META:PHI — MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION: PARTNERS IN HEALTH INTEGRATION
NEWSLETTER
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PROGRAM INNOVATION

Experiences at the Peterborough RAAM Clinic with 'Rapid Sublocade Injections'

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At the Peterborough RAAM clinic we were very excited to hear about the auto micro-induction of Buprenorphine XL. There are many potential benefits to this option, which we call 'Rapid Sublocade Injection' (RSI).

Between December 12, 2023 and April 16, 2024 we gave 18 'RSI's to patients with varied buprenorphine history – last use differed from months to years, and in two unique circumstances, there had been no previous buprenorphine use. Patients last used fentanyl from one to 72 hours prior to the RSI. Thus far, we have followed up with 16/18 patients:

- 13/18 tolerated the protocol well
- 9/18 have returned for a second injection
- 3/18 had notable precipitated withdrawal

The trickiest part to these injections has been managing possible withdrawal from fentanyl (while waiting for the BUP XL to start working) vs. precipitated withdrawal (PW). Anecdotally, many successful scenarios have been for patients who used fentanyl within hours of coming to clinic (12/18 patients). We considered an injection to be successful if the patient was satisfied with the process, did not have PW, and followed up with us at least once, post injection.

The three patients who developed severe PW had last used fentanyl within 4, 18 and 20 hrs. Two of them (last fentanyl use18 and 20 hrs prior) had also recently used either hydromorphone or hydromorph contin, which was not disclosed at the time of injection. Both felt they were developing PW within hours of the injection and thus felt the need for SL buprenorphine, which had been provided to use as needed. Their withdrawal then became much worse and they both presented to the ED, with one requiring admission. The third patient (last fentanyl use 4 hours prior) developed PW closer to 12 hours later. This person used high dose SL buprenorphine and fentanyl to treat the withdrawal.

We have struggled to make sense of the precipitated withdrawal. One theory relates to other opioids in the patient's system and patients misinterpreting increasing fentanyl withdrawal as PW, and subsequently self-treating with SL buprenorphine too early (thus causing true PW). This has led us to use extra SL buprenorphine more cautiously to treat PW. Instead, we have moved towards using hydromorphone to treat PW or fentanyl withdrawal while awaiting the full effect of BUP XL (see algorithm). Another theory on the cause of PW is that there are differences in how individuals metabolize BUP XL: some patients feel the effect within a few hours, whereas it could be 10 hours for others. A faster onset of action for some patients may put them at higher risk for PW in the first few hours. Unfortunately, there is not yet any published data on buprenorphine plasma levels within the first 24 hours after injection. (We welcome any information available to help us understand this issue.)

As a means to mitigate the risk of PW, we have developed our own protocol to more carefully select patients for the rapid injections. Recommendations to best manage fentanyl withdrawal, precipitated withdrawal, and benzodiazepine withdrawal are included in our algorithm. Please note that this is still a work-in-progress and we look forward to learning more as we continue to provide 'RSI' to our patients who request it.

FACES FROM THE FIELD

Karleigh Darnay MSW, RSW
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Youth Wellness Hubs Ontario (YWHO) operates 27 hub networks providing drop-in access to youth-centered, community-based mental health and wellness services for young people aged 12-25. Youth, family members, and service providers are instrumental in informing these services. While hubs share core components across the province, they are locally adapted to offer a range of evidence-based supports, including mental health, substance use, primary care, education, employment, housing, peer support, family support, care navigation, and other community and social supports. YWHO follows an Integrated Youth Services (IYS) model, promoting multidisciplinary collaboration across care providers, services, and sectors.

Karleigh Darnay, of mixed Anishinaabe and European descent and a member of Garden River First Nation, is the Clinical Practice Lead at the YWHO Provincial Office at CAMH. She provides clinical leadership for the YWHO service delivery model, and youth mental health and substance use system design and transformation initiatives. Karleigh has led the research, synthesis, and development of YWHO's substance use model in collaboration with YWHO staff and network partners.

