

Opioid Substitution Therapy

Guidelines for Saskatchewan Addiction Counsellors

June 2018

saskatchewan.ca



TABLE OF CONTENTS

ACKNOWLEDGEMENTS	1
INTRODUCTION	2
Roles in Opioid Substitution Therapy	3
EFFECTS OF OPIOIDS AND OPIOID USE DISORDER	4
OVERVIEW OF THE PHARMACOLOGY OF METHADONE	4
BUPRENORPHINE/NALOXONE	6
SASKATCHEWAN'S CLINICAL PRINCIPLES FOR ALCOHOL AND DRUG MISUSE SERVICES	7
CLINICAL PRINCIPLES FOR ALCOHOL AND DRUG MISUSE SERVICES IN SASKATCHEWAN	7
OPIOID SUBSTITUTION THERAPY OVERVIEW	9
STEP 1 - SCREENING PROCESS	10
Screening Process: Using Primary Mental Health and Addiction Assessment Tool	12
STEP 2 - ASSESSMENT	13
Comprehensive Assessment	15
STEP 3 - OPIOID SUBSTITUTION THERAPY	16
OTHER ISSUES RELATED TO OST	17
REFERENCES	19
RESOURCES	20
APPENDIX A	21
APPENDIX B	23
APPENDIX C	24

ACKNOWLEDGEMENTS

Saskatchewan Ministry of Health in consultation with addiction service providers, physicians, pharmacists, clients and nurses determined that the *Methadone Assisted Recovery Guidelines 2004* were in need of updating to reflect the evidence, practice and program developments that have transpired in opioid addiction/dependence treatment. Informal focus groups were conducted in Prince Albert, Regina, and Saskatoon during November and December of 2015 and changes in practice and evidence are reflected in the 2018 edition of this document. Saskatchewan Ministry of Health thanks those individuals for their time and advice.

Since 2004 the Ministry of Health has also developed the *Framework for Mental Health and Alcohol and Drug Misuse, Clinical Principles for Alcohol and Drug Misuse Services in Saskatchewan and Alcohol and Drug Misuse Services Outreach Standards*.

The Ministry of Health principles and standards, together with prescriber and pharmacist guidelines, provide guidance and standards for Opioid Substitution Therapy services in Saskatchewan.

INTRODUCTION

An Opioid Use Disorder implies the presence of a number of criteria (see **Appendix A**) that reflect not only physiological dependency but also impaired control over use, negative social consequences and risky use [*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM V)* criteria]. Opioid Substitution Therapy (OST) provides safe, accessible, effective and consistent treatment for individuals with opioid dependence. Two prescription medications are available for OST – methadone and buprenorphine/naloxone (Suboxone®). These medications allow patients to discontinue opioid use without experiencing withdrawal symptoms. There is significant evidence that OST reduces the risk associated with behaviors that lead to the transmission of human immunodeficiency virus (HIV), hepatitis C virus (HCV) and other blood borne pathogens by reducing the sharing of needles and other drug paraphernalia, including spoons, filters, water, etc. It reduces criminal activity associated with opioid use and supports patients/clients to participate in healthier lifestyles. In OST the addiction counsellor serves as the case manager to facilitate a team approach to address the barriers preventing clients from dealing with their Opioid Use Disorder. In this document addiction counsellors will be referred to as addiction counsellors/case managers to reflect that role.

OST includes counselling, case management and other medical and psychosocial services. These guidelines describe the role, services, and skills required of the addiction counsellor/case manager, depending on her/his level of involvement with individuals who have been prescribed methadone or buprenorphine/naloxone for an Opioid Use Disorder. Opioid Use Disorder, and addiction generally, are a complex process involving many biological,

psychological, social and spiritual factors. Clients with an Opioid Use Disorder have a high frequency of psychiatric co-morbidity. Many individuals may lack necessary coping strategies and other life skills that allow them to function successfully.

Addiction counsellors/case managers play a key role in OST such as receiving the initial referral, screening for opioid dependency, comprehensive assessment, direct interventions with the individual, interventions on behalf of the individual, case management, counselling, providing linkages to needed services and evaluation/outcome assessments.

Methadone and buprenorphine/naloxone may only be prescribed as per the College of Physicians and Surgeons of Saskatchewan (CPSS) Bylaws.

Methadone and buprenorphine/naloxone are covered by the provincial Drug Plan. Coverage is subject to the individual's usual deductible and co-payment. Key partners in OST are prescribers and pharmacists. *The Saskatchewan Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction* (College of Physicians and Surgeons of Saskatchewan, 2016) provide the standards and guidelines for OST in Saskatchewan. *Guidelines for Participation in the Methadone Program for Saskatchewan Pharmacists* (Erickson, Postnikoff, Rhode, & Wurtz, 2001, updated 2010) provide direction to pharmacists. In collaboration with clients, addiction counsellors, pharmacists, and prescribers direct OST. The professional guidelines and standards are intended to compliment and provide direction for safe, competent and effective OST services.

They are referenced in this document and should be reviewed by addiction counsellors/ case managers working in this program to fully understand the responsibilities of all the partners. *The Clinical Principles for Alcohol and Drug Misuse Services in Saskatchewan*, (December 2012) provide addiction counsellors with additional knowledge and skills required for supporting clients with an Opioid Use Disorder.

Methadone fact sheets are available at <http://www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services/alcohol-and-drug-support/alcohol--drug-and-addictions-resources>.

Information about OST in Saskatchewan (the what, where, why, who, when, how, and how much) is routinely provided to clients and the general public by addiction counsellors, pharmacists, and physicians. Information is to be communicated in a respectful way using simple concepts and clear language. In addition, addiction counsellors have a responsibility to provide evidence based education to the public and to clients regarding the benefits and risks of OST.

