl@ssss.gouv.qc.ca
- Urgent clinical questions:
  CHUM telephone line, available 24/7: 514 890-8316.
- The Checklist for Organizing a Transfer tool, with a section on travel, is available in Appendix 2.

5.7.2 Travel

Travelling can be part of the recovery process, but the person's adherence to OAT is at risk of being disrupted. For people on methadone who can manage their medication safely, tablets may be taken, but for the duration of the trip only. According to Health Canada rules, a maximum 30 day supply of OAT can be taken out of the country.[9,77,122] If methadone tablets are prescribed to facilitate travel, the CMQ, OIIQ and OPQ guidelines4 (in French only) indicate that a new prescription must be issued (stating the reason for and length of the trip), that unused tablets must be returned to the pharmacist, and that this measure must be used on an exceptional basis.

> Taking OAT continuously is essential to avoid withdrawal and relapse. At each visit, and particularly during transition periods (e.g., discharge from hospital, entering or leaving prison), the clinician should ensure that the person:
>
> - Has a valid prescription and a follow-up appointment, and
> - Will be able to obtain their medication. [Our translation]
>
> **INESSS guide to optimal use (2021)[9]**

The Checklist for Organizing a Transfer tool, provided in Appendix 2, has a section on travel.

5.8 Reducing access and retention barriers in care and services

As mentioned in Chapter 1, social inequalities can create barriers to treatment. Barriers to access and retention can therefore be found at the structural, process, and individual levels.[123] Structural barriers include structural stigma, large regions where transportation is complicated, and difficulties accessing information on substance use disorder treatment. Barriers related to process include the regulations and restrictions adopted by service institutions and the relationships between persons in treatment and their service providers. At an individual level, the person in treatment may have had bad experiences with treatment in the past or have misinformation about it.[123]

In all cases, professionals and managers can work together to relax treatment requirements and provide people with the means to access care or continue their treatment. For example, for people in very vulnerable situations, this may mean offering walk-in services and speeding up the assessment processes. For people who are employed or have young children, it may mean less frequent appointments, telephone follow-ups, or evening and weekend opening hours to not interfere with work or parental responsibilities. To this end, professionals and managers can identify ways to avoid exacerbating someone's already vulnerable situation by ensuring that treatment does not hinder their other responsibilities and activities, while still working toward their recovery goals.

For help in identifying barriers to access and retention in care and services, contact ESCODI at escodi.ccsmtl@ssss.gouv.qc.ca.

5.9 Recognizing the needs and contributions of the person's family and friends

Family and friends can play a number of roles, including intervening in the event of an overdose,[124] helping gain access to services,[125] and supporting the recovery process.[126] They can also contribute to the analysis of the person's situation and treatment planning.[126-128] In addition, a positive social support network helps achieve effective OUD treatment.[129]

However, it can sometimes be difficult for family and friends to be involved in their loved one's treatment,[128] as the participation of a third party can raise issues of confidentiality and patient autonomy. However, when persons in treatment wish to involve a family member or friend in the therapeutic process, they can give their consent to the sharing of certain information.

Family and friends may sometimes need help coping with their status as caregivers. The loved ones of people in treatment for OUD have training and information needs that have been documented. Among other things, they appreciate receiving information about the treatment and how to administer naloxone.[130] Sometimes, family and friends also want to better understand substance use disorders.[131]

♡ *Perspectives of family members and friends:*

We'll do anything to help. We can provide day-to-day support and intervene in the event of an overdose. Our opinion should be taken into account if the patient agrees to have us involved in the monitoring.

The family and friends of someone with OUD can also feel stigmatized. It's important that they receive support as caregivers.

Family members and friends could benefit greatly from information on the various families of psychoactive drugs. This could help them better understand drug use and overdose risks.

As part of their work with persons in treatment and their loved ones, healthcare professionals have the opportunity to raise awareness among family and friends of the need to prevent, identify, and intervene in the event of an overdose. They can also encourage positive relationships between persons in treatment and others by including loved ones in the planning of the therapeutic process and by stressing the importance of positive relationships between persons in treatment and family and friends.[101] They can also direct family and friends to relevant resources.

Useful resources for family and friends:

- Services for family and friends offered by an addiction rehabilitation centre (CRD).
- **Drugs, Help and Referra**l (confidential 24/7 support): Services by chat or telephone at 1 800 265-2626
- PROFAN training on dealing with overdoses (514 910-1880; **profan@aidq.org**)

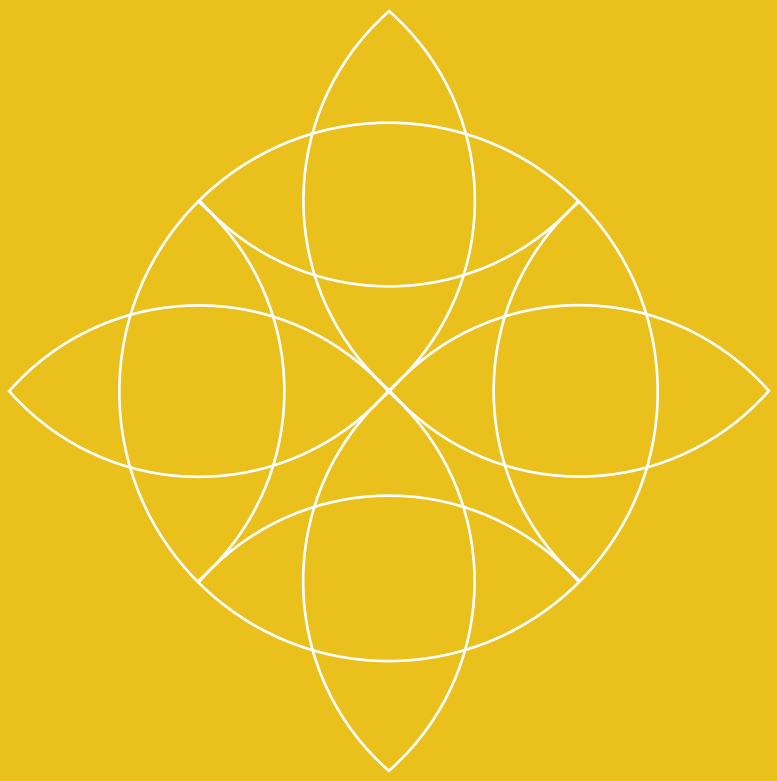
5.10 Support, continuity, and the therapeutic relationship: a checklist

In summary, Chapter 5 recommends investing in the therapeutic relationship to prevent treatment disruptions. By recognizing the risks and benefits of the safety measures in an OAT, and by weighing them through reflective strategies, professionals can support continuous care for the person.

