Buprenorphine-naloxone for the treatment of opioid use disorder in primary care

June 11, 2018

Dr. Nikki Bozinoff

Disclosures

- I have no conflicts of interest to declare
- I am a family physician
- I completed a 1-year ABAM accredited fellowship in Addiction Medicine

Learning Objectives

- Explain the pharmacology and pharmacodynamics of buprenorphine-naloxone.
- Determine when buprenorphine-naloxone compared with methadone is appropriate in the treatment of OUD.
- Understand how to complete an office-based induction with buprenorphine-naloxone without precipitating opioid withdrawal.
- Describe harm reduction interventions applicable in primary care

Case 1: Mel

- 50 M, investment planner

- Bilateral knee osteoarthritis
- Tx: Hydromoph Contin 9 mg TID with 2mg QID for breakthrough pain

- He picks up his prescriptions monthly and is supposed to see you every 3 months for renewals. Sometimes he calls the office stating that he can't come in because of work and asks for a renewal without an office visit. Once or twice in the last 6 months the pharmacy has requested permission to release his medication early because of work-related travel.

- On this request you realize that you haven't seen him in almost 6 months, and tell the pharmacy that he cannot have an early release and needs to come in before you will authorize any more prescriptions.

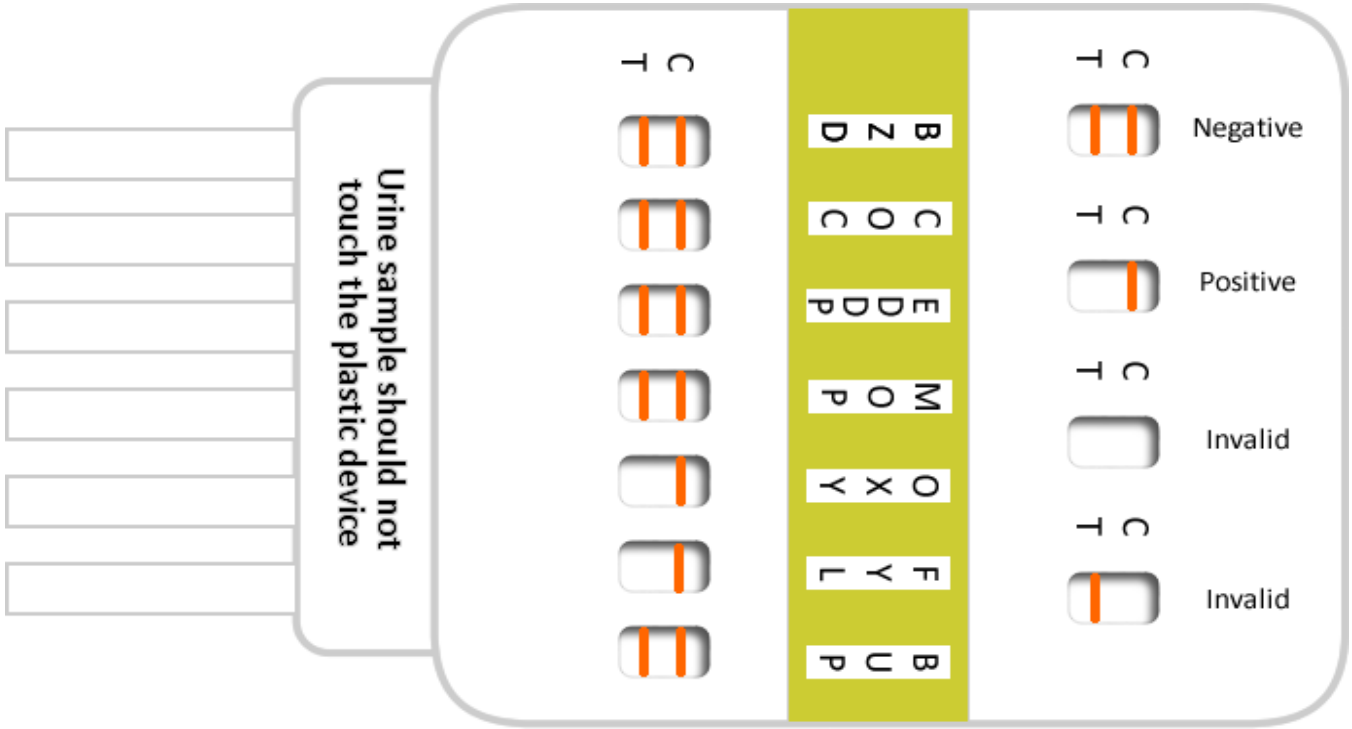
Mel (cont'd)

- **Past Medical History:**
- Chronic knee pain secondary to osteoarthritis
- Hypertension
- Hyperlipidemia
- Insomnia

- **Medications:**
- HM Contin 9 mg TID with 2mg QID for breakthrough pain
- atorvastatin 40 mg PO qhs
- Ramipril 5 mg po daily
- Zopiclone 15 mg po qhs

- **Allergies:** no known drug allergies

Mel's urine immunoassay



Mel (cont’d)

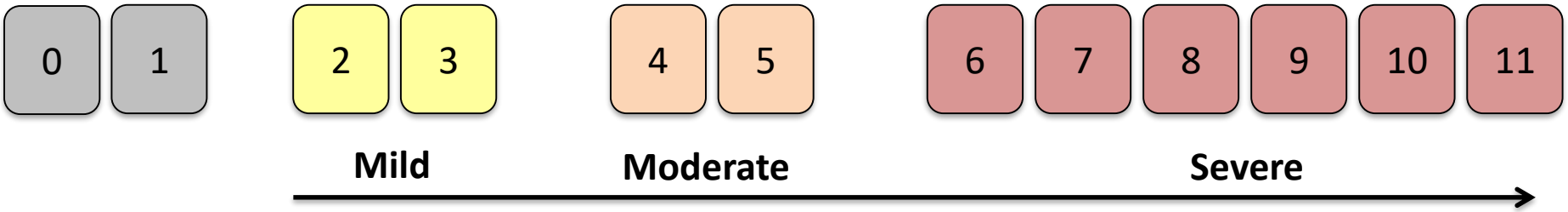
- What do the urine results suggest?
- What else would you like to know?

Diagnosis of Opioid Use Disorder

Opioid use disorder	
Impaired control	
1	Using ***LARGER*** amounts over ***LONGER*** periods of time
2	Waiting to ***USE LESS*** with ***UNSUCESSFUL*** efforts to ***DECREASE*** or ***DISCONTINUE***
3	Spending lots of ***TIME*** obtaining, using and recovering
4	***CRAVING*** the drug
Social impairment	
5	Failure to fulfill major role ***OBLIGATIONS***
6	Continuing use despite ***SOCIAL*** or ***INTERPERSONAL*** problems
7	May give up or reduce important ***ACTIVITIES***
Risky Use	
8	Recurrent substance use in situations where it is ***PHYSICALY HAZARDOUS***
9	Continuing to use substance despite knowledge of ***PHYSICAL*** or ***PSYCHOLOGICAL PROBLEM***
Pharmacological criteria	
10	Increased ***TOLERANCE***
11	***WITHDRAWAL*** symptoms resulting in to consumption of substance to relieve symptoms