ROLES IN OPIOID SUBSTITUTION THERAPY

Prescriber	Pharmacist	Addiction Counsellor/ Case Manager
<ul style="list-style-type: none"> • Medical assessments • Diagnosis • Prescribing medications for opioid substitution therapy • Coordination with pharmacist and counsellor/case manager • Referrals for specialized services • Education 	<ul style="list-style-type: none"> • Dispensing • Regular patient encounters • Observation of daily dose • Liaison with physician and counsellor/case manager • Education 	<ul style="list-style-type: none"> • Screening and comprehensive assessment process (including mental health and suicide risk) • Coordinate with pharmacists, prescribers, other case managers, i.e. HIV • Education • Intervention/referrals in social and legal matters • Case management, counselling • Evaluation/outcome assessments

EFFECTS OF OPIOIDS AND OPIOID USE DISORDER

Opioids briefly stimulate the higher centres of the brain but then depress activity of the central nervous system. Opioids reduce anxiety and pain, and produce euphoria and a sense of well-being. Short-term effects appear soon after a single dose and disappear in a few hours. Immediately after injecting an opioid, the individual feels a surge of pleasure or a "rush", typically followed by a profound sense of detachment. The dose required to produce this effect may at first cause restlessness, nausea, and vomiting.

Opioid overdose is a particular risk with illicit use where the actual substance and strength may not be accurately known. Signs of opioid overdose include: the individual cannot be roused; pupils contract to pinpoints; skin is cold, moist, and bluish; and profound respiratory depression. For the opioid dependent individual, opioid withdrawal symptoms may occur within a few hours after the last dose of opioids. During withdrawal, the individual experiences the exact opposite of the drug effects of opioids, including increased anxiety, pain, agitation, nausea, vomiting, diarrhea, abdominal cramps and muscle aches and pains. Opioid withdrawal is generally less dangerous than alcohol, barbiturate, and benzodiazepine withdrawal but still causes significant health risks. For more information about opioids go to <https://www.canada.ca/en/health-canada/services/healthy-living/your-health/medical-information/opioid-pain-medications-frequently-asked-questions.html>.

Naloxone is an antidote to opioid overdose and improves breathing and consciousness. Take Home Naloxone (THN) kits and training are available to individuals at risk of an opioid overdose. Overdose recognition and response training is also encouraged for friends and family of people who use opioids. More information can be found at: <http://www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services/alcohol-and-drug-support/alcohol--drug-and-addictions-resources>.

OVERVIEW OF THE PHARMACOLOGY OF METHADONE

Methadone is used to treat pain, an Opioid Use Disorder or both. Methadone is a synthetic opioid with actions similar to those of morphine. Methadone has three important functions: relief of pain for about 6 hours; suppression of opioid withdrawal and craving for about 24 hours; and a mood stabilizing effect for longer periods.

Treating an Opioid Use Disorder involves the daily administration of methadone over an extended period of enrollment. Methadone is typically dispensed from a pharmacy as an oral drink in a flavored juice such as orange 'Tang'. For at least three months after OST begins, the pharmacist or individual dispensing the methadone witnesses the client drinking the prescribed methadone (**direct observed therapy**). The *Saskatchewan Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction* refer to this as daily witnessed ingestion. Methadone is absorbed in the gastrointestinal tract within 45 minutes and its effect usually peaks within two to three hours after ingestion.

When an individual is stabilized on methadone, the administration of a single adequate dose (usually between 60 to 120 mg) will suppress withdrawal and craving for about 24 hours without causing euphoria or sedation. Individuals can therefore function normally and are able to perform mental and physical tasks without impairment. In sufficient doses, methadone “blocks” the euphoric effects of other opioids. It is chemically unrelated to opiates, therefore, when required, other opiates are sometimes also prescribed (i.e. post-op pain, chronic pain).

Three important functions of Methadone:

- **Pain relief for about 6 hours**
- **Suppression of opioid withdrawal and cravings for about 24 hours**
- **A mood stabilizing effect for longer periods**

Methadone can be dangerous if misused.

- **Real dangers of respiratory failure and death exist with doses greater than 30mg for individuals not accustomed to methadone. A dose as little as 10mg can be fatal to a child.**

Methadone is primarily metabolized by the liver. A very small percentage of individuals metabolize methadone rapidly (for example, those with specific enzyme pathways in their liver, pregnant women, those on medications that enhance the metabolism, and those involved in intense physical activity) and they can experience withdrawal even on a relatively high methadone dose. Split doses

may be necessary for these individuals.

Side effects of methadone can vary, depending on the individual. An increase in methadone dosage may cause drowsiness for three days, making driving and other activities requiring alertness hazardous. If methadone is abruptly discontinued, withdrawal syndrome may develop with many of the symptoms previously described.

Abstinence-based alcohol and drug treatment is only effective for a small number of individuals who have an Opioid Use Disorder. It is generally recognized that for opioid-dependent individuals, counselling alone is not effective because the withdrawal and cravings are so intense. Methadone alone may work if prescribed in sufficient doses to control withdrawal and craving. Methadone accompanied by skilled counselling has better outcomes than methadone alone. However, it is recognized that methadone should not be denied for treatment when counselling is not available. For more information on methadone use in the treatment of Opioid Use Disorder you may go to <https://www.canada.ca/en/health-canada/services/health-concerns/reports-publications/alcohol-drug-prevention/best-practices-methadone-maintenance-treatment.html>.

According to the National Institute on Drug Abuse, medication assisted treatment is also used very effectively for tobacco dependence and for alcoholism.

BUPRENORPHINE/NALOXONE

The partial agonist buprenorphine, a proven therapy for opioid dependence, combined with the opiate antagonist naloxone, limits intravenous misuse and the potential for diversion. The naloxone component of Suboxone®, administered orally or sublingually, has no detectable pharmacological activity because of its almost complete first pass metabolism and low sublingual bioavailability.

The Canadian Research Initiative in Substance Misuse National Guideline for the Clinical Management of Opioid Use Disorder strongly recommends buprenorphine/naloxone as the preferred first-line treatment when possible, due to its demonstrated effectiveness and safety in the primary care setting. Suboxone® must be dispensed on a daily basis under the supervision of a healthcare professional until the patient has sufficient clinical stability and is able to safely store Suboxone® take-home doses.