Checklist

- ☑ Give priority to the therapeutic relationship
- ☑ Understand the benefits and risks inherent in OAT
- ☑ Weigh the benefits and risks
- ☑ Manage missed appointments and doses
- ☑ Manage conflicts between professionals and patients
- ☑ Avoid breaks in treatment
- ☑ Reduce barriers to access and retention in treatment
- ☑ Recognize the needs and contributions of family and friends

CHAPTER 6



Professional roles and responsibilities in the organization of services

Chapter 6. Professional roles and responsibilities in the organization of services

Support for people living with an OUD can be initiated and continued in a number of care settings. Depending on the level of vulnerability and needs, the person may be offered care and services at primary care clinics, specialized clinics, hospitals or prisons, or by outreach teams. When care and services are provided in a specialist clinic or by outreach teams, the professionals providing support to the person in treatment are called the "partner care team."

6.1 Partner care team

Depending on their discipline, various professionals are responsible for carrying out the treatment of OUD. To ensure that services are coordinated in accordance with professional standards of practice, this chapter describes the roles and responsibilities that may be assumed by the members of the partner care team, under the coordination of professionals in management roles.

Beyond this team, partnerships with other professionals and teams help provide a coordinated response to all the biopsychosocial needs of people on OAT.

Lastly, it is important to remember that the person in treatment is also part of the partner care team. "Every patient is a partner in his or her own care. Patients are required to provide a number of treatments for themselves and make the medical decisions affecting them. As such, they are themselves caregivers, with specific experiential knowledge. As a result, they are full members of the care team. This is why the idea of a caregiver-patient relationship must give way to that of a caregiver-caregiver relationship." [Our translation][132]

6.2 Collaborating with other professionals

Interprofessional (or interdisciplinary) collaboration[S] can be defined as a process of mutual and reciprocal transformation of the self and the other through sustained contact so that actions are coordinated to better meet the complex needs of service users.[113] The goal is to "use an approach based on a holistic view of the person, whether through teams working in a single location or in partnership."[3]

S The terms "interdisciplinary" and "interprofessional" are used interchangeably in this guide. While the former refers more specifically to the concept of discipline (a set of rules, standards, practices, and theories), the latter refers to the profession (or the application of a discipline).[113] Ultimately, both terms reflect the relationship between the actors.[113]

The results of a survey of directors, managers, and practitioners in the field of OAT highlight the importance of interprofessional collaboration and interdisciplinary training to meet the complex needs of persons seeking help.[133]

> "The OIIQ, the CMQ and the OPQ believe that, in all care settings, interprofessional collaboration and shared management in a context of collaborative practice help ensure the delivery of quality and safe care, improve access by the public to health care and services, and facilitate the coordination and continuity of care for patients." [Our translation]
>
> **Joint position statement by the OIIQ, the CMQ and the OPQ on interprofessional collaboration: enhancing the quality and safety of care (2015)**[134]

As part of OAT follow-up, a complementary range of services can be implemented by the partner care team. Adopting a similar perspective to that of the partner care team, the Montreal Model "is based on the recognition of the patient's experiential knowledge gained from living with a disease, which is complementary to the healthcare professional's scientific knowledge."[135] The patient is therefore considered a caregiver, a complete member of the treatment team. Patients are involved throughout the care process, particularly in the context of chronic illness, where their care skills are mobilized.[135]

Factors that promote effective interprofessional collaboration include team structure (size, membership, team facilitators), social processes (conflict management, communication, peer support), formalized processes (team vision and goals, quality control, problem solving, meetings, decision making), attitudes (accountability and support for innovation) and recognition of the benefits of collaboration and flexibility.[136]

Clinical perspective:

We can never stress enough how important it is for us – practitioners, caregivers and people in treatment – to join forces. To try to work together as a team, across professions and their statuses, across the barriers that too often separate disciplines, each organization, across the invisible barriers that separate those who help from those who are helped. We need to be guided by an acute awareness that, faced with complex situations, we need to coordinate our work together.

Persons with OUD may also have multiple physical and psychosocial comorbidities. To meet the needs associated with these comorbidities, collaboration with care and service partners is essential. In this respect, good knowledge of local resources, and the professionals who work there, facilitates referrals.

Who does what to mobilize the relevant care partners?

Physicians and specialized nurse practitioners can:

- ✓ Collaborate with physicians from a variety of specialities to improve the management of comorbidities.

All professionals (physicians, nursing assistants, psychosocial professionals, peer helpers, community pharmacists) can:

- ✓ Work with the regional addiction rehabilitation centre (CRD) to obtain clinical support or specialized interventions for someone who wants it;
- ✓ Work with community organizations to help improve the psychosocial well-being of people who feel they need it.

6.3 Sharing tasks according to professional roles and responsibilities

Support for people living with OUD extends beyond an OAT prescription; it involves providing complementary care and services designed to meet the individual's needs. In this respect, all teams working with people who are in OAT should systematically offer a minimum basket of services that reduces drug use complications. An expanded basket of services, ideally offered on-site, should also be available for people with more complex needs (i.e., concurrent healthcare and psychosocial needs).[3] The service baskets are presented in Chapter 4.

Supporting persons with OUD can sometimes involve grey areas when professional roles are being shared. We have identified the following specific activities that can be attributed to each discipline, according to expertise and responsibilities.