Adapted from DSM 5

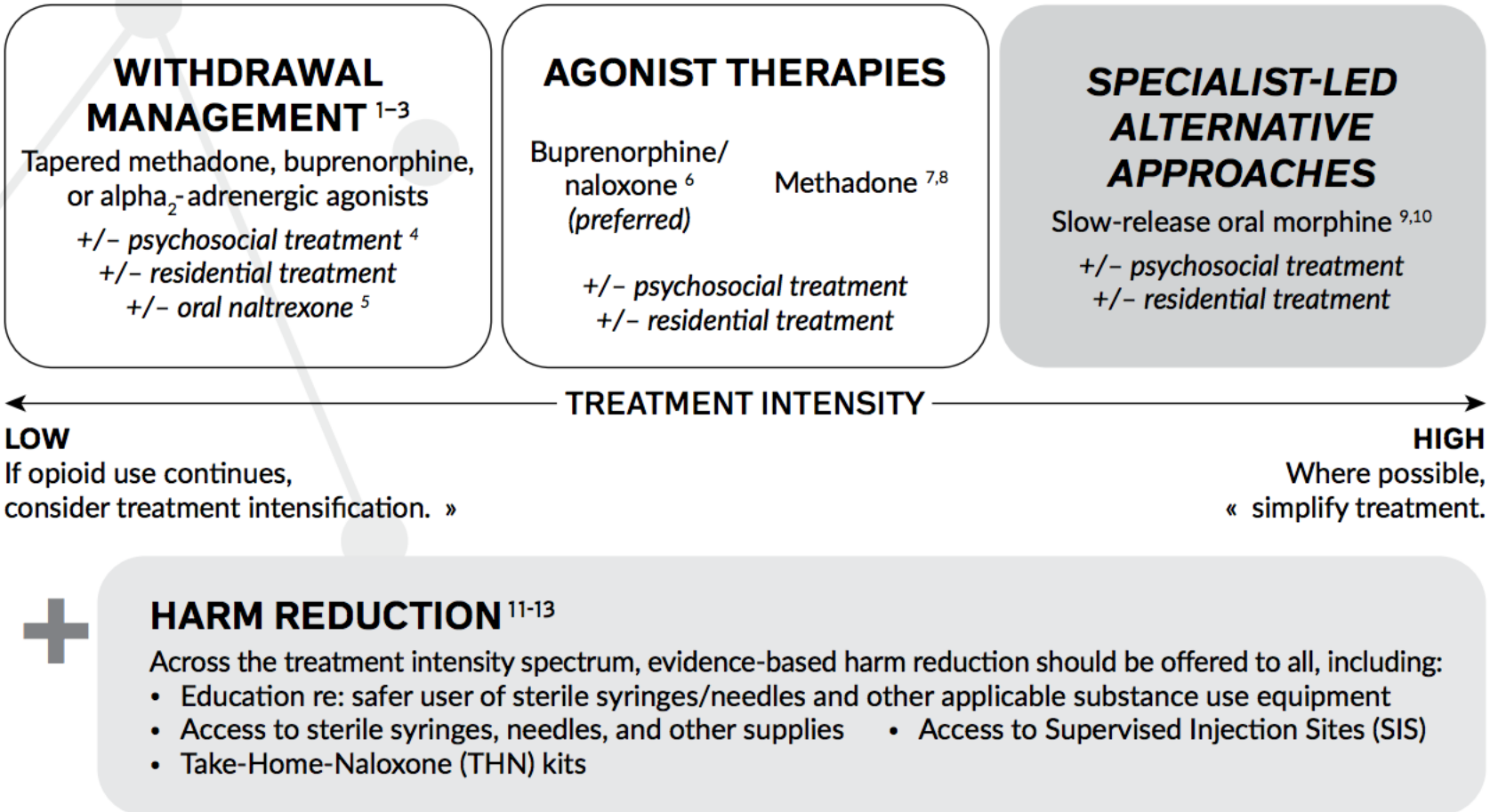
Severity



Treatment of Opioid Use Disorder

Treatment Options for OUD

Table 1. Clinical management of opioid use disorder



http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

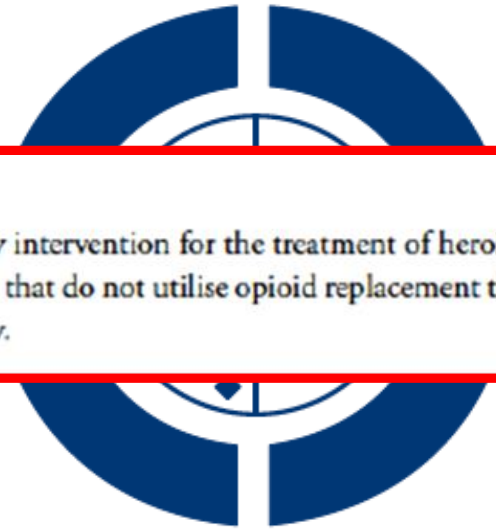
Starting a Patient on Opioid Agonist Therapy

- Severe OUD
  - DSM5 Criteria
  - IVDU, OD history
- Complete history and physical
- Labs:
  - CBC, RFT, LFT, ECG, BBV, urine preg test
- Informed consent

Methadone

Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review)

Mattick RP, Breen C, Kimber J, Davoli M



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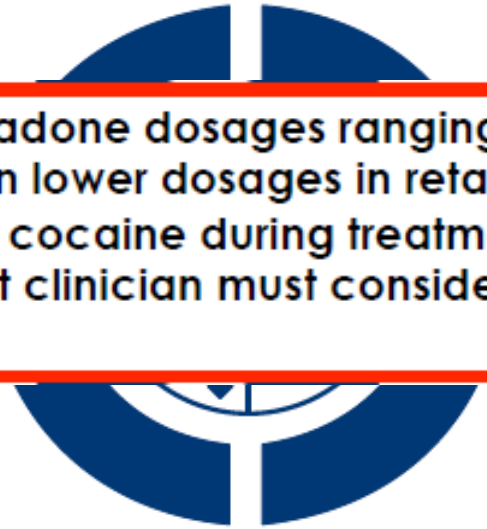
Authors' conclusions

Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments that do not utilise opioid replacement therapy. It does not show a statistically significant superior effect on criminal activity or mortality.

Methadone maintenance at different dosages for opioid dependence (Review)

Faggiano F, Vigna-Taglianti F, Versino E, Lemma P

Authors' conclusions: Methadone dosages ranging from 60 to 100 mg/ day are more effective than lower dosages in retaining patients and in reducing use of heroin and cocaine during treatment. To find the optimal dose is a clinical ability, but clinician must consider these conclusions in treatment strategies.



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Addiction

SSA

Addiction

RESEARCH REPORT

doi:10.1111/add.12682

The impact of methadone maintenance therapy on hepatitis C incidence among illicit drug users