The Centre for Addiction and Mental Health has additional information regarding the use of Suboxone® available at <https://www.porticonetwork.ca/documents/489955/0/Buprenorphine+and+Naloxone+-+Clinical+Practice+Guidelines+2012+PDF/fd1eee5d-fd7f-4b58-961f-b45350a8b554>.

Take Home Medication

Taking methadone or buprenorphine/naloxone at home is referred to as “carries”. Carries promote the normalization of an individual’s lifestyle and behavior. Addiction counsellors/case managers have a significant role in providing information about an individual’s functional stability with regard to:

- Program participation
- Cognitive impairment
- Acceptable urine screens in the last three months
- Social integration (e.g., employed, actively caring for children or attending school)

The prescriber decides when and if carries are to be given to an individual. Provincial guidelines do not allow carry privileges for the first three months of treatment. Addiction counsellors/case managers may play a role in adjudicating requests for either exceptional or regular carries and communicating with the prescriber.

Clients and addiction counsellors/case managers should always discuss all drug use and prescription drug use with the OST prescriber and/or the pharmacist. Certain drugs can increase the effects of methadone and buprenorphine/naloxone so it is important to share the complete medication profile.

SASKATCHEWAN'S CLINICAL PRINCIPLES FOR ALCOHOL AND DRUG MISUSE SERVICES

OST design considerations should reflect the *Provincial Framework for Alcohol and Drug Misuse and Mental Health Services* and use as a foundation for service, the *Clinical Principles for Alcohol and Drug Misuse Services in Saskatchewan and Outreach Standards*. Links to these documents can be found at <http://www.sken.ca/clinical-tools/>.

Evidence based counselling practices are the basis for counsellor/client interactions. Clients with an Opioid Use Disorder are often experiencing complicated and challenging life circumstances. Special consideration should be given to active case management of situations and circumstances such as: OST and pregnancy; physical health issues and access to primary care or infectious disease care; concurrent disorders; adolescent clients; transfers to other prescribers; hospital admission and discharge planning; and offenders in custody.

Addiction counsellors/case managers need to be knowledgeable about:

- Substance use and dependency;
- Opioid Use Disorder;
- Physical, mental, social health as well as legal aspects of opioid dependency;
- Use of methadone and buprenorphine/naloxone in the care and treatment of an Opioid Use Disorder;
- OST processes and outcomes.

CLINICAL PRINCIPLES FOR ALCOHOL AND DRUG MISUSE SERVICES IN SASKATCHEWAN

- **Clinical Principle 1:** Alcohol and drug misuse, abuse and dependence are shaped by biological, social and other factors, which may include family, environment, and other extra therapeutic factors.
- **Clinical Principle 2:** Alcohol and drug dependence is a chronic condition.
- **Clinical Principle 3:** The patterns of youth alcohol and drug misuse are different from those of adults and require specialized treatment responses.
- **Clinical Principle 4:** Treatment programs need to be knowledge or evidence-informed.
- **Clinical Principle 5:** The needs of special populations are recognized and responded to appropriately and with sensitivity.
- **Clinical Principle 6:** Mental health and alcohol and drug services are integrated for clients with concurrent alcohol and drug misuse and mental health issues.
- **Clinical Principle 7:** Programs exist for clients and the community that reduce the short and long term impacts of alcohol and drug misuse.

The phases of OST may be described as:

- Initiation – assisting the client to reduce/ stop using illicit opioids and starting prescribed methadone or buprenorphine/ naloxone.
- Stabilization – establishing an individual’s therapeutic dose.
- Determination – identifying issues in drug use and physical/mental/social/legal health.
- Action – working on the identified issues.
- Maintenance – decision time regarding methadone or buprenorphine/naloxone use - primarily to reduce the harms associated with opioid use, long-term OST, or medically supervised withdrawal from methadone or buprenorphine/naloxone.

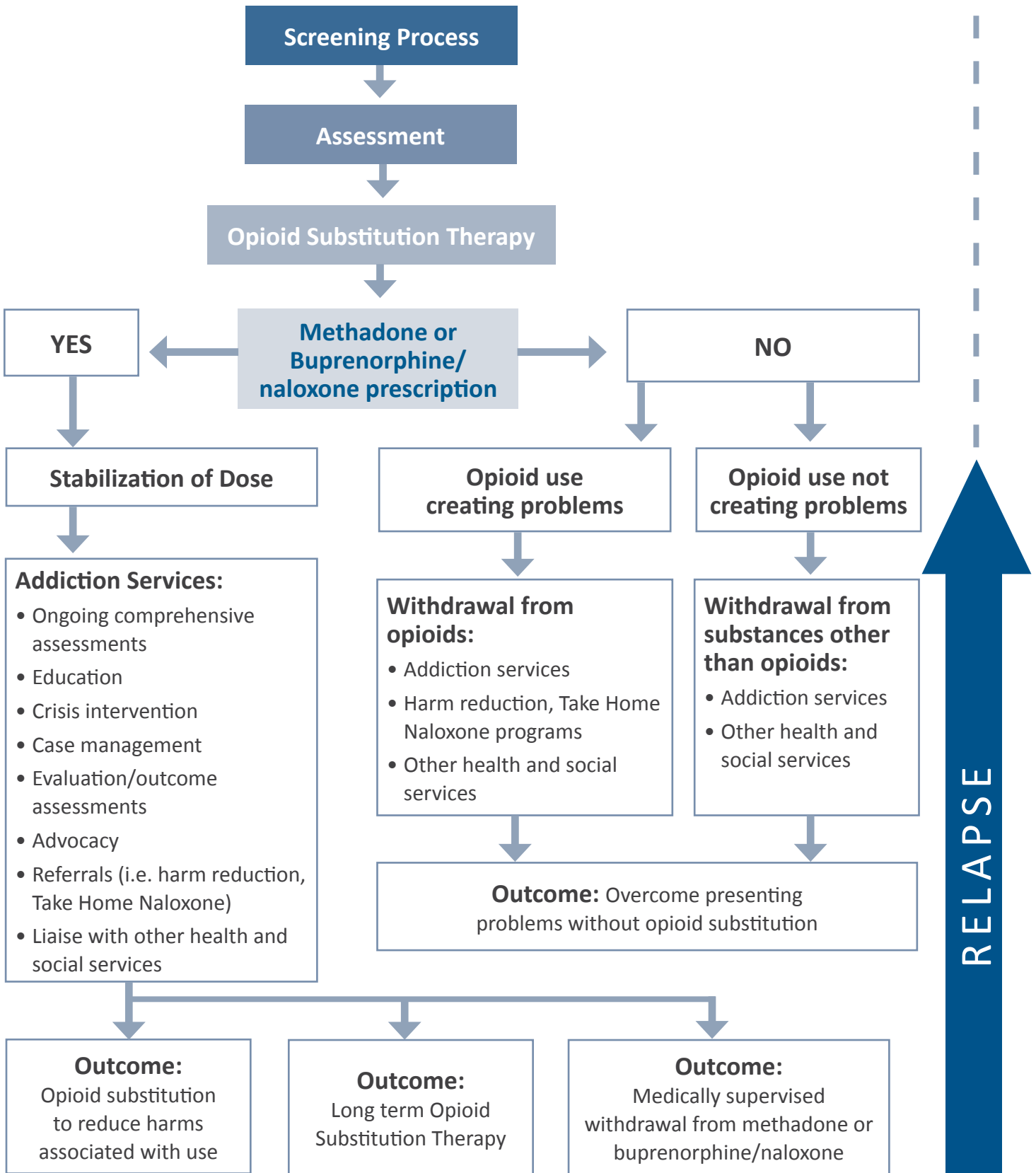
OST has three possible outcomes:

- Long-term treatment for those with high function and no significant substance use;
- Medically supervised withdrawal from methadone or buprenorphine/naloxone for those who can overcome opioid dependency; or
- Opioid substitution to reduce the harm associated with opioid use, with continued but less intense engagement in care.

During OST there may be considerable overlap and cycling between the three outcomes and may take several years with multiple relapse episodes.

OPIOID SUBSTITUTION THERAPY OVERVIEW

Individuals presenting with opioid and other substance abuse



STEP 1 - SCREENING PROCESS

The screening process is the first step in the assessment process that may be completed by a trained addiction counsellor/case manager. The complete process involves addiction and program screening, comprehensive assessment, assessment feedback, and treatment/recovery planning. With good communication and planning all steps in OST can be shared by the prescriber and the counsellor. If the screening confirms a likelihood that the individual has an Opioid Use Disorder, the addiction counsellor will refer the client to a prescriber with accompanying rationale and recommendations. The prescriber retains final responsibility for diagnosing and commencing OST. Other options include referring the individual to community-based treatment services such as detoxification, outpatient, or inpatient treatment.

The addiction counsellor/case manager during screening seeks to:

- Identify the opioid use problems the individual is facing.
- Determine the extent to which the problems are alcohol and/or drug related.
- Determine whether it is appropriate or necessary to immediately initiate a comprehensive assessment and referrals to additional services.
- Develop rapport and trust with the individual.
- Engage the individual so that he/she is motivated to meet again and continue with the assessment process.

The screening process has five components:

- Gather information through interviews with the individual, family member(s), and other relevant person(s) individually and/or together after obtaining the appropriate consents from the individual, as indicated in *The Health Information Protection Act* and your employer's policies.
- Use appropriate screening instruments, such as the Substance Abuse Subtle Screening Inventory (SASSI), Drug and Alcohol Screening Test (DAST), Michigan Alcoholism Screening Test (MAST), Problem-Oriented Screening Instrument (POSI), Drug Use Screening Inventory - Revised (DUSI-R).
- Give feedback to the individual and select future actions.
- Briefly intervene to deal with the presenting crisis.
- Orient the client to available services and expectations.

Health conditions associated with injection drug use include (but not limited to):

- Endocarditis
- Abscess
- Blood clots and embolisms
- Septicemia
- HIV
- Hepatitis B, hepatitis C, and other liver diseases
- Cellulitis and phlebitis
- Adverse drug interactions
- Bacterial pneumonia
- Pulmonary complications

Screening information is collected in five areas:

- Substance Use
- Physical Health
- Mental Health
- Social Health
- Legal Health

Upon intake, addiction counsellors/case managers share information from screening interviews and comprehensive assessments with prescribers.

A prescriber conducts initial consultations during intake to determine whether each individual meets the College of Physicians and Surgeons of Saskatchewan OST admission criteria. Based on all available information, the prescriber makes the decision to prescribe methadone or buprenorphine/naloxone and/or refer the individual to other health care services. Before prescribing, **the prescriber must ensure the individual signs a treatment agreement** (see Appendix J - *Saskatchewan Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction/Dependence*). A signed treatment agreement between the prescriber and client details comprehensive care for the opioid dependent individual that includes methadone or buprenorphine/naloxone, medical, addiction, and other health, social and legal services. The treatment agreement directs those involved in the care and treatment of the individual to advise and share healthcare information as required on a need to know basis.