6.3.1 Physicians' role in supporting people living with OUD

Physicians are "capable of establishing with patients, by sharing information and incorporating information from other members of the care team, an overall view of their health status, coordinating their care plans and, if required, helping guide them through the health care and services system." [Our translation][137] Physicians assess, treat and monitor patients' overall health, in compliance with: (1) their code of ethics, (2) the *Règlement sur les dossiers, les lieux d'exercice et la cessation d'exercice d'un médecin,* and (3) the *Règlement sur les normes relatives aux ordonnances faites par un médecin.*[58]

Physicians provide clinical monitoring to "identify clinical alerts, anticipate risky situations and rapidly detect complications and deterioration in the state of health of patients using opioids."[4] [Our translation] They record their interventions in the person's file, based on the information listed on page 26 of the CMQ, OPQ and OIIQ guidelines (in French only).[4]

The CMQ, OPQ and OIIQ guidelines (in French only)[4] also emphasize that the physician involved in the care and services of someone in treatment for OUD must also speak to the person about the safe storage and management of opioids, record the clinical reasons for a decision to offer a treatment that differs from the guidelines, and comply with the laws and regulations on prescribing narcotics. In the context of the COVID-19 pandemic, the exemptions granted by Health Canada allow prescriptions to be given verbally until further notice.[4]

What are the main roles that can be performed by...

A physician

IN OAT

- Diagnose OUD
- Assess the person's condition
- Support informed decision-making about the choice of an OAT and prescribe an OAT
- Monitor the patient on OAT
- Discuss safe storage and management of opioids with the patient
- In iOAT: assess the person's condition before and after injection, supervise injections, administer an intramuscular injection if necessary, manage any immediate complications

IN OAT-RELATED SERVICES

- Screen for and treat STIs (including HCV and HIV))
- Vaccinate
- Prescribe contraception and pregnancy tests
- Assess and manage the person's mental health
- Provide primary health care
- Prescribe pre- and post-exposure prophylaxis
- Provide primary health care (e.g., for soft tissue infections, wounds, abscesses)
- Offering harm reduction supplies, teaching people how to use them, and providing counselling on safer consumption and naloxone administration (see Tools for Teaching Safer Injection on the ESCODI website).
- Help manage polydrug use (see the Boîte à outils [in French only] on ESCODI's website). The Drug Awareness Chart and The Drugs Wheel can also be useful sources of more information about street drugs
- Offer smoking cessation interventions
- Provide comprehensive health care, as required

6.3.2 Roles played by nurse practitioners specialized in mental health, and those specialized in primary care, as they support people living with OUD

Nurse practitioners assess patients' state of health, prescribe and interpret diagnostic tests, and prescribe medical treatments and medication.[138] Nurse practitioners specialized in mental health (NPSMHs) can improve the accessibility, quality, safety, and continuity of the care provided to persons with a mental disorder, including a substance use disorder.[139]

NPSMHs may treat a physical health problem "if they have the knowledge and skills to do so" and "[if] the problem is related to the mental disorder or its treatment, or [if] the physical health problem has an impact on the reason for the consultation or hospitalization."[139] For example, they may treat cellulitis linked to a substance use disorder. For more information on the scope of practice of NPSMHs, please refer to the Specialized Nurse Practitioners and Their Practice guideline, particularly page 17.

"Other classes of specialized nurse practitioners, for example nurse practitioners specialized in primary care and those specialized in adult care, are not empowered to assess mental disorders, so they cannot conclude whether OUD is present." [Our translation][4] Thus, a specialized nurse practitioner who is not specialized in mental health can adjust an OAT, but they cannot initiate it.

Like physicians, nurse practitioners must speak with patients about the safe storage and management of opioids, document their clinical reasons when they offer a treatment that differs from the guidelines, and comply with the laws and regulations on prescribing narcotics.[4]

Nurse practitioners also document their interventions and record them in the person's file, based on the items identified on page 26 of the CMQ, OIIQ and OPQ guidelines (in French only).[4]

What are the main roles that can be performed by...

A nurse practitioner specialized in mental health?	A nurse practitioner specialized in primary care
IN OAT	
• Contribute to the assessment, an informed choice of drug therapy and a treatment plan	
• Diagnose OUD	—
• Prescribe an OAT	• Prescribe an OAT if the diagnosis and treatment plan are established by an NPSMH or a physician
• Adjust the OAT	• Adjust the OAT if the diagnosis and treatment plan are established by an NPSMH or a physician
• In iOAT: assess the condition before and after injection, supervise the injection, administer the intramuscular injection if necessary, and manage any immediate complications	
IN OAT-RELATED SERVICES	
• Diagnose and manage mental health	• Care for a patient with a mental disorder
• Screen for STIs	
• Vaccinate	
• Prescribe contraception	
• Administer pregnancy tests	
• Provide physical health care (soft tissue infections, wounds, abscesses)	
• Draw blood	
• Offer local services (availability of services as close as possible to the population, e.g., outreach)	
• Help manage polydrug use (see the Boîte à outils [in French only] on ESCODI's website). The Drug Awareness Chart and The Drugs Wheel can also be useful sources of more information about street drugs	
• Offering harm reduction supplies, teaching people how to use them, and providing counselling on safer consumption and naloxone administration (see Tools for Teaching Safer Injection on the ESCODI website).	
• Offer smoking cessation interventions	

6.3.3 Roles played by nurses and nursing assistants in supporting persons with OUD

"The practice of nursing consists in assessing health, determining and carrying out the nursing care and treatment plan and providing nursing and medical care and treatment in order to maintain and restore the health of a person in interaction with his environment, prevent illness and provide appropriate symptom relief."[140]

In addition, nurses provide clinical monitoring to "identify clinical alerts, anticipate risky situations and rapidly detect complications and deterioration in the state of health of patients on opioids."[4] [Our translation] If a patient shows signs of intoxication, the nurse may refuse to administer a dose of OAT. The nurse also documents their interventions and records them in the patient's record, based on the items identified on page 26 of the CMQ, OIIQ and OPQ guidelines.[4] (in French only)

The main distinctions between the practices of nurses and that of nursing assistants are in terms of their contributions to assessments and the administration of intravenous medication. More specifically, nursing assistants may "participate in the assessment of a person's state of health and in the carrying out of a care plan, provide nursing and medical care and treatment to maintain or restore health and prevent illness, and provide palliative care."[141] Nursing assistants do not administer intravenous medication. They may administer prescribed medications or other prescribed substances via routes other than the intravenous route."[141] Nursing assistants may actively participate in intravenous therapy involving a short intravenous catheter of less than 7.5 cm (insert the catheter, administer an intravenous solution without additives, insert and irrigate an isotonic solution).[142]

What are the main roles that can be performed by...

