METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION: PRIMARY CARE – HOSPITAL INTEGRATION

NEWSLETTER

PROGRAM INNOVATION

Seeking Safety
Women's College Hospital

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Social Worker, Mental Health and Addictions

PTSD and substance misuse often go hand in hand, with substance use offering those who have experienced trauma an escape from the intrusive, negative thoughts and emotional pain stemming from past experiences. This co-occurrence provides the rationale for Seeking Safety, a structured treatment approach that offers group participants an opportunity to learn coping strategies and skills for both PTSD and substance use. Integrated treatment for both has been shown to be more successful, cost effective, and sensitive to patients' needs than parallel or sequential approaches.

Groups can be open to all or tailored to specialized populations. At Women's College Hospital, we run groups lasting thirteen sessions, with ten to twelve participants, three times per year. We have two facilitators, myself and an addiction psychiatrist, and follow the work plan set out in the Seeking Safety Manual written by Dr. Lisa Navajits.

Here are some comments from participants:

"It gave me an understanding of why I have always felt the way I do...that I am not crazy or a bad person."

"It was helpful, I feel more hope and more confident."

"There's a light at the end of the tunnel."

The main goal of the program is to establish safety, specifically strategies around self-care and harm reduction to decrease risk of further trauma. Other goals include learning strategies for fostering healthy relationships, asking for help, and boundary setting. Sessions focus on decreasing symptoms of PTSD and substance use by practicing coping strategies learned in group, which can be implemented in everyday life.

More information can be found at http://metaphi.ca/assets/documents/provider%20education/SW_SeekingSafety.pptx.

CLINICIAN SPOTLIGHT

Photo by Christy Sutherland

Caryn Green MD CCFP
Addiction Physician, Women's College Hospital

After completing my family practice residency at St. Paul's Hospital in Vancouver, I held a number of community positions providing care to Vancouver's most vulnerable: those facing institutional oppression, substance use disorders, homelessness, mental illness, and trauma. I worked with NGO The Portland Hotel Society in a clinic embedded in the Alexander Street Community, a ten-floor Housing First project. PHS responded to the opioid crisis by extending after-hours physician coverage, doing outreach in shelters and alleyways, and piloting injectable OAT programs in our housing projects. We reached those using injectable substances by providing safe injection opportunities, prescribing OAT on the spot, and providing many resuscitations alongside peer workers. PHS continues to provide cutting-edge, evidence-based, harm reduction–centred care.

During the crisis I also worked at the Mobile Medical Unit, a mobile crisis hospital that was deployed for three months in a Downtown East Side parking lot. The MMU partnered with local emergency and addiction clinicians to provide care to patients brought in by ambulance following overdose. We were able to initiate many people on OAT with community follow-up.

There are many differences between the addiction care models in B.C. and Ontario. Ontario physicians generally work fee-for-service, resulting in much of the outreach work being done by salaried nurse practitioners. B.C. physicians working with marginalized communities are almost entirely covered by sessionals, meaning that physicians are at the forefront of community outreach efforts. My driving passion is serving marginalized and underserved people by offering low barrier, anti-oppressive addiction care. I hope to continue this work in Ontario by working in and opening low-barrier rapid access addiction clinics, and I look forward to collaborating with my Ontario colleagues to find creative ways of providing addiction care to our most vulnerable.

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Join the META:PHI Google group:
E-mail sarah.clarke@wchospital.ca to be added.

EVENTS

RAAM monthly videoconferences:

Nurses	**May 8**
Counsellors	**May 10**
Prescribers	**May 14**
Administrators	**May 16**

E-mail kate.hardy@wchospital.ca to join a videoconference or to have a provincial event featured here.

PERSPECTIVES

Testing for analogues of powdered fentanyl: The need for reliable chromatography and immunoassays

Delmar Donald MD CCSAM
Addiction Physician, Bluewater Methadone Clinic

I am aware of six opioid-related deaths in Lambton County in the past two months, which is in excess of the 2017 provincial rate of eight per 100,000. The rate in B.C. is 29 deaths per 100,000, which is a glimpse into Ontario's future if we don't respond efficiently and effectively to the increasingly lethal street opioid supply. In Southern Ontario, we're starting to see false negative urine tests for fentanyl, both immunoassays and chromatographies. This lack of reliable testing, reminiscent of the dark ages before immunoassays could detect pharmaceutical-grade fentanyl, makes our current situation riskier than anything we've seen in decades.

I requested input from CAMH and Dynacare on what factors could be at play. CAMH identified two fentanyl analogues, W15 and 19, that are not picked up on standard chromatography. My contact at Dynacare was not aware of any testing issues, but indicated that it is not a simple process to improve testing.

While chromatography is important, immunoassays are more useful clinically. Developing a new immunoassay can be done quickly, but Health Canada approvals would likely take a year. Such a timeline is inexcusably long given the urgency of the crisis. I've been informed that manufacturers of dip tests are trying to adjust sensitivity of dips; however, lowering the threshold will only result in more false positives. Manufacturers need to develop tests that identify new fentanyl analogues, and Health Canada needs to fast-track their approvals. As clinicians, we must make a concerted effort to advocate for the availability of appropriate testing.

False negative urine drug screens can have deadly consequences. Patients might be falsely reassured that their drug supply is not contaminated with fentanyl. Patients on methadone or buprenorphine might knowingly use powdered fentanyl so their use is undetected and they can continue to receive carries, possibly increasing diversion of OAT medications.

Illicit fentanyl is not only harder to detect, but it can be harder to treat with buprenorphine and methadone. Powdered fentanyl is very long-acting, and the patient may have to wait days before starting buprenorphine to avoid precipitated withdrawal. People using powdered fentanyl have extremely high tolerance, so it could take weeks to reach a methadone dose high enough to fully relieve withdrawal symptoms, putting patients at high risk of relapse to fentanyl and subsequent overdose death.

IN THE NEWS

Emotional demonstration marks National Day of Action on overdose deaths (Now Toronto)
https://nowtoronto.com/news/overdose-crisis-national-day-of-action-2019/

Ontario cuts funding to three supervised drug-use sites (The Globe and Mail)
https://www.theglobeandmail.com/canada/article-ontario-to-close-three-supervised-drug-use-sites/

More than 10,300 Canadians lost their lives to opioids in less than 3 years (CBC)
https://www.cbc.ca/news/health/opioids-phac-1.5092387

Addictions and Mental Health Ontario presents to Standing Committee on Social Policy on Bill 74, The People's Health Care Act (Addictions and Mental Health Ontario)
https://amho.ca/bill-74-standing-committee/

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www.metaphi.ca

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