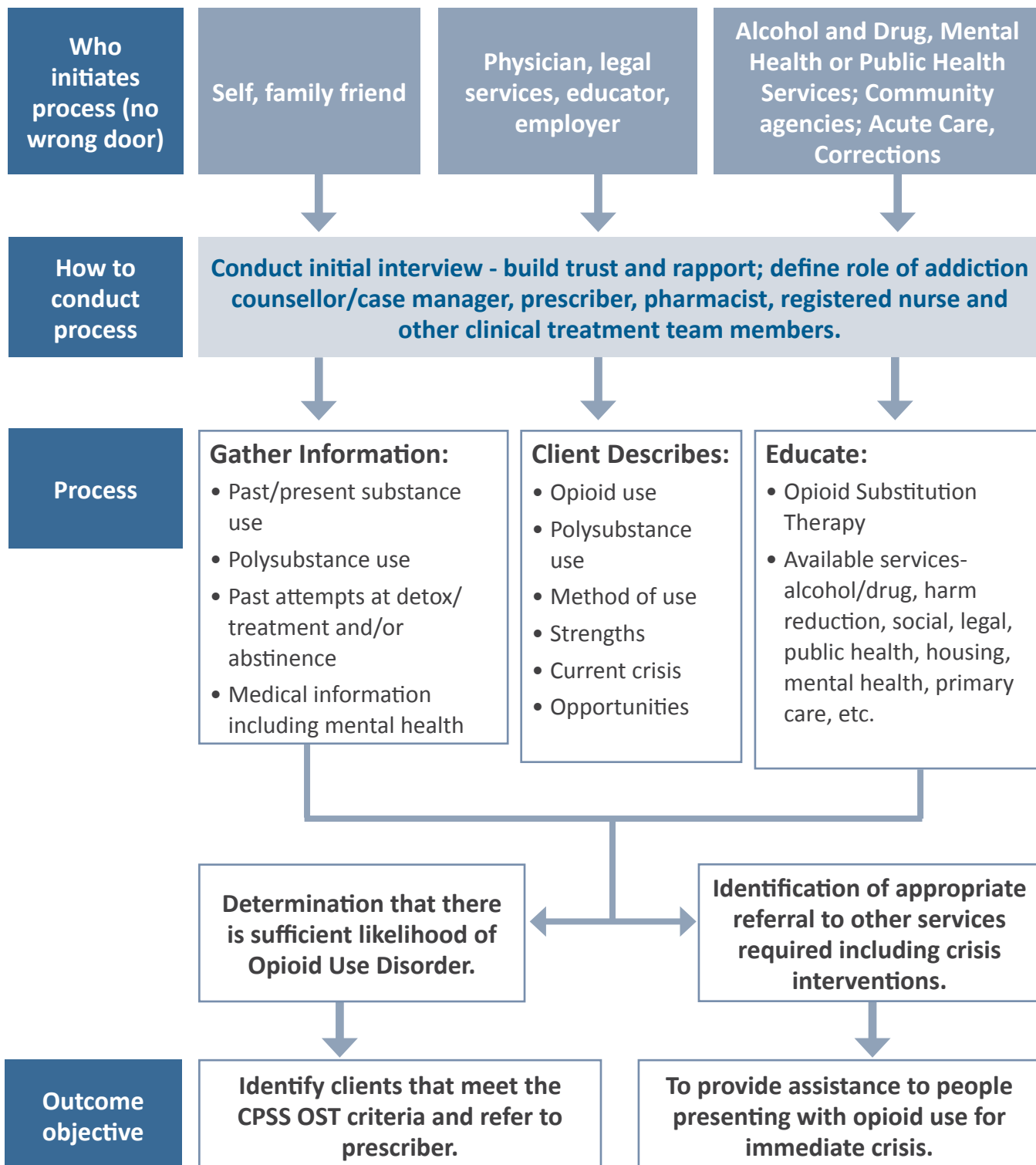
There are many serious health issues associated with injection drug use and referral to a primary health care provider for the appropriate assessment, including testing for communicable diseases such as HIV and HCV, should be initiated prior to or at the same time OST is started. This can be facilitated by the prescriber or the addiction counsellor. When required, the addiction counsellor may follow up on the outcome of the physical assessment with the family physician after appropriate consent is obtained.

During orientation of new clients, the addiction counsellor/case manager seeks to:

- Provide information about healthcare providers involved in OST.
- Outline addiction counsellor/case manager services.
- Outline client responsibilities.
- Provide education on opioid substitution and address client expectations, questions and concerns.
- Educate clients on the roles of clinic staff, community pharmacists, and other community service providers.
- Inform clients of other available services delivered through primary care clinics, participating community pharmacies, harm reduction programs, overdose prevention programs (Take Home Naloxone) and alcohol and drug services.

SCREENING PROCESS: USING PRIMARY MENTAL HEALTH AND ADDICTION ASSESSMENT TOOL

<http://www.publications.gov.sk.ca/freelaw/partners/mental-health/PrimaryAssessment.pdf> (see Appendix C)



STEP 2 - ASSESSMENT

The comprehensive assessment is the second step of the assessment process that is to be completed by a trained addiction counsellor/case manager. It is recommended that the addiction counsellor continue with the comprehensive assessment only when an individual is sufficiently stabilized on prescribed methadone or buprenorphine/naloxone to meaningfully engage in the process.

OST GOALS:

- Reduce harms of drug use
- Treat medical and psychiatric co-morbidity
- Bring substance dependence into remission
- Achieve the highest possible level of psycho-social function

The comprehensive assessment has two purposes:

- To collect information about the effect of alcohol or drug use on the individual's life.
- To identify strengths that can provide a foundation for recovery.

Like the screening process, the comprehensive assessment includes obtaining information through interviews and discussions with the individual and collateral contacts on their substance use, physical health, mental health, social health and legal health.

Ongoing comprehensive assessment, case management, and evaluation/outcome assessment can be better defined, and

therefore more effective, once an individual is medically stabilized on a therapeutic methadone or buprenorphine/naloxone dose. Comprehensive assessment is an ongoing process between the addiction counsellor/case manager and the individual in OST.

The assessment process provides opportunities for the addiction counsellor/case manager to:

- Give feedback to the individual.
- Outline options for recovery planning.
- Briefly intervene to deal with current crisis.
- Select future recovery actions and plans.

Interventions on behalf of the individual could include:

- Liaison with the treatment team.
- Co-ordination of care/case management.
- Liaison with outside agencies with whom the individual is involved.
- Referrals to outside agencies (funding, therapy, upgrading, vocation work, legal counsel).
- Advocacy over non-medical issues (social or legal).
- Education of family members.

Co-Management of Record Keeping in OST

The medical chart is the primary record and is required to include the following information from the addiction counsellor's file:

- Screening information that may include recommendation and treatment plan.
- On-going addiction counsellor progress notes.
- Release of Information/Consent forms.
- Copies of referrals made by the addiction counsellor.
- Saskatchewan Ministry of Health, Alcohol and Drug Admission/Discharge Forms.