A nurse (technician or graduate)	An assistant nurse
IN OAT	
▸ Contribute to an informed choice of pharmacotherapy and the treatment plan	
▸ Contribute to the follow-up of OAT	
▸ Liaise (within the team and with other departments)	
▸ Inject buprenorphine (Sublocade®) if trained for it	
▸ Supervise Suboxone® induction	–
▸ In iOAT: assess the person's condition before and after injection, supervise the injection, administer intramuscular injection if necessary, manage any immediate complications	▸ In iOAT: help assess the person's condition before and after the injection, supervise the injection, administer the intramuscular injection if necessary, manage any immediate complications in a community setting
IN OAT-RELATED SERVICES	
▸ Draw blood	
▸ Help manage polydrug use (see the Boîte à outils [in French only] on ESCODI's website). The Drug Awareness Chart and The Drugs Wheel can also be useful sources of more information about street drugs	
▸ Offering harm reduction supplies, teaching people how to use them, and providing counselling on safer consumption and naloxone administration (see Tools for Teaching Safer Injection on the ESCODI website).	
▸ Play a pivotal role in facilitating the exchange of information between members of the treatment team, including the person in treatment	
▸ Initiate and perform screening for STIs	▸ Screen for STIs in accordance with a prescription or protocol
▸ Prescribe medication for the treatment of a gonococcal infection or a Chlamydia trachomatis infection (if empowered to prescribe)	▸ Administer non-intravenous drugs or substances to treat an STI when prescribed
▸ Determine vaccination	▸ Vaccinate at the request and in the presence of a nurse or physician (or without their presence under certain conditions)
▸ Initiate and administer pregnancy tests	▸ Take samples (pregnancy tests) as prescribed and initiate pregnancy tests in certain settings
▸ Prescribe contraception (if empowered to prescribe)	–
▸ Prescribe medication for the treatment of pediculosis (if empowered to prescribe)	–
▸ Provide primary care (e.g., wound care)	▸ Offer primary care (e.g., wound care) following an assessment by a nurse
▸ Offer smoking cessation interventions and prescribe certain drugs (if empowered to prescribe)	–

6.3.4 Roles played by psychosocial professionals in supporting persons with OUD

Psychosocial professionals working in the field of substance use disorders have varied backgrounds in diverse fields of study (e.g., special education, social work, criminology, sexology), hold different degrees, and belong to different professional groups.[58]

For people diagnosed with a mental disorder (including OUD) or a neuropsychological disorder, assessing social functioning, psychological functioning, or adaptive capacity is reserved for social workers, psychologists, and psychoeducators, respectively.[141]

Clinical perspectives:

Psychosocial workers act on the social determinants of health, which include meeting basic needs, social reintegration, mental and physical health, access to health care, social affiliations, socio-professional reintegration, recognition of diversity, relations with the justice system, and action on macro-systemic issues.

Meeting a person's basic needs (food, clothing, etc.) can help alleviate a difficult situation. You can't talk about change with someone who's hungry or cold!

What are the main roles that can be performed by...

A psychosocial professional

IN OAT
Contribute to the assessment, informed choice of pharmacotherapy, and the treatment plan
With the authorization of the person in treatment, provide their family and friends with information on OAT and the available services
Help the person understand the information and make informed decisions
IN OAT-RELATED SERVICES
Assess social functioning (social workers only)
Assess psychological functioning (psychologists only)
Assess adaptive capacity (psychoeducators only)
Assess the person's needs and develop an intervention plan
Act on the social determinants of health (including meeting basic needs, such as access to housing and accommodations, food, clothing, identity documents, income, health insurance, and drug insurance)
Offering harm reduction supplies, teaching people how to use them, and providing counselling on safer consumption and naloxone administration (see Tools for Teaching Safer Injection on the ESCODI website).
Help manage polydrug use (see the Boîte à outils [in French only] on ESCODI's website). The Drug Awareness Chart and The Drugs Wheel can also be useful sources of more information about street drugs
Contribute to mental health assessments and management
Offer local services (e.g., outreach)
Provide support in all steps related to treatment goals
Promote adherence and commitment to treatment
Help the person cope with the effects and constraints of treatment
Involve family and friends in the treatment and offer them support
Play a pivotal role in facilitating information sharing among the members of the treatment team, including the person in treatment
Support people in their legal proceedings
Accompany people to medical appointments (e.g., to dental appointments)
Manage conflicts, make people feel welcome, make contact and respond to primary needs in the waiting room
Set up mutual aid groups

6.3.5 Role played by a peer (a person with experiential knowledge of OUD) in supporting a person living with OUD

Peers have experiential knowledge. They can draw on their own experiences to better understand subjective realities, reach otherwise unreached groups, improve services, and reduce stigmatization. The role played by peers in OUD can include: harm reduction education, intervening and providing direction in accessing services, scientific research, and program governance. Peers can help professionals and administrators identify barriers to treatment and retention. They can also help defuse crisis situations and act as mediators. To support the integration of peers into service delivery, it is important to ensure clarity and flexibility in roles, training, supervision and teamwork.[143]

The following resources can support teams interested in adding peers:

- **Association québécoise pour la réadaptation psychosociale : Pair-aidance** (in French only)
- **Peer Support Québec**
- **Pairs-aidants en santé mentale : de quoi parle-t-on?** (in French only)

Perspectives of peers:

People who use drugs often don't feel understood by people with "normal" lives. They are more likely to connect with someone whose past resembles their own, someone who understands their reality. The bond of trust will therefore be stronger, right from the start. The help of a peer can be a way to open doors in the most difficult and misunderstood cases. In addition, a peer acts as a positive influence.

Peers can translate the language of professionals to that of patients, providing support and reassurance, and helping patients adhere to their treatment.

The clinical team may consider offering peer support from the very start of treatment. Patients could also be given a list of peer support organizations in their region.

What are the main roles that can be performed by...