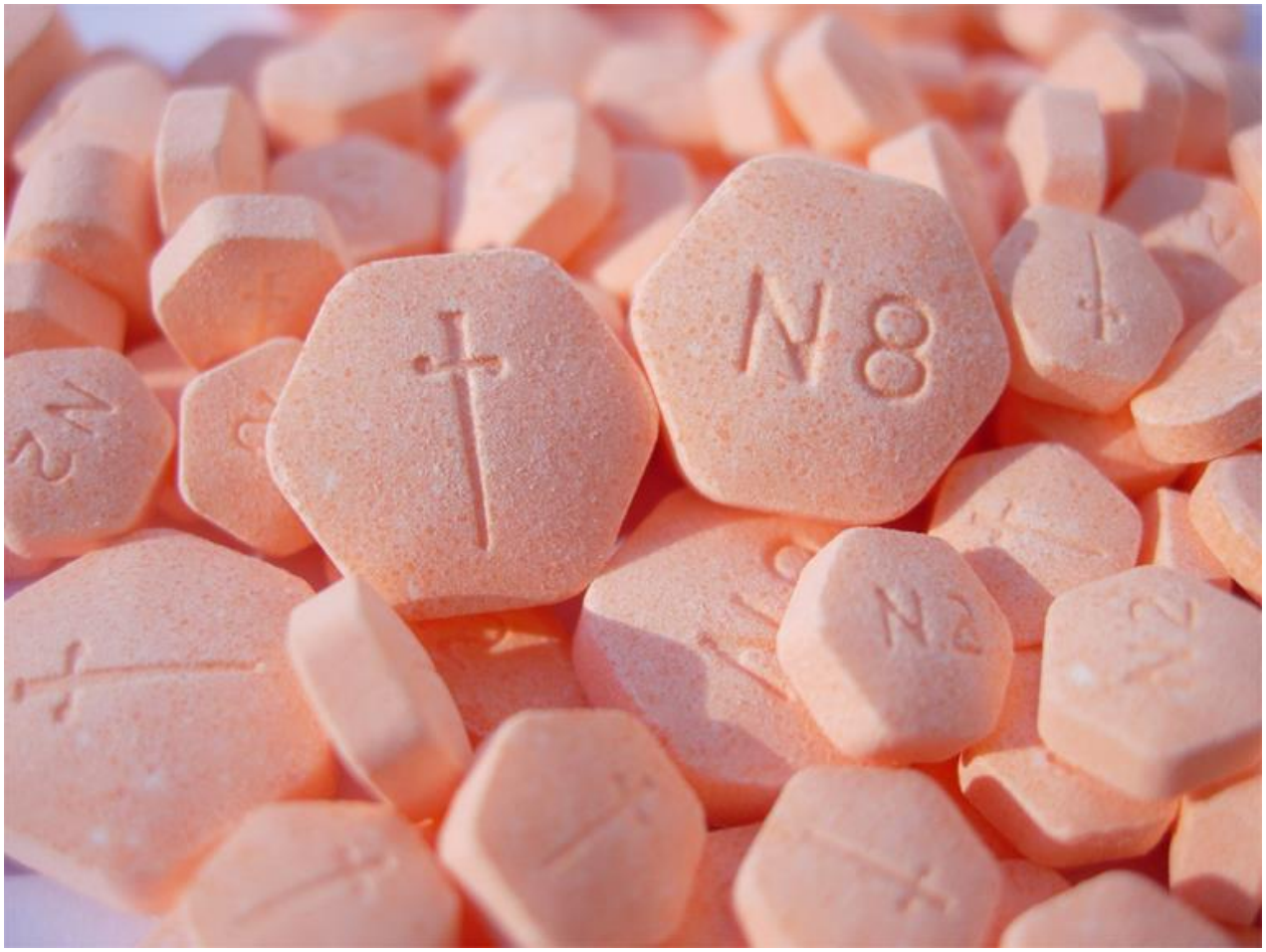
Seonaid Nolan[1,2], Viviane Dias Lima[1,2], Nadia Fairbairn[1], Thomas Kerr[1,2], Julio Montaner[1,2], Jason Grebely[1,3] & Evan Wood[1,2]

British Columbia Centre for Excellence in HIV/AIDS, St Paul's Hospital, Vancouver, Canada,[1] Department of Medicine, Faculty of Medicine, University of British Columbia, Vancouver, Canada[2] and The Kirby Institute, University of New South Wales Australia, Sydney, NSW, Australia[3]

Conclusion Participation in methadone maintenance treatment appears to be highly protective against hepatitis C incidence among illicit drug users. There appears to be a dose–response protective effect of increasing methadone exposure on hepatitis C incidence.

Aims To determine the relationship between methadone maintenance therapy (MMT) and hepatitis C (HCV) seroconversion among illicit drug users. **Design** A generalized estimating equation model assuming a binomial distribution and a logit-link function was used to examine for a possible protective effect of MMT use on HCV incidence. **Setting** Data from three prospective cohort studies of illicit drug users in Vancouver, Canada between 1996 and 2012. **Participants** A total of 1004 HCV antibody-negative illicit drug users stratified by exposure to MMT. **Measurements** Baseline and semi-annual HCV antibody testing and standardized interviewer-administered ques-

Buprenorphine-Naloxone



How Does Buprenorphine-Naloxone Compare to Methadone?

Methadone	Buprenorphine-Naloxone
Higher risk for overdose, particularly during treatment initiation	Decreased risk of overdose and parenteral abuse
Generally requires daily witnessed ingestion in pharmacy	Allows for safer take home schedules
More severe side effect profile including CNS/Resp depression	Milder side effect profile
Long time to achieve therapeutic dose (weeks-months)	Rapid titration to achieve therapeutic dose (hours-days)
Higher potential for drug-drug interactions (i.e. ABx, ARVs)	Lower potential for drug interactions, monitor for meds metabolized by CYP 3A4
Increased cardiac arrhythmias as a result of QTc prolongation	Decreased risk of QTc prolongation

Methadone	Buprenorphine-Naloxone
Improved retention in treatment	Lower retention in treatment
May be easier to initiate	If proper induction approaches not used, may precipitate withdrawal
No maximum dose	Maximum dose of 24 mg SL/daily
Approved in Canada for pain management	Used off-label for pain management
May be more difficult to taper off	May be easier to taper off
Less flexible take home dosing	More flexible take home dosing

Providence HEALTH CARE
How you want to be treated.

Vancouver CoastalHealth

Possible first-line treatment options			
2. Initiate opioid agonist treatment with buprenorphine/naloxone whenever feasible to reduce toxicities and facilitate safer take-home dosing.	⊕⊕⊕⊕ High	Strong	9
3. Initiate opioid agonist treatment with methadone when treatment with buprenorphine/naloxone is not preferable (e.g., challenging induction, high risk for drop-out).	⊕⊕⊕⊕ High	Strong	9

Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence.

Mattick RP, Breen C, Kimber J, Davoli M

Conclusions: Buprenorphine is an effective medication in the maintenance treatment of heroin dependence, retaining people in treatment at any dose above 2 mg, and suppressing illicit opioid use (at doses 16 mg or greater) based on placebo-controlled trials.