Good communication among prescribers, addiction counsellors/case managers, pharmacists, and other healthcare providers is essential to protect the privacy and confidentiality of health information in the co-management of individuals involved in OST. The addiction counsellor/case manager will comply with federal and provincial regulatory requirements (*The Health Information Protection Act*). The sharing of information between addiction counsellors/case managers and prescribers, requires a signed client consent form authorizing communication and release of information. The information that is to be shared shall be on a need to know basis and applicable to the medical management and treatment of the client.

Sharing Information for Transfers

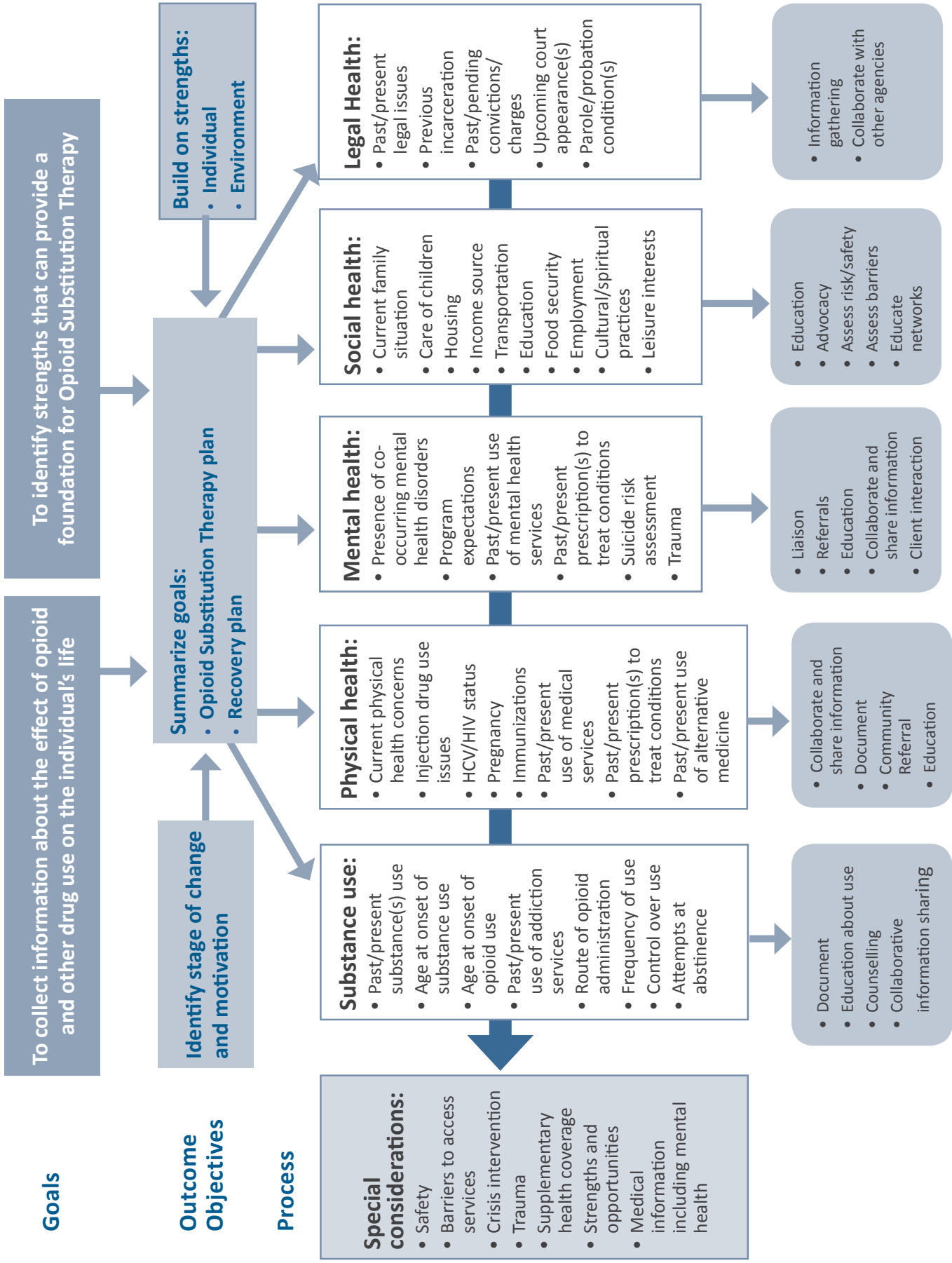
A transfer should be initiated in situations where clients are temporarily re-locating (work, visiting relatives, etc.) or permanently relocating to another community.

Transfer and pharmacy arrangements should be set up ahead of time whenever possible to avoid interruption of OST and to minimize inconvenience to the client, other prescribers, dispensing pharmacies and institutions. Addiction counsellors/case managers may be required to co-ordinate the transfer of a client to another prescriber.

The following information should be forwarded to facilitate a transfer:

- Addiction counsellor screening form.
- Copy of most recent prescription with expiry date.
- List of any other prescribed medications.
- Witnessed drink/carry information.
- Prescriber's treatment plan/evaluation documentation.
- Motivational assessment report and other information regarding the individual's recovery plan.

COMPREHENSIVE ASSESSMENT



STEP 3 - OPIOID SUBSTITUTION THERAPY

Research suggests that it takes two or more years to go through OST phases and arrive at one of three outcomes: long-term OST; medically supervised withdrawal from methadone or buprenorphine/naloxone; or OST used to reduce the harm associated with drug dependency with continued but less intense engagement in care. During OST, there may be considerable overlap and cycling between the three outcomes.