A peer

IN OAT

- Help identify needs
- Help a person understand information and make informed decisions (explaining in lay language)

IN OAT-RELATED SERVICES

- Provide support in the response to basic needs
- Offering harm reduction supplies, teaching people how to use them, and providing counselling on safer consumption and naloxone administration (see Tools for Teaching Safer Injection on the ESCODI website).
- Help manage polydrug use (see the Boîte à outils [in French only] on ESCODI's website). The Drug Awareness Chart and The Drugs Wheel can also be useful sources of more information about street drugs
- Help people navigate public and community services
- Act on the social determinants of health (helping people take steps to meet their basic needs)

6.3.6 Roles played by community pharmacists in supporting persons with OUD

Pharmacists can play several roles in OAT. They analyse the patient's record and follow up to ensure that the prescribed OAT is appropriate, sufficient, safe, and effective. They also advise other health professionals and persons in treatment on optimal medication usage. Verbal or written communication between a pharmacist and other members of the partner care team helps ensure continuity of care.[4]

Pharmacists may adjust or extend OAT prescriptions in accordance with the conditions set out by law.[T] A pharmacist may also recommend changes to the prescriber.[4] Furthermore, "if he deems that the conditions are met and he has reasonable grounds to believe that the patient's interest so requires, he must refuse to fill the prescription, in accordance with article 37 of the Code of Ethics of Pharmacists, and take the appropriate measures following his decision."[4] [Our translation]

Pharmacists must supply, prepare, and confidentially manage the drug therapy in accordance with the standards of practice specified in section 3.2 of the CMQ, OIIQ and OPQ guidelines (in French only).[4] They must take all reasonable measures to prevent the loss or theft of narcotics under their responsibility, and maintain a register.[4]

Like physicians and nurses, pharmacists involved in the care and services of persons receiving treatment for OUD must also discuss the safe storage and management of opioids with the patient, record their clinical reasons when offering a treatment that differs from the guidelines, and comply with the laws and regulations on prescribing narcotics.[4]

Lastly, pharmacists monitor drug therapy. When persons in treatment go to a pharmacy, pharmacists assess their physical and mental state (e.g., signs of withdrawal or intoxication, signs of destabilization) to ensure that the treatment is safe. In accordance with their code of ethics, they may refuse to dispense a prescription if they consider that this is in the patient's best interests, and then take appropriate action. When a person has missed doses, the pharmacist may refer to Appendices III and IV of the CMQ, OPQ and OIIQ guidelines.[4]

T Exemption valid until 2026.

What are the main roles that can be performed by...

A pharmacist

IN OAT

- Contribute to assessments, an informed choice of drug therapies, and treatment plans
- Monitor drug therapy (supervised administration)
- Adjust, extend, or substitute a drug under certain conditions and liaise with the prescriber (see details here) (in French only)
- Administer medication in emergency situations (e.g., naloxone)
- Transfer an opioid prescription anywhere in Canada
- Have OAT delivered to someone who is unable to travel
- Prescribe a laboratory test or clinical measure that is necessary and relevant for appropriate use of the medication
- In iOAT: assess a person's condition before and after injection, supervise the injection, manage any immediate complications

IN OAT-RELATED SERVICES

- Vaccinate
- Initiate accelerated treatment of the person's partners (gonorrhea and chlamydia)
- Initiate post-exposure prophylaxis for HIV
- Initiate emergency oral contraception or hormonal contraception for an initial period not exceeding six months
- Initiate smoking cessation
- Offering harm reduction supplies, teaching people how to use them, and providing counselling on safer consumption and naloxone administration (see Tools for Teaching Safer Injection on the ESCODI website).
- Help manage polydrug use (see the Boîte à outils [in French only] on ESCODI's website). The Drug Awareness Chart and The Drugs Wheel can also be useful sources of more information about street drugs

How can pharmacists optimize their role with persons with OUD?

- Tool: **Optimisation du rôle du pharmacien communautaire auprès des personnes en situation de précarité** (in French only)

Clinical perspectives:

Pharmacists are well placed to play a central role in monitoring the social, physical and mental state of people on OAT, since they see them on a regular basis (in some cases, every day). By listening, showing empathy and observing, they can play an important role in ensuring adherence to treatment and in helping patients maintain a sometimes fragile balance. If necessary, they can intervene directly with a patient, or with the patient's treatment team.

A large part of a pharmacist's contribution is based on the support provided by members of his or her team (e.g., technical assistants, cashiers, clerks). They are the first point of contact for persons picking up their OAT, and they must be sufficiently trained to receive and serve them in an atmosphere that fosters trust and is free from any biases. In this way, people can find stability in their pharmacy, and this will have an impact on the stability of their treatment.

6.3.7 Roles specific to professionals with management and coordination tasks

In the treatment of OUD, management, coordination, and supervision roles may be performed by professional managers or clinician managers. These roles may be positioned at different levels in the organizational structure, but they all have several common denominators.

Four specific areas of management pertain to the management role in OUD treatment: (1) ensuring the appropriate combination of complementary services and the continuum of care, (2) supporting clinical programming based on known best practices, (3) supporting professional practices based on known best practices, and (4) implementing accountability mechanisms.

These four areas are described in detail below, along with practical examples drawn from a consultation conducted with managers (in French only).

Ensuring the complementarity of services and the continuum of care

Ensuring the appropriate combination of complementary services and the continuum of care also means ensuring the right intensity of services for people seeking treatment. To this end, people in management roles can establish collaborative relationships with com-

munity partners, foster interdisciplinary collaboration within the partner team, implement processes and procedures so that everyone knows "who does what" in the continuum, incorporate peers into care teams, and carry out activities to promote and raise awareness of OUD treatment in the community (share information on services and evidence-based practices). Tools are available on the ESCODI website to help identify and reduce treatment access barriers.

Perspectives of managers:

As managers, we aren't necessarily clinical experts. Rather, we are process experts. Once we know best practices, we can work on care trajectories and the various processes needed to implement them.

There are a lot of services available, and people often aren't aware of them. We need to raise awareness of these services, which are out there, and accessible. It's an issue that I'm working hard on with my teams.

Managers are responsible for influencing, publicizing and promoting the services for which they are responsible, within their own departments as well as with all external and internal partners.

We introduced the status report. It's a cascade of information from top to bottom, bottom to top. Once a week, we have a short meeting involving the assistant to the immediate superior, the nurses and the people working on OAT. This enables us, for example, to target patients who are having problems, check the waiting list and resolve certain deadlocks.