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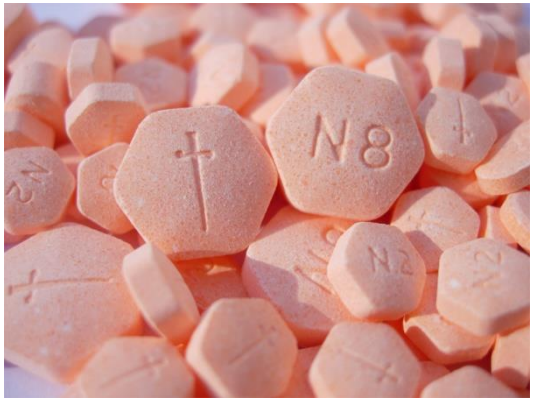
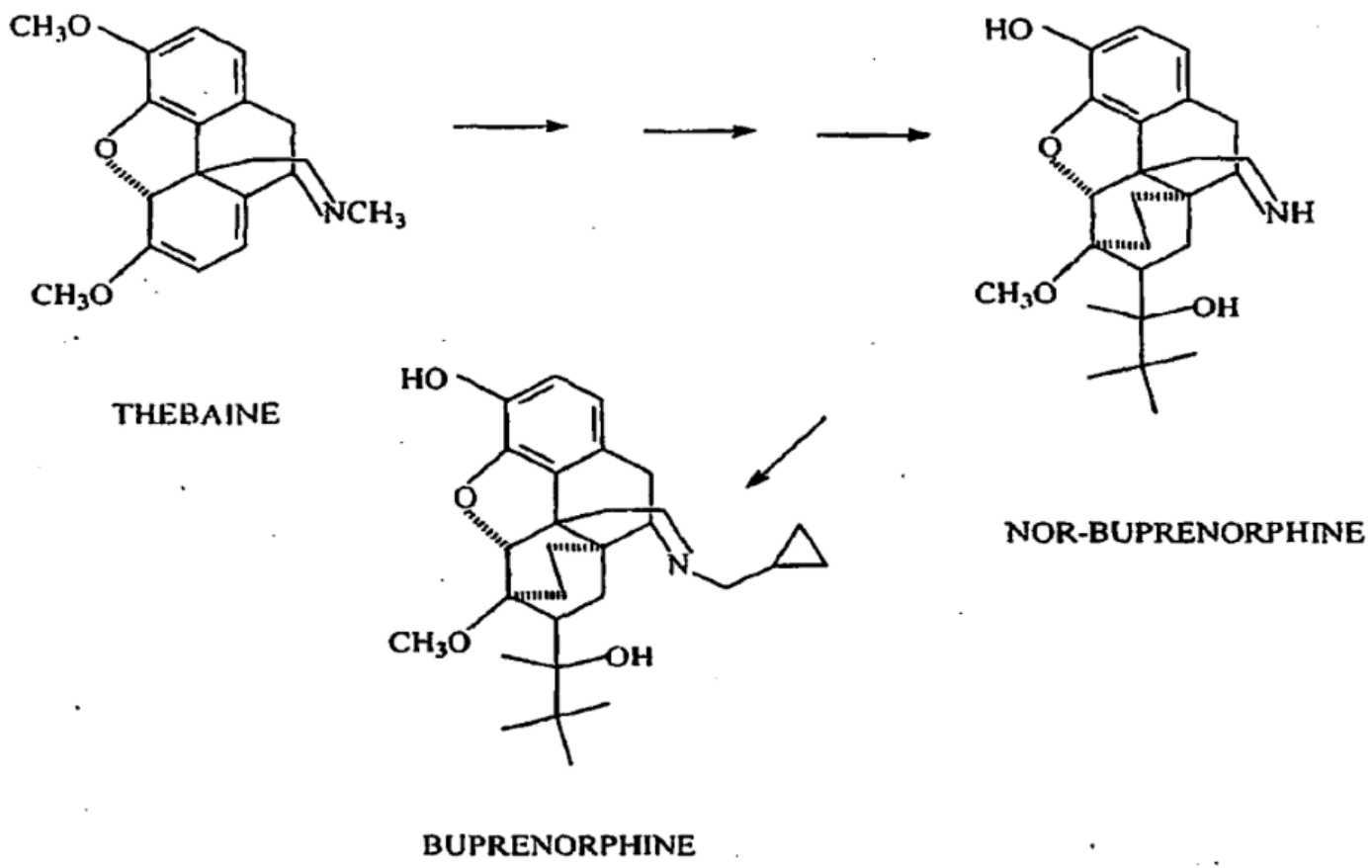
Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence

Amato L, Minozzi S, Davoli M, Vecchi S

Pharmacology of Buprenorphine-Naloxone



Buprenorphine is semi-synthetic



Pharmacology

- Buprenorphine
  - **partial mu agonist** and **kappa antagonist**
  - has a **high binding affinity** but **lower intrinsic activity** compared to other opioids
- Naloxone
  - Opioid antagonist
- 4:1 ratio
  - 8/2, 2/0.5 mg tabs

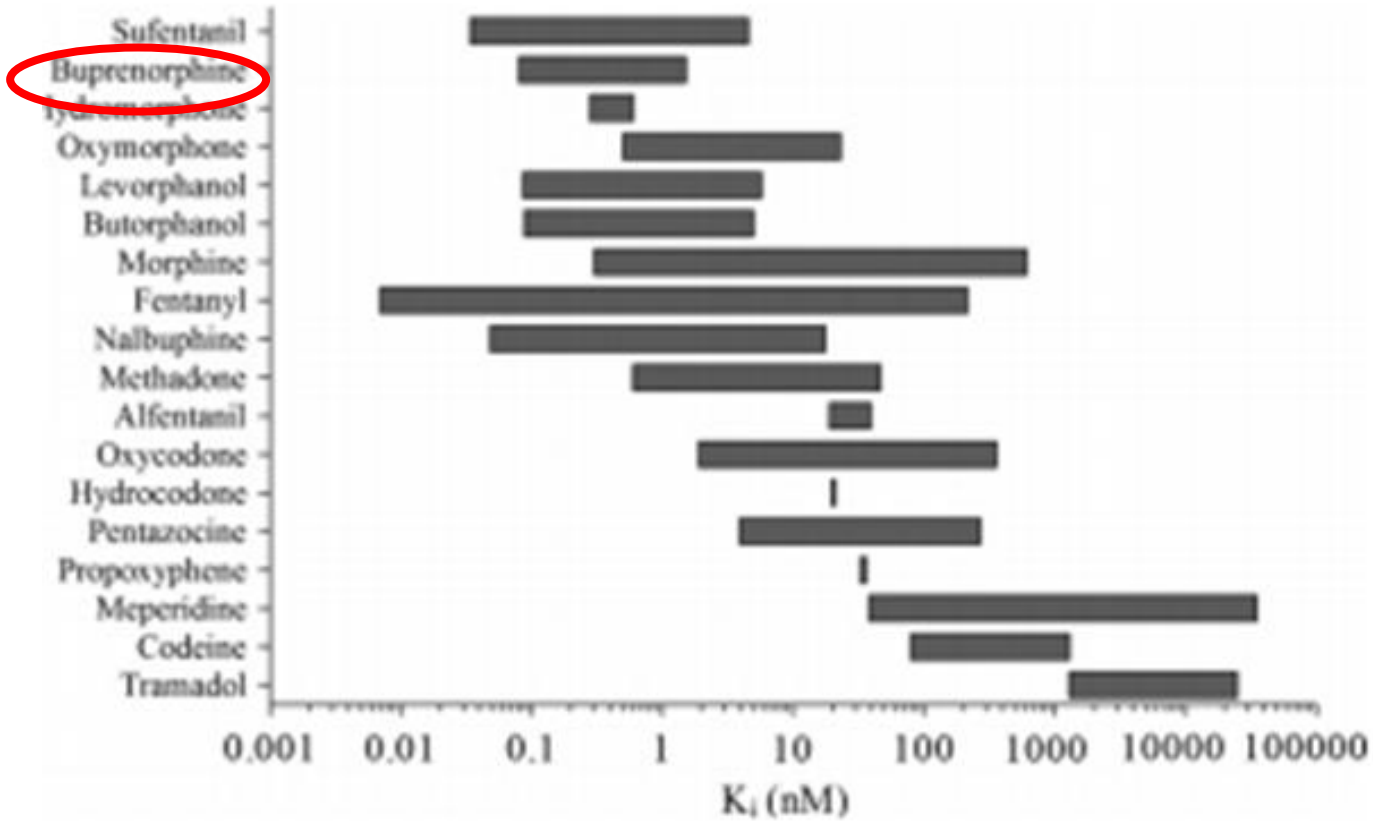
Bioavailability

	Buprenorphine	Naloxone
Oral	3%	~0%
Sub-lingual	55%	<5%
Parenteral	<5%	70%

Partial Mu Agonist and Kappa Antagonist

RECEPTOR TYPE	MU	DELTA	KAPPA
SUPRASPINAL ANALGESIA	+ + +	-	-
SPINAL ANALGESIA	+ +	+ +	+
PERIPHERAL ANALGESIA	+ +	-	+ +
RESPIRATORY DEPRESSION	+ + +	+ +	-
CONSTIPATION	+ +	+ +	+
EUPHORIA	+ + +	-	-
DYSPHORIA	-	-	+ + +
SEDATION	+ +	-	+ +
PHYSICAL DEPENDENCE	+ + +	-	+

High Binding Affinity



Volpe, 2011

Lower Intrinsic Activity

Lower Intrinsic Activity

Case 2

- 27y F presents to your office
- Has been using illicit oxycodone tablets daily for several months, scared about the risk of fentanyl after her friend recently overdosed
- Has tried to stop but having severe opioid withdrawal symptoms and cravings
- Interested in starting on buprenorphine-naloxone

- What other information would you want to know?
- What treatment options would you consider?