Strengths, skills, experiences and resources vary considerably from individual to individual. It is important and sensible to focus on goals that the individual is willing to work towards. Clinical Principle 4 (see page 7) provides direction for evidence informed treatment and recovery approaches that addiction counsellors/case managers can use to provide the right help at the right time. These will include paying attention to:

- Discovery/recovery of function, purpose and goals
- Development of an individual's recovery plan
- Motivation to change
- Current needs/crisis interventions required
- Case management and coordination
- Relapse prevention
- Life skills enhancement
- Aftercare

Role of Residential Detoxification and Inpatient Treatment

Residential detoxification and inpatient services are required at timely points in individualized treatment and recovery plans. OST is to be maintained as an integral part of the treatment process when individuals require detoxification from substances other than opioids. During episodes of inpatient care, the continuance of prescribed methadone or buprenorphine/naloxone is to be maintained as an integral part of the client's recovery program. The logistics of managing this function are to be accomplished between the community case manager and the facility. As prescribed methadone or buprenorphine/naloxone is part of the ongoing recovery plan, the individual needs to maintain connection with a prescriber, a dispensing pharmacy, and her/his community case manager throughout their stay in an inpatient facility. It is generally not therapeutic to discontinue methadone or buprenorphine/naloxone during detoxification and treatment for other substance use.

OTHER ISSUES RELATED TO OST

OST and Pregnancy

The primary intent of OST for a pregnant woman with an Opioid Use Disorder is to create a stable environment for the pregnancy and to improve maternal and neonatal outcomes. Individuals who are pregnant and have an Opioid Use Disorder should be given priority for service. Women who are addicted or abusing opioids do better with OST than with no treatment as it prevents them from going in and out of withdrawal, which in turn decreases the risk of miscarriage or spontaneous abortion. It also decreases the risk of infection from injection drug use, provides medical and psychosocial stability and engages them in care. Information on the role of OST in pregnancy and questions regarding the effects on the baby should be directed to a physician.

Concurrent Disorders

Research indicates that mental health issues, including trauma, are to be expected in any individual with a Substance Use Disorder. Many clients in OST may have mental health issues that have been undiagnosed, misdiagnosed, untreated or ineffectively treated due in part to ongoing drug use.

During the initial screening interview, it is important to explore and document the individual's mental health and/or psychiatric history. This may include any past diagnoses, contacts with a psychiatrist or mental health professionals, hospitalizations, medications taken and perceived effect by client, personal struggles with stress, anxiety, depression, childhood trauma, head trauma, suicide attempts and major losses/grief. It is also important to examine present issues, mood

states, currently prescribed medications, illicit drug use to manage symptoms, assessing risk to the individual or others, and contact with psychiatry.

Stabilization on prescribed methadone or buprenorphine/naloxone allows for a clearer, more accurate assessment of mental health symptomology. Accurate assessment allows for appropriate diagnosis, treatment and/or referral for treatment. Research supports providing treatment for addiction and mental health issues simultaneously thus coordination of care is imperative. The goal for individuals is to achieve stability and return of function in both areas. In some cases, OST alone will lead to the eradication of substance induced disorder.

Youth

Best practice information identifies a need for older youth and emerging adults to have access to OST. They require safe living environments in order to participate in treatment services and to maintain regular appointments with the services required as part of a recovery plan. As youth may distrust systems, significant effort is needed to build trust with youth and engage them in accessing services.

As more knowledge and experience has been gained through OST programs, individual circumstances have introduced the question of prescribing methadone or buprenorphine/naloxone to youth. These individuals are typically "emancipated", actively injecting, may be involved in the sex trade or criminal activity, have significant social instability and come from family situations with significant challenges and an inability to provide appropriate support.

Detoxification, stabilization, support, and outreach services have been shown to be effective strategies with youth presenting with substance use. These services are particularly important for marginalized youth who inject drugs. *The Alcohol and Drug Misuse Services Youth Outreach Standards* provide direction for programming.

Offenders in Custody

Evidence shows there is a significant reduction of injection drug use in prisons among offenders prescribed methadone or buprenorphine/naloxone for an Opioid Use Disorder. Studies have shown that increased use of OST in prison was associated with less injection drug use, a fact that is consistent with community studies.

It is important that individuals on prescribed methadone or buprenorphine/naloxone while incarcerated are referred to community based agencies prior to or at discharge. It is preferable to plan the referral, but at a minimum, to send a notification to the community-based agency when an unplanned release occurs. Health care providers prescribing to patients in the corrections setting have a professional duty to ensure treatment bridging occurs until care can be assumed in the community.

REFERENCES

Brands B, Marsh D, Hart L, & Jamieson W. (2002) Literature review methadone maintenance treatment. Ottawa, ON: Health Canada, Office of Canada's Drug Strategy.

British Columbia Centre on Substance Use and B.C. Ministry of Health. A Guideline for the Clinical Management of Opioid Use Disorder. Published June 5, 2017. Available at: <http://www.bccsu.ca/care-guidance-publications/>

The College of Physicians and Surgeons of Ontario (2011, February) Methadone Maintenance Treatment Program Standards and Clinical Guidelines retrieved from <http://www.cpso.on.ca/policies-publications/cpgs-other-guidelines/methadone-program/mmt-program-standards-and-clinical-guidelines>

College of Physicians and Surgeons of Saskatchewan. (2015, May). Saskatchewan Methadone Guidelines and Standards for the Treatment of Opioid Addiction/Dependence; retrieved from <https://www.cps.sk.ca/Documents/Programs%20and%20Services/Methadone/SK-Methadone-Guidelines-2015-Mar-FINAL.pdf>

Correctional Service of Canada [CSC]. (2002). Specific national methadone maintenance treatment guidelines. Ottawa, ON: Author.

Erickson J, Postnikoff L, Rhode L, & Wurtz W. (2001, October, updated Sept. 2010). Guidelines for participation in the Methadone program for Saskatchewan pharmacists, in Saskatchewan Pharmaceutical Association Standards, Guidelines & Policy Statements (36-67). Regina, SK: retrieved from <http://saskpharm.ca/site/manual?nav=03>

The Canadian Research Initiative in Substance Misuse National Guideline for the Clinical Management of Opioid Use Disorder (2018). <https://crismprairies.ca/home/projects-2/national-opioid-use-disorder-guidelines>

Saskatchewan Health. (2000). Meeting the challenges: Saskatchewan model of recovery services. Regina, SK: Saskatchewan Health, Community Care Branch.