Supporting clinical programming based on known best practices

Supporting clinical programming based on known best practices may mean deconstructing the first, second, and third lines of care to promote a global approach. Strategic human resource management also permits the prioritization of essential services (e.g., baskets of services—see Chapter 4), allocation of roles and responsibilities based on skills and expertise, and provides teams with support that is tailored to their level of experience.

Opportunities for managers:

A manager can help widen the gateways to treatment (e.g., the emergency department).

A manager can support returning stabilized patients to primary care, to their general practitioner, in order to free up places in addiction rehabilitation centres and initiate more complicated treatment.

A manager can designate a professional to act as the responding professional, or assign a coordinating role to an experienced professional.

Support professional practices based on recognized best practices

Concerning support for professional practices based on evidence and recognized expertise, the manager's role revolves mainly around knowledge transfer (i.e., training, mentoring, awareness-raising, inter-regional meetings, interdisciplinary meetings, and informal knowledge sharing).

Supporting professional practices also involves ensuring the occupational health and safety of professionals through training courses such as Omega. Omega training enables workers to deal with workplace aggression.

Perspectives of managers:

We are fortunate to have a pharmacist interested in OUD who has contacted various doctors to convince them to join us in the OAT program. He offers training sessions with our caregivers and community partners.

When we have meetings on OAT, we set aside some time for refresher training. We watch videos and then discuss what we have understood. Often, the doctor can add to the discussion if any questions are raised. It's a great way to share ideas.

In the investment plan, there was an extensive list of suggested training courses, many of which were online. We went through them to make sure we were up to speed.

Some doctors lacked knowledge in this area, so they didn't dare prescribe. So we organized some dinner conferences. Doctors from emergency departments and detention centres came, and they really enjoyed it. Afterwards, they were super motivated.

As a manager, you need to have integration plans for new employees. You need to have some amount of standardization. The pandemic brought at least one good thing: there's a lot available online these days, and that's really helpful.

We match people up. An experienced employee is paired with a new employee.

Implementing accountability mechanisms

As part of their duties, managers implement planning and assessment activities. They assess the needs of clients presenting with OUD, identify means for meeting those needs, deploy the appropriate means, and document progress towards goals.

Tools are available on the ESCODI website (in French only) to support the production of a status report on the regional organization of services for OUD treatment.

Perspectives of managers:

It could be in terms of access. I have to make sure that my team offers the right service at the right time, based on the patient's needs.

We assess the needs on our territory and draw up an action plan, so that it'll lead to concrete action, not just observations.

We need indicators. We need to go far enough in the evaluation to confirm whether we have actually implemented a given service. Is it being used? Do the partners know about it?

How can managers recruit physicians to treat persons with OUD?

- Tool: **Stratégie de recrutement de médecins de famille et d'optimisation de l'interdisciplinarité auprès des populations ayant un trouble de l'usage de substances et en situation de précarité** (in French only)

6.3.8 Other support staff

The smooth running of a partner care team may rely on the presence of other actors, such as administrative staff, receptionists, and security guards. These individuals must be trained to ensure that people are warmly received and that crisis situations are deescalated. They also help manage schedules to facilitate smooth service delivery. When people come in to receive services, the quality of their contact with all the clinic's staff is always of the utmost importance. Positive interactions can contribute to their well-being and give them a sense of security.

6.4 Training and skill development

"The professional orders strongly recommend that professionals who will be treating patients with OUD take some training before offering such care and services. In addition to acquiring knowledge about OUD, it is recommended that they have a period of preceptorship with an experienced professional or are able to consult, formally or informally, an experienced professional who has acquired expertise in this field." [Our translation]

CMQ, OPQ and OIIQ guidelines (2020)[4]

Perspective of a person in treatment:

The most important qualities for working in the field of OUD treatment are:

- *Good listening skills*
- *A non-judgmental attitude*
- *A receptive nature*
- *Open-mindedness*
- *Humanism*
- *Kindness*
- *Respect*

The box below proposes a series of courses that are relevant for all staff members to promote consistent interventions and task sharing. Opportunities to shadow/observe experienced staff members can also be useful for skill development.

What training should be offered to all the professionals in the partner care team?

- Cardiopulmonary resuscitation (CPR)
- Administration of naloxone
- Crisis management, Omega training
- Training from the INSPQ (**Traitement du trouble lié à l'utilisation d'opioïdes: une approche de collaboration interdisciplinaire**) (OUD treatment: an interdisciplinary approach, in French only)
- Training in harm reduction

Profession-specific training can also help develop expertise, particularly in comorbidities (e.g., mental health, chronic or acute pain, STIs). In addition, crisis situations sometimes occur when providing care to populations in vulnerable and marginalized situations. For professionals, managing aggressive behaviour and communicating with confused patients can contribute to frustration, stress, avoidance, and low job satisfaction.[144]

In addition to training, mentoring and regular interdisciplinary meetings can support members of the partner care team.[3]

6.5 Checklist of professional responsibilities

Table 3. Summary of the main responsibilities that can be assumed by members of the partner care team