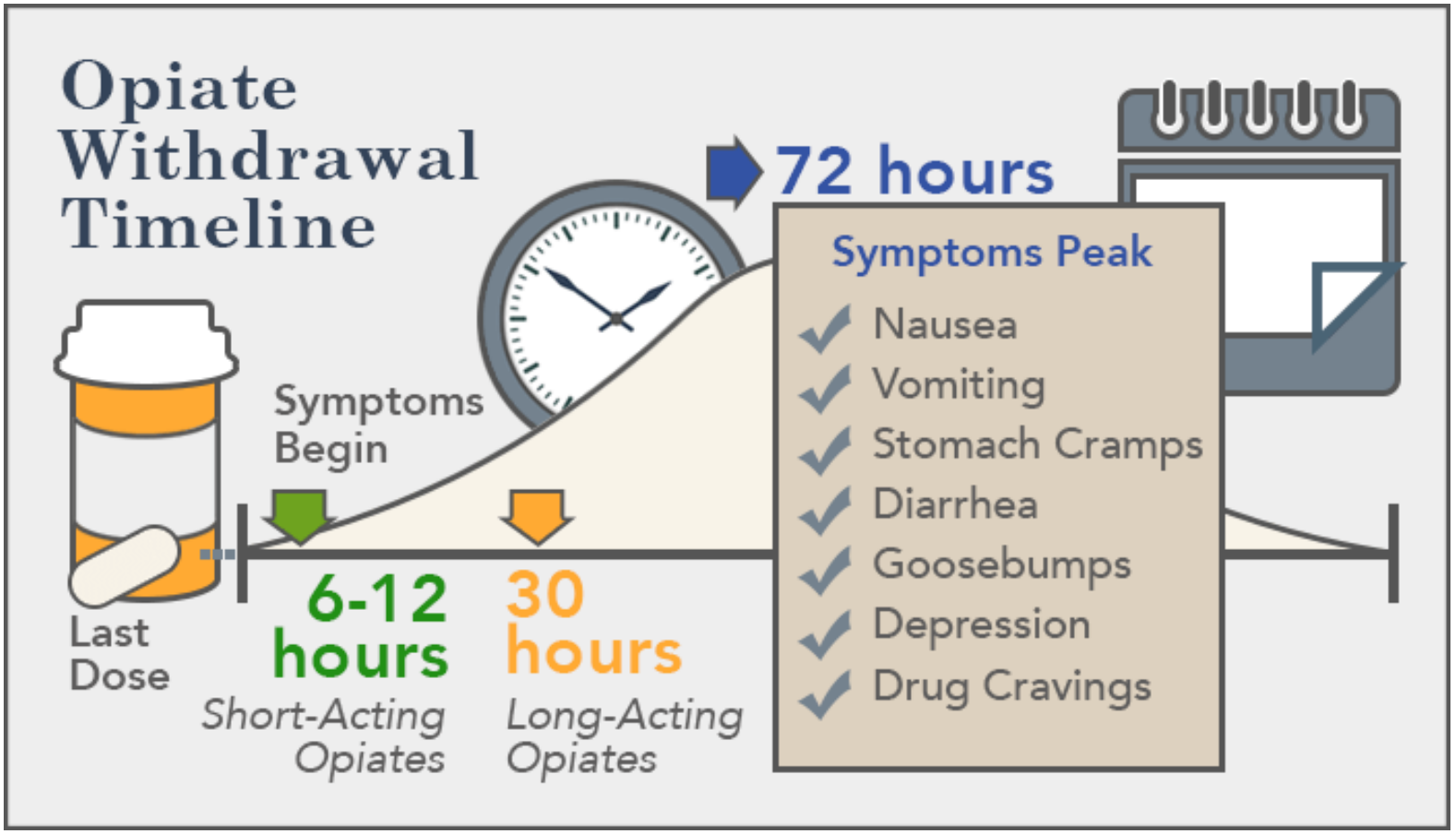
Office-Based Induction

- generally safe and straight-forward
- Main goal is to **avoid precipitated withdrawal**

Precipitated Withdrawal

- Buprenorphine has a **high affinity** for the opioid receptors and will bump other opioids off the receptors
- Because it has **lower intrinsic activity**, the person goes into precipitated withdrawal because the receptors are only partially stimulated
- Causes opioid withdrawal symptoms

Opioid Withdrawal Syndrome



Office-Based Induction

- generally safe and straight-forward!
- Main goal is to **avoid precipitated withdrawal**
- Requires two criteria:
  - **minimum time period** since last opioid use
    - Short-acting opioids: 12-24h
    - Long-acting opioids: 48-72h
  - **moderate-severe opioid withdrawal** state
    - Clinical Opioid Withdrawal Scale (COWS) > 13
- Give low initial dose (1-2 mg) to minimize risk

Clinical Opiate Withdrawal Scale (COWS)

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *over last* 1/2 *hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past* 1/2 *hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

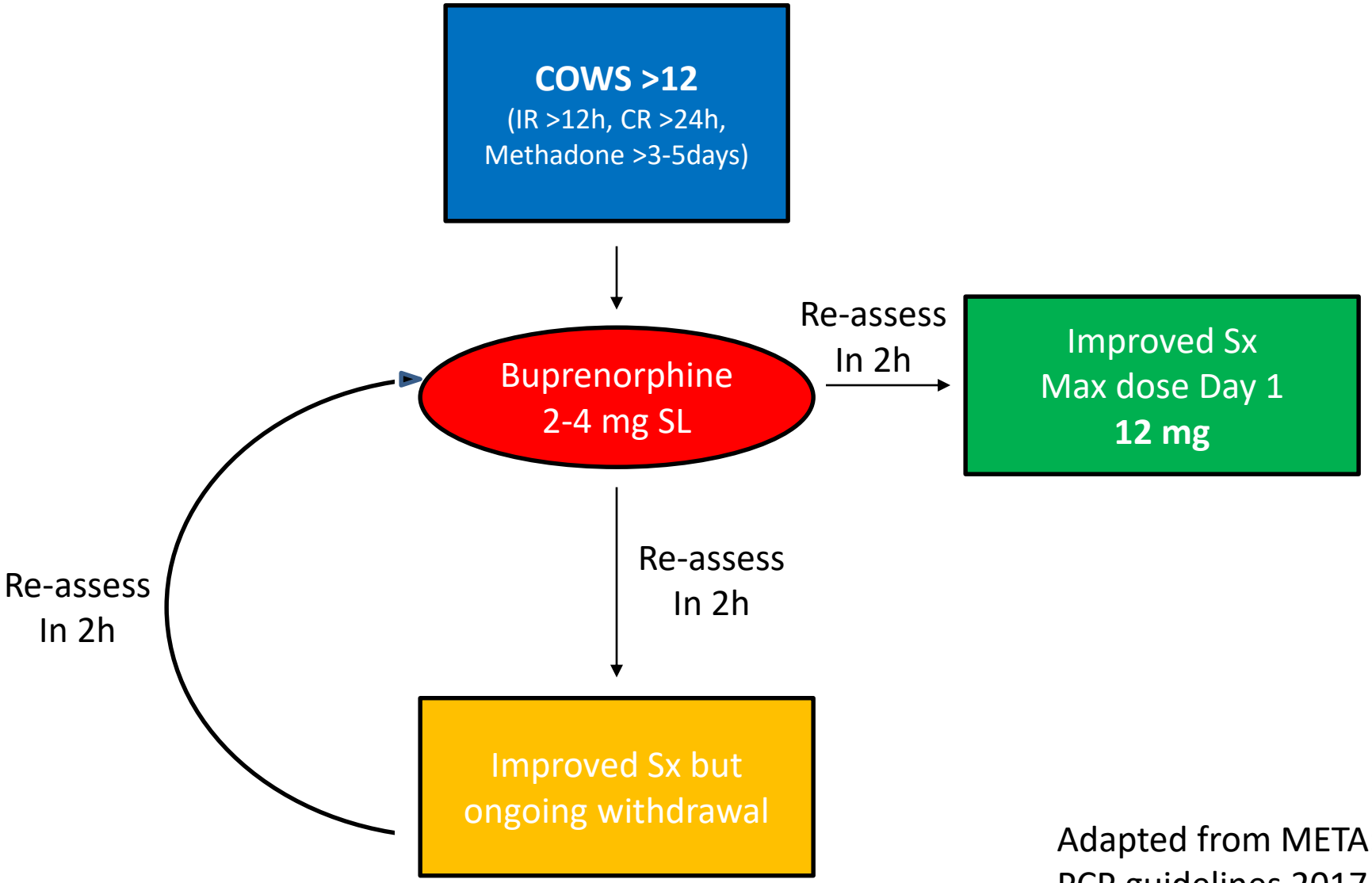
Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