RESOURCES

About Opioids. Retrieved September 2017. Government of Canada. <https://www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids.html>

Best Practices Methadone Maintenance Treatment (2002) Prepared by Jamieson, Beals, Lalonde and Associates, Inc. for the Office of Canada's Drug Strategy Health Canada; retrieved from <http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/methadone-bp-mp/index-eng.php>

The Canadian Research Initiative in Substance Misuse National Guideline for the Clinical Management of Opioid Use Disorder (2018). <https://crismprairies.ca/home/projects-2/national-opioid-use-disorder-guidelines>

Clinical Principles for Alcohol and Drug Misuse Services in Saskatchewan, (2012, December), Outreach Standards, (2013 February); Saskatchewan Ministry of Health retrieved from <http://www.sken.ca/clinical-mhas-standardsframeworkprinciples-in-saskatchewan/>

A Cross-Canada Scan of Methadone Maintenance Treatment Policy Developments: A Report Prepared for the Canadian Executive Council on Addictions, (2011, April) Luce, J, Strike, C; retrieved from <http://www.ceca-cect.ca/pdf/CECA%20MMT%20Policy%20Scan%20April%202011.pdf>

The Fundamentals of Methadone Maintenance Treatment, Centre for Addiction and Mental Health (2003) retrieved from <https://www.porticonetwork.ca/web/knowledgex-archive/amh-specialists/the-fundamentals-of-methadone-maintenance-treatment>

Methadone Assisted Recovery Guidelines for Addiction Counsellors (2004), Saskatchewan Health.

Methadone maintenance treatment for offenders (2006). Saskatchewan Corrections and Public Safety, Regina, SK.

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) (2012), National Institute on Drug Abuse, retrieved from <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>

Provincial Framework for Alcohol and Drug Misuse and Mental Health Services (2012, May); Saskatchewan Ministry of Health; retrieved from <http://www.sken.ca/wp-content/uploads/2014/10/Foundationa- Framework.pdf>

Trauma Informed Practice and the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers (April 2018). Vancouver, B.C.: Centre of Excellence for Women's Health. www.bcccewh.bc.ca

APPENDIX A

Diagnostic Criteria for Opioid Use Disorder

Adapted from the *Saskatchewan Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction/Dependence* (College of Physicians and Surgeons of Saskatchewan, 2016)

Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders V, Text Revision, Copyright 2013, American Psychiatric Association.

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

10. Tolerance, as defined by either of the following:

- a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
- b. A markedly diminished effect with continued use of the same amount of an opioid.

Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

9. Withdrawal, as manifested by either of the following:

- a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
- b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Specify if:

- In early remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).
- In sustained remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).
- On maintenance therapy: This additional specifier is used if the individual is taking a prescribed agonist medication such as methadone or buprenorphine and none of the

criteria for opioid use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). This category also applies to those individuals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.

- In a controlled environment: This additional specifier is used if the individual is in an environment where access to opioids is restricted.

*Please note that in May 2013, the fifth edition of the Diagnostic and Statistical Manual of Men-

tal Disorders, DSM-V, was published. The section Substance Use Disorders now combines substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance is addressed as a separate use disorder (e.g. opioid use disorder). For more information on the revised chapter of “Substance Use Disorder), please see the following link: <http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf>

APPENDIX B

Contact Information

Directory of Mental Health and Addictions Services

<http://www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services>

College of Physicians & Surgeons of Saskatchewan

Opioid Agonist Therapy Program

http://www.cps.sk.ca/imis/CPSS/Programs_and_Services/Opioid_Agonist_Therapy_Program.aspx?OATPCCO=1#OATPCCO

APPENDIX C

Provincial Mental Health and Addictions Primary Assessment



Provincial Mental Health and Addictions Primary Assessment

Save As

HSN File Number

Last Name First Name Middle Name Maiden Name Preferred Name

Address City Province Postal Code

Date of Birth Gender Phone Number (ie 5555555555)

Day Month Year Male Female

Treaty Number (if applicable) Language English Other Health Region

Family Physician

Parent/Guardian(s)

Full Name Middle Name Preferred Name

Allergies

Informed consent and confidentiality has been explained to the client Date

Sources of Information

Reason for referral (reconfirm screening information/update)

Client/Family Perspective (client or family member's understanding of problem/motivation)

BACKGROUND INFORMATION

1. Developmental History N/A to presenting problem

2. Physical Health History (complete medication reconciliation where appropriate) N/A to presenting problem

3. Educational/Occupational Status and History N/A to presenting problem

4. Family Functioning and Relationships N/A to presenting problem

5. Financial N/A to presenting problem

6. Spirituality/Cultural Practices and Needs N/A to presenting problem

7. Social Involvement and/or Activities

N/A to presenting problem

8. Personal and Family Psychiatric History

N/A to presenting problem

9. Danger to Self or Others and Abuse History

N/A to presenting problem

10. Substance Use, Problem Gambling and Other Addictive-Related Behaviours

N/A to presenting problem

11. Legal

N/A to presenting problem

12. Motivation/Resiliency/Protective Factors

N/A to presenting problem

Client/Family Goals

Clinical Impressions/Conceptualization

Baseline Measures

PROVISIONAL MULTIAXIAL DIAGNOSIS

Note the diagnosis arrived at in accordance with scope of practice of diagnostician

Axis 1a - DSM-IV-TR Clinical Disorder

Axis 1b - Other Conditions that may be focus of clinical attention

Axis 2a - Personality Disorders and Cognitive Disabilities

Axis 3 - General Medical Conditions

Axis 4 - Psychosocial and Environmental Problems

Check

- Problems with primary support group
- Problems related to the social environment
- Education Problems
- Occupational Problems
- Housing Problems
- Economic Problems
- Problems with access to health care services
- Problems related to interaction with legal system
- Other psychosocial and environmental problems

Axis 5A Functioning: Current at time of evaluation

Axis 5B Functioning: Highest in past year

V Codes-DSM-IV-TR:

1.
2.
3.

Z Codes-ICD-10:

1.
2.
3.

S Codes:

1.
2.
3.

TREATMENT PLAN (including timelines)

- Mutually agreed treatment plan developed and discussed in partnership with client

Completed by Date