	MD	NPSMH	PCNP	Pharm.	Nrs (grad./ tech.)	Ass. Nrs.	Int. psych.	Peers	Mngr.
Diagnosing OUD	✓	✓							
Prescribing OAT and discussing safety management	✓	✓	✓						
Adjusting or extending OAT	✓	✓	✓	✓					
Transferring a prescription from one pharmacy to another				✓					
Inject buprenorphine (Sublocade®) if trained for it	✓	✓	✓		✓	✓			
Supervising Suboxone® induction	✓	✓	✓		✓				
Monitoring drug therapy	✓	✓	✓	✓	✓	✓			
In iOAT, assessing pre- and post-injection status, supervising injections and managing any immediate complications	✓	✓	✓	✓	✓	✓*			
In iOAT, administering, as required (intramuscular)	✓	✓	✓		✓	✓			
Contributing to assessments and informed choices	✓	✓	✓	✓	✓	✓	✓	✓	
Supporting family and friends	✓	✓	✓	✓	✓	✓	✓	✓	
Screening for STIs	✓	✓	✓		✓*	✓*			
Treating STIs	✓	✓	✓	✓*	✓*	✓*			
Vaccinating	✓	✓	✓	✓	✓	✓*			
Administering pregnancy tests	✓	✓	✓		✓	✓*			
Prescribing contraception	✓	✓	✓	✓*	✓*				
Making mental health diagnoses	✓	✓							
Managing mental health	✓	✓	✓						
Providing primary health care	✓	✓	✓		✓	✓*			
Drawing blood	✓	✓	✓		✓	✓			
Offering harm reduction supplies, teaching people how to use them, and providing counselling on safer consumption and naloxone administration	✓	✓	✓	✓	✓	✓	✓	✓	
Helping manage polydrug use	✓	✓	✓	✓	✓	✓	✓	✓	
Prescribing pharmacological interventions for smoking cessation	✓	✓	✓	✓	✓*				
Assessing social functioning							✓		
Acting on the social determinants of health					✓	✓	✓	✓	
Offering local care and services	✓	✓	✓	✓	✓	✓	✓	✓	✓
Supporting treatment-related initiatives	✓	✓	✓	✓	✓	✓	✓	✓	
Encouraging adherence to treatment	✓	✓	✓	✓	✓	✓	✓	✓	
Helping people cope with the effects of treatment	✓	✓	✓	✓	✓	✓	✓	✓	
Assuming a role as patient navigator		✓	✓		✓	✓	✓		
Supporting basic needs					✓	✓	✓	✓	
Ensuring the continuum of care and services									✓
Supporting clinical programming									✓
Supporting known best practices									✓
Implementing accountability mechanisms									✓

*Certain restrictions apply.

Conclusion

This guide has been designed as a clinical tool to promote support for people with OUD by applying a flexible, individualized, and collaborative approach. The clinical principles in this guide apply to persons from all ethnic, cultural, and religious backgrounds; of all sexual orientations and gender identities; of all socioeconomic backgrounds; of all ages and health conditions; without exception and without discrimination, while respecting individual differences and the needs that may arise from them.

This guide is not prescriptive. It is based on a philosophy and on clinical approaches that are designed to support the application of the CRISM National Guideline, the INESSS Optimal Usage Guide, and the regulatory and professional frameworks present in Québec. It is intended as a complement to existing tools.

The recommendations in this guide encourage professionals to work together with persons in need from a chronic illness perspective (with a long-term trajectory), recognize their experiences and skills, and help reduce the stigmatization associated with substance use.

Support guide: a checklist

Philosophy

- ☑ Accounting for social inequalities in health
- ☑ Autonomy
- ☑ Benevolence and humility
- ☑ Sensitivity to trauma and violence
- ☑ Solidarity
- ☑ Justice and equity
- ☑ Integrity and dignity
- ☑ Ethical principle of vulnerability
- ☑ Harm reduction and a holistic vision

Steps

- ☑ Make the person feel welcome
- ☑ Make an OUD diagnosis
- ☑ Tailor the assessment to the situation
- ☑ Provide essential harm reduction materials
- ☑ Support working together on choosing a drug therapy
- ☑ Prescribe a drug therapy
- ☑ Make changes or adjustments as required

Strategies

- ☑ Deliver baskets of services
- ☑ Maintain the therapeutic relationship
- ☑ Balance risks and benefits
- ☑ Manage missed appointments and doses
- ☑ Manage conflicts between professionals and patients
- ☑ Avoid breaks in treatment
- ☑ Reduce barriers to access to care
- ☑ Work in collaboration with the partner care team
- ☑ Take training and share knowledge

Patient's perspective – Some keywords to remember

- ★ Humanism
- ★ Respect
- ★ Partners
- ★ Objectives
- ★ Trust
- ★ Relationship
- ★ Information
- ★ Transparency

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APPENDICES

APPENDIX 1

Common Side Effects of Opioid Agonist Treatment (OAT)

Constipation

Constipation is a frequent side effect of opioids. It is caused by activation of peripheral μ-receptors in the gastrointestinal tract. Symptoms include decreased stool frequency, passage of hard stool, difficulty evacuating or a sensation of incomplete evacuation. The prevalence ranges from 40% to 90% across people who use opioids.[1,2,3] High opioid tolerance does not protect against constipation. Lifestyle habits such as diet and physical activity can help prevent constipation. A laxative is also generally recommended as a preventive measure. The use of an emollient such as polyethylene glycol or a stimulant such as sennoside are appropriate interventions, alone or in combination. Traditional laxatives can prevent opioid-induced constipation but frequently fail to treat it. In such cases, a combination of several agents is required. In more refractory cases, it is possible to give a peripheral μ-receptor antagonist such as naloxegol or methylnaltrexone. However, these products are expensive and not reimbursed by RAMQ or most private insurers. In exceptional cases, patients insured with RAMQ can apply for a patient exemption.

Sweating

Although poorly documented in the scientific literature, sweating or hyperhidrosis is a possible side effect of all opioids. This side effect seems to be much more frequent with methadone, with a prevalence of almost 45%.[4,5] When sweating occurs during OAT initiation, it is essential to differentiate between hyperhidrosis and opioid withdrawal. In cases where isolated and prolonged hyperhidrosis on methadone reduces quality of life, the patient can consider switching to another OAT. There is no recognized treatment for excessive sweating induced by opioids. The clinician can propose non-pharmacological solutions (reducing heat exposure, wearing light clothing, limiting alcohol and caffeine consumption). A few case reports describe the use of anticholinergic agents, such as antihistamines or oxybutynin, to treat methadone-related hyperhidrosis.[5] This strategy cannot be broadly recommended due to lack of data. Using these agents also poses a risk of significant adverse effects. The risks and benefits must be discussed with the patient.