Treatment of Precipitated Withdrawal

- Empathy
- Reassure the patient
- Dimenhydrinate, loperamide, fluids, acetaminophen, ibuprofen
- Consult Addiction Medicine resources for management
- Attempt another initiation of buprenorphine-naloxone the next day in office

In office/ED induction



Adapted from META:PHI
PCP guidelines 2017

Home Inductions

- Take-home inductions may prove effective for some individuals due to scheduling issues or inability to present to clinic hours in withdrawal
- May use COWS or Subjective Opiate Withdrawal Scale, which uses plain language
- Education important
- Ideally they could call a provider with questions
- May still use daily witnessed dosing after the induction

Patient Education

- Advise that the **tablet is SL and can take up to 10 minutes to dissolve**
  - Advice patient not to swallow or drink water
  - try to avoid smoking or drinking coffee 1 hour before
  - After 10 minutes, patient can swallow tablet/saliva
- Naloxone component is only active when it is snorted or injected, will cause withdrawal!

Office-Based Induction: Day 2

- The daily dose is established as equivalent to the total amount that was administered on Day 1
- Doses may be subsequently increased in 2-4 mg increments each day as needed for ongoing treatment of withdrawal symptoms and cravings
- Dose may be increased to a max 24 mg /day (HC)
- If side effects occur, the dose should be maintained or lowered until side effects resolve

Rx Buprenorphine

- **Rx should include**
  - Patient's name, date of birth, and health card number
  - The pharmacy address and fax number
  - The dose
  - Start and end dates
  - Day(s) of the week the patient takes a dose at the pharmacy under the observation of the pharmacist, and days of the week the patient takes the dose at home.
  - To start with a new unknown patient, all doses should be observed at the pharmacy

St. Michael's

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St. Jamestown Health Centre

410 Sherbourne Street, 1st Floor
Toronto, ON
M4X 1K2

tel: 416-864-3096
fax: 416-864-6035

Valid only at
The pharmacy listed below:

Pharmacy (specfiy):
with address

MDM 410 Sherbourne
T:
Fax:

Buprenorphine (Suboxone) Prescription Form

Name: PATIENT TEST
OHIP: ON 1423424924 MB DOB: Dec 16, 1950

Date: Mar 19, 2018

℞ **Suboxone** 8 mg. Eight
dispensed daily *Dose in words* Graph....

Last prescription: 4/4 mg: Tue Sep 8, 2015 - Mon Oct 5, 2015

Start Date Thu Mar 8, 2018 *End Date* Wed Mar 14, 2018 *Inclusive*

Dose observed in the pharmacy on days checked:

☑ *Mon* ☑ *Tue* ☑ *Wed* ☑ *Thur* ☑ *Fri* ☑ *Sat* ☑ *Sun*

The following doses are to be dispensed as ***take home doses:***

☐ *Mon* ☐ *Tue* ☐ *Wed* ☐ *Thur* ☐ *Fri* ☐ *Sat* ☐ *Sun*

Special Instructions:

All doses observed.

Suboxone dose must be withheld if five or more consecutive doses are missed, and contact the prescribing physician. Suboxone dose must be withheld if patient appears intoxicated, and contact the prescribing physician. Fax a copy of this prescription to the prescribing physician (fax # 416-864-6035) if there are any concerns about the prescription.

Signature

Suzanne Turner MD
Print Name CPSO # 93676

Dose Adjustment with Buprenorphine

- **Dose increase** 2-4 mg at each follow up visit
  - Weekly in stabilization phase
  - UDS – to show compliance and absence of illicit substances
- Reasons to ***increase***
  - Withdrawal
  - Craving
  - Need to see benefit with increase in above
- Reasons to ***decrease***
  - Sedation
- Usual dose range 8-16 mg SL OD*
- **Maximum** dose 24 mg SL OD

MAINTENANCE PHASE OF BUPRENORPHINE

Take home doses

- Often referred to as “Carries”
- ***CAMH/CPSO 2011 guidelines***

> **It is preferable to have tighter boundaries which subsequently loosened in response to patient stability than to have initially looser boundaries subsequently tightened in response to patient non-stability [78, 89]:** This evidence supports the approach that patients have observed dosing initially until their dose is stabilized and they begin to demonstrate improved control of their opioid dependence. This approach is supported by authorities in the field [49].

- ***Health Canada***
  - All doses observed (exception of weekends/ holidays) for 2 months
  - If eligible earlier “need to justify”

Take home doses

- What criteria indicate stability?
  - Stable dose
  - Stable housing
  - Concurrent disorders/Suicide
  - Absence of regular illicit substance use
    - Alcohol?
    - THC?

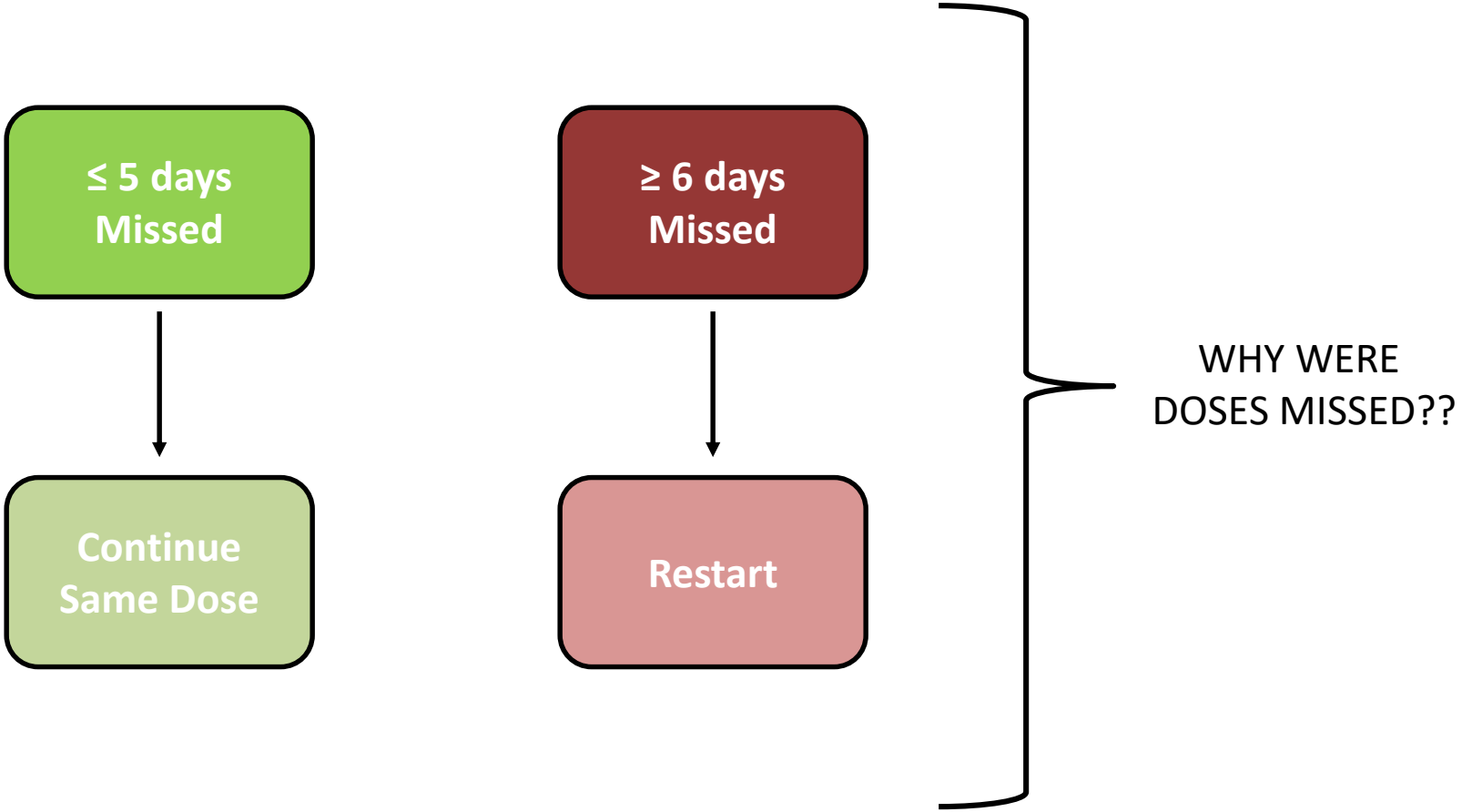
CPSO 2011 Buprenorphine Guideline

Take-home Doses

- **Before** first take-home dose
  - Discuss safety, storage (lock-box)
  - Consider written take-home agreement
- **Increasing** take-home doses
  - No evidence to guide on optimal rate of progression
  - ?q1-2 weeks is ”reasonable”
  - Increase doses sequentially, and monitor stability
  - Max interval between observed doses - 1-2weeks
- **Decreasing** take-home doses
  - If “instability” – regular substance use, loss of housing etc

CPSO 2011 Buprenorphine Guideline

Missed Doses



Management of missed doses

Table 1: Suggestions for Managing Missed Doses [19]

Buprenorphine Dose	Number of Consecutive Days Missed	New Starting Dose
> 8 mg	> 7 days	4 mg
> 8 mg	6–7 days	8 mg
6–8 mg	6 or more days	4 mg
2–4 mg	6 or more days	2–4 mg

CAMH/CPSO 2011

Case 2: Discussion (Cont)

- 27y F returns to your office, she has been stable for two months on buprenorphine-naloxone
- Feeling better, wondering how long she needs to stay on it for
- Would like to taper off, “I’m just trading one addiction for another”

When to Taper Buprenorphine-Naloxone?

ORIGINAL ARTICLE

ONLINE FIRST

Adjunctive Cou
Buprenorphine-
Opioid Depende

A 2-Phase Randomized C

Roger D. Weiss, MD; Jennifer Sharp
Hilary S. Connery, MD, PhD; Willia
Marc N. Gourevitch, MD, MPH; Del
Andrzej S. Kosinski, PhD; Robert Li
Jeffrey Selzer, MD; Eugene C. Semo

Context: No randomized trials h
ments for prescription opioid deper
creasing prevalence.

Objective: To evaluate the effic
tended buprenorphine hydrochlori
chloride treatment, with different
ties, for patients dependent on pre

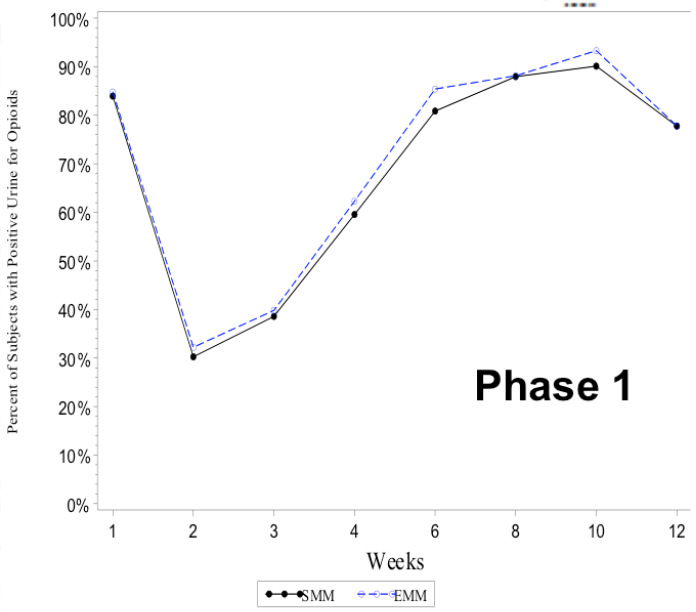
Design: Multisite, randomized clinic
adaptive treatment research design. I
1) included 2-week buprenorphine
tion, 2-week taper, and 8-week postmedi
up. Patients with successful opioid use outc
study; unsuccessful patients entered phase 2
week) buprenorphine-naloxone treatment
and 8-week postmedication follow-up.

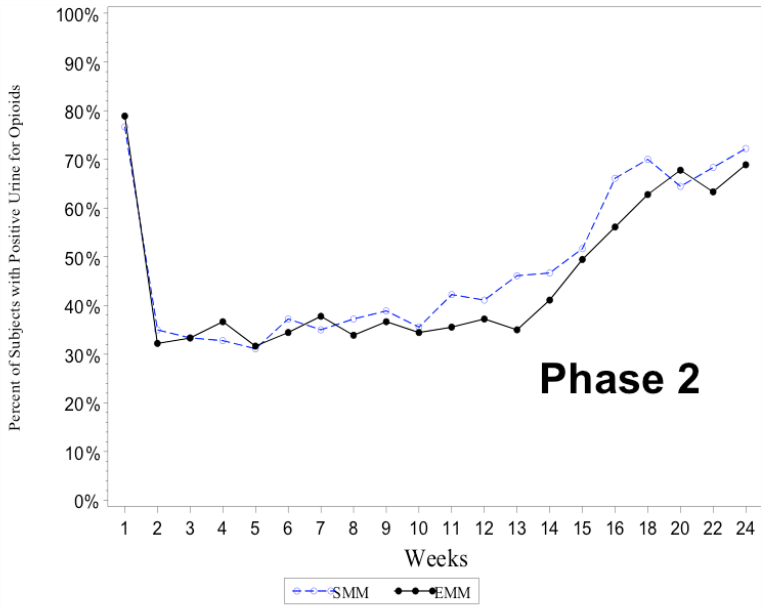
Setting: Ten US sites.

Patients: A total of 653 treatment-seeki
dependent on prescription opioids.