Hypogonadism

Opioids are known to disrupt the hypothalamic-pituitary axis and can frequently lead to hypogonadism through inhibition of GnRH secretion in the hypothalamus. Chronic opioid use increases the risk of developing this endocrine disorder, which affects almost 74% of opioid users.[6,7] However, hypogonadism can emerge as soon as a week after treatment initiation. This condition is generally reversible when the substance is discontinued. It is not recommended to systematically screen all male patients on OAT for hypogonadism. When a client presents with indicative signs and symptoms (fatigue, reduced libido, erectile dysfunction, loss of muscle mass, testicular atrophy, gynecomastia, hair loss, etc.), two morning total testosterone assays may be requested to confirm the diagnosis. If the result is below normal, or if there is a strong clinical suspicion of hypogonadism despite a normal result, a bioavailable or free testosterone assay may be ordered to clarify the diagnosis.[8] An LH and FSH assay should then be ordered to clarify the nature of the diagnosed hypogonadism. The clinician should investigate other potential contributors to the hypogonadism and manage them as appropriate (e.g. diabetes, hypothyroidism, renal or liver failure, obesity, etc.). Once a diagnosis has been made, testosterone supplementation can be initiated to relieve patient symptoms and restore normal serum testosterone levels. Various forms

of testosterone are available on the market. Injectable, oral, and topical forms are reimbursed by RAMQ and private insurers. Nasal gel is not covered.

QT Segment Prolongation

QT segment prolongation on ECG can be a key factor in choosing or continuing an OAT. While there are few or no reports of QT prolongation with buprenorphine formulations or slow-release oral morphine (SLOM), it is an issue with methadone use. The prevalence of significant prolongation beyond the normal range varies widely from one reference to another but is thought to be around 15% for methadone.[9] Approximately 5% of patients on methadone for OUD could end up with a QTc > 500 ms, which passes the threshold of high cardiac risk.[10] This phenomenon appears to be dose-dependent, but the effect is possible even with small doses of methadone. When methadone is initiated, a baseline ECG is recommended in patients with risk factors (e.g., personal or family history of cardiac arrhythmia, multiple medications or substances that can prolong the QT wave, bradycardia, electrolyte disorders, patients already known to have prolonged QT, etc.). Unless the risk is deemed too high, methadone initiation should not be delayed while waiting for the ECG result. The QT can then be monitored periodically (e.g., when the dose is increased or when adding a drug known to prolong the QT). When a patient's QT is between 450 and 500 ms, caution is advised. If the patient requires a dose increase, the clinician and patient should discuss the risks and benefits of further dose titration. When QT prolongation is above 500 ms on methadone, switching to another OAT should be considered. Drugs known to prolong QT should always be introduced with caution for people on methadone, and an alternative should be considered when possible. Specialized resources can be consulted to identify drugs that may prolong QT.[11]

There is no clear correlation between buprenorphine and QT prolongation. Some studies suggest that a slight prolongation is possible, while several others report no significant effect of the molecule on QT.[12,13,14] Patients already known to have long QT should be advised to take caution with buprenorphine. However, the risk is considered low and insignificant. No special follow-up is recommended for patients taking buprenorphine.

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APPENDIX 2 Checklist for Organizing a Transfer

You are transferring a stabilized patient to primary care:

- Send a transfer letter to the family physician (template here).
- Send the link to the Québec Clinical Guide on Support for People Living With Opioid Use Disorder (available here).
- If possible, and with the patient's agreement, send the summary of the OUD follow-up (template here) as well as the relevant progress notes and assessments.
- Be available to provide support to the family physician.

You are transferring a patient to another region of Québec:

- Contact the addiction rehabilitation centre (CRD) in your region to identify local OAT services.
- Complete the permanent transfer form (available here) (in French only).
- Forward the transfer form and verify the wait time.
- Arrange for a prescription to allow the patient to continue receiving treatment until the new referral is complete (to avoid a break in treatment).
- Confirm that the new healthcare team will manage the patient, to avoid a break in treatment.

You are transferring a patient to another region outside Québec:

- Identify the OAT services that are available in the destination city.
- Tip: a community pharmacist in your destination city can help!
- Contact the clinic in the destination city.
- Send the permanent transfer form (available here) (in French only).
- Prepare a prescription so that the patient can continue to receive treatment until the new management of the patient begins (to avoid a break in treatment).
- Confirm that the patient will be managed by the new healthcare team, to avoid a break in treatment.
- Discuss the terms of payment for medication.

Your patient is leaving on a trip (less than one month) within Canada:

Option 1: The patient can take their medication with them.

- Give instructions on safe storage of the medication.
- Make sure that the patient also has naloxone.

Option 2: The patient can receive doses from a pharmacy in another province.

- Your OAT prescriptions are valid in all pharmacies in Canada, except in Nova Scotia and in Newfoundland and Labrador. (You can order prescription pads using the following online forms: Nova Scotia and Newfoundland and Labrador. Note: Bear in mind that this can take up to two weeks.)
- Discuss drug payment arrangements.

Your patient will be travelling abroad for less than a month:

Option 1: The patient can take their medication with them.

- Give instructions on safe storage of the medication.
- Make sure that the patient also has naloxone.
- Give the patient a letter stating that he or she is on treatment to facilitate customs clearance (English/French template) (English/Spanish template).
- Methadone tablets must be prescribed separately (new prescription), indicating the reason for and length of the prescription.

Option 2: A temporary transfer may be possible for some destination countries.

- Consult the INDRO international website for more information on destinations.
- OAT is prohibited in some countries: discuss the risks with the patient.
- Send the temporary transfer form (available here) (in French only).

Your patient will be travelling (more than one month) in Canada:

Option 1: You can monitor the patient remotely.

- Your OAT prescriptions are valid in all Canadian pharmacies except in Nova Scotia and in Newfoundland and Labrador. (You can order prescription pads using the following online forms: Nova Scotia and Newfoundland and Labrador. Note: Bear in mind that this can take up to two weeks.)

Option 2: You can make a permanent transfer.

- Send the permanent transfer form (available here) (in French only).

Your patient will be travelling abroad for more than a month:

- For some destination countries, a permanent transfer can be arranged.
- The INDRO website can be useful for finding prescribers abroad.
- Send in the permanent transfer form (available here) (in French only).

You are discharging a patient into the community after hospitalization, incarceration, or therapy:

- Please note! Avoid breaks in service in order to reduce the risk of overdose.
- A patient on OAT **absolutely** must leave your department with a prescription.
- You can send a permanent transfer form (available here) (in French only) to the family physician or addiction specialist for follow-up.
- Contact the community pharmacist to ensure that there will be coordination between the detention centre/hospital/therapy pharmacy and the community pharmacy.
- Provide a prescription so that the patient can continue to receive treatment until management resumes (to avoid a break in treatment).
- Remember to provide the patient with a naloxone kit.

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