Interventions: In both phases, patients were randomized to standard medical management (SMM) or SMM

ARCH GEN PSYCHIATRY/VOL 68 (NO. 12), DEC 2011





Conclusions: Prescription opioid-dependent patients are most likely to reduce opioid use during buprenorphine-naloxone treatment; if tapered off buprenorphine-naloxone, even after 12 weeks of treatment, the likelihood of an unsuccessful outcome is high, even in patients receiving counseling in addition to SMM.

receiving counseling in addition to SMM.

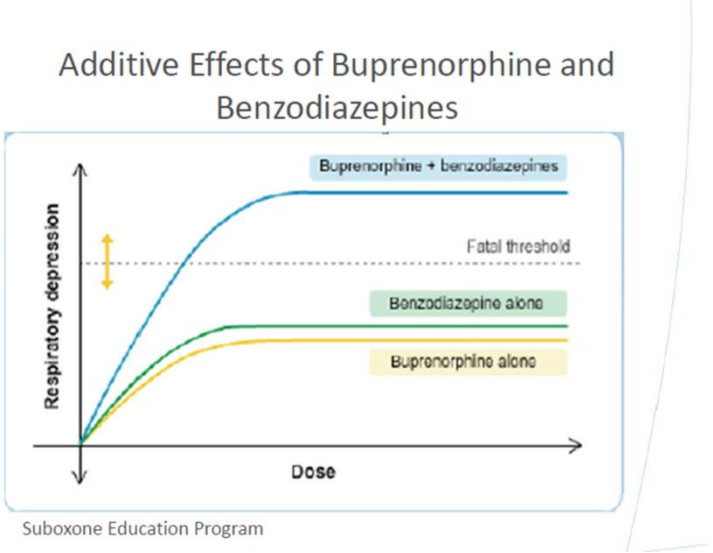
Buprenorphine-Naloxone Taper

- Recommend minimum of 1 year of treatment prior to tapering
- Long half-life (24-36h), less intense withdrawal syndrome than for short-acting opioids
- If tapering, consider going slowly in increments of 2 mg every 2-4 weeks
- Reassess for worsening withdrawal symptoms, cravings or return to opioid use
- Consider stabilizing or increasing dose if needed

Other Considerations with Buprenorphine-Naloxone

Buprenorphine-Naloxone and Adverse Drug Reactions

- Most common: headache, nausea, dry mouth
- Respiratory/CNS depression is very rare, but increased risk when used in combination with alcohol or other sedative-hypnotics



Buprenorphine-Naloxone Contraindications

- Caution in patients with hepatic or respiratory disease
- History of hypersensitivity reactions to either buprenorphine or naloxone
- Pregnant or breastfeeding women (naloxone is category C)
  - Can apply for Special Access for buprenorphine (Subutex) through Health Canada

Issues: Potential for Diversion

- Previous reports of buprenorphine (Subutex) abuse for euphoric effect
- Reports of parenteral abuse of buprenorphine-naloxone by those with low degree of opioid physical dependence, or willing to endure relatively short duration of naloxone
- Buprenorphine-naloxone has street value and risk for diversion

Province	Coverage	Criteria	MD Prescribing Requirements
BC	Regular Benefit	1st line	No exemption required (NEW!)
Alberta	Regular Benefit	1st line	No exemption required
Saskatchewan	Exceptional Status	2nd line	Methadone exemption OR one day with MD with exemption
Manitoba	Exceptional Status	2nd line	Methadone exemption
Ontario	Regular Benefit	1st line	No exemption required
Quebec	Exceptional Med	2nd line	No exemption required
NB	Special Authorization	2nd line	Methadone exemption OR "experience in treatment of OUD"
Nova Scotia	Standard Benefit <24y, Exemption Status >24y	1st line <24y, 2nd line >24y	No exemption required
PEI	Special Authorization	2nd line	No exemption required
Newfoundland and Labrador	Special Authorization	2nd line	No exemption required
Yukon, NWT, Nunavut	Information unavailable		

SuboxoneCME.ca

Opioid Dependence Education

Welcome to the SUBOXONE® Education Program

This educational program will introduce you to treatment applications and benefits of SUBOXONE® (buprenorphine (as buprenorphine hydrochloride) and naloxone (as naloxone hydrochloride dihydrate)) **for the treatment of opioid dependent patients.**

The SUBOXONE Education Program is a risk management program that is founded on the following four core components that provide for the safe and effective use of the drug within a framework of medical, social and psychological treatment:

- **training of the prescribing physicians in the use of SUBOXONE sublingual tablets;**
- **maintenance of a list of SUBOXONE Education Program trained physicians;**
- **daily dosing supervised by a healthcare professional for a minimum of two months;**
- **take-home doses should only be considered after a period of two months based upon assessment of clinical stability, length of time in treatment and ability to safely store SUBOXONE. Take-home doses should be assessed and reviewed on a regular basis.**

In order to obtain the completion certificate for this program you must take the Modules 2 through 6 in consecutive order, completing all of the Progress Checks, Case Studies and Module Tests.

To begin the program, click on the **Start Now!** spotlight below

Help Demo

Take a quick tour of the course functions and features.

Start Now!

Get started with the SUBOXONE Education Program now.

Ask Med Info

Call the Medical Information Unit at FREE 1-877-782-6966 for any SUBOXONE product or medical information question.

Program overview

View a listing of the Program Modules and their interior sections and pages here.

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Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians

This course is held under the auspices of the Office of Continuing Education and Professional Development, Faculty of Medicine, University of Toronto and Centre for Addiction and Mental Health in Toronto, Ontario.

Description

This course aims to present a framework for providing maintenance treatment for opioid dependence with buprenorphine/naloxone, including its use in a primary care setting. The course walks the learner through the key elements of selecting, preparing, initiating and maintaining a patient with opioid dependence on buprenorphine/naloxone maintenance treatment.

A blend of narrative text, video role-plays, short answer and multiple choice questions frame the course. Excerpts and recommendations are embedded from the CAMH publication, Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline.

Buprenorphine/Naloxone for Opioid Dependence:

Clinical Practice Guideline

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Withdrawal Management

Some patients may request withdrawal management only

Consider:

- Symptomatic treatment of withdrawal
- Education regarding overdose risk
- Harm reduction: take-home naloxone kit

POPP
Peer
Overdose
Prevention
Program

5 STEPS TO SAVE A LIFE

1 **SHAKE&SHOUT**
shake the person's shoulders and shout their name

2 **CALL 9-1-1**
if the person is not responding

3 **NALOXONE**
inject 1 ampoule (1mL) of naloxone into arm or leg muscle

4 **COMPRESSIONS**
push firmly and quickly on the centre of the chest

5 ? 2nd Dose **IS IT WORKING?**
if there is no change after 3-5 minutes, give a 2nd dose of naloxone and continue chest compressions until the ambulance arrives

SITE Needle & Syringe Program
Programme sur les aiguilles et les seringues

Harm reduction 101

- Always have naloxone around
- Use with others
- Test your dose
- Use at an overdose prevention site
- Get clean equipment

Summary

- Opioid use disorders have an increasing risk of overdose and death, but are treatable!
- Opioid agonist therapy (medications) are the gold standard for treatment of opioid use disorders
- Buprenorphine-naloxone represents a newer alternative to methadone with greater access and lower risk profile
- Family physicians can treat OUD in office!
- Office-based inductions are possible with a careful approach to avoid precipitated withdrawal

Thanks to Dr. Kit Fairgrieve, Dr. Jennifer Wyman, Dr. Monique Moller, Dr. Kirstie Peden and Dr. Erin Lurie for generously sharing some of their slides and reviewing this workshop

Thank you for attending!

Questions or Comments are Welcome!

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