The in-person and virtual services available at hub networks facilitate early intervention and age-appropriate, evidence-based care. Substance use services at YWHO include psychoeducation, prevention, early intervention, harm reduction, peer support, primary care (including withdrawal management and pharmacological interventions), and navigation to Rapid Access Addiction Medicine (RAAM) clinics.

After extensive research and consultations with youth, families, hubs, researchers, and clinicians, YWHO will be rolling out a YWHO Substance Use Service Model in the coming weeks. This model will be available on the YWHO website and aims to provide recommendations for evidence-based and evidence-generating substance use service pathways for young people vulnerable to substance use harms. As part of its commitment to measurement-based care, YWHO will continue to gather data, youth-defined outcomes, and research to demonstrate the evidence for these approaches and continually improve services to meet community needs.

The YWHO Substance Use Service Model emphasizes engagement, prevention, and harm reduction as fundamental pillars of its substance use healthcare continuum. It acknowledges the intersections of individual, social, and structural factors influencing youth health and provides guidance for wholistic approaches. YWHO has also developed training materials in collaboration with clinicians and diverse youth who use substances. These materials, available on YWHO's Training Page, offer foundational substance use knowledge for service providers to deliver evidence-based treatments.

By integrating services and strengthening system-level collaboration, YWHO ensures that young people and their families have access to compassionate, informed, and comprehensive care across all hub networks. Please contact Karleigh for more information (Karleigh.darnay@camh.ca)

In the Media: ER Patients Who Need Alcohol Medications

PERSPECTIVES

The Benefits of Depot Buprenorphine in Corrections

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The opioid poisoning crisis has profoundly impacted incarcerated populations. The highest risk of death for these individuals is within the first four weeks after leaving a correctional facility. During incarceration, they also face a significant risk of overdose due to the availability of illicit drugs. Substantial evidence supports opioid agonist therapy (OAT) to reduce the risk of overdose and death from overdose and is equally applicable to both community and incarcerated populations.

I work in a small provincial correctional facility situated near a small Northern Ontario city. This setting has afforded me unique opportunities to continue to engage with formerly incarcerated individuals across various community settings, including hospitals, primary care, addiction programs, and public spaces like grocery stores and Tim Hortons. This proximity allows me to become familiar with individuals who move between the community and incarceration, and to understand their previous treatment plans, which is invaluable in tailoring ongoing care.

Over the past four years, my work in corrections and other areas of addiction medicine, particularly administering OAT, has led to several notable anecdotal observations. My practice focuses primarily on using buprenorphine as the first-line treatment for opioid use disorder (OUD) as it is most accessible (especially in isolated communities), with a specific emphasis on Buprenorphine XL. From my personal experience interviewing, listening to, and assessing individuals who have received BUP XL, several patterns have emerged:

***Challenges with Withdrawal*:** Withdrawal from fentanyl can be intolerable. Missed doses of sublingual (SL) buprenorphine/naloxone or methadone can occur for a variety of reasons both prior to incarceration (social circumstances, accessibility barriers, engagement in criminal activity, etc.) and at incarceration (verification of OAT prescription/last witnessed methadone, obtaining new OAT prescription, etc). However, individuals on BUP XL experience fewer issues, as missing a next dose does not appear to cause as significant withdrawal, especially if within a 2 week window. In contrast, missed doses of methadone or SL buprenorphine for more than a couple of days, especially when combined with prior fentanyl use, result in severe withdrawal.

Benefits of Buprenorphine XL: BUP XL provides a buffer against missed doses. The plasma concentration of buprenorphine is gradually eliminated over weeks to months, depending on the number of initial BUP XL injections received. This slow elimination process results in less severe withdrawal symptoms, improving the quality of life for incarcerated individuals. It reduces their risk of significant withdrawal when they are initially incarcerated and protects them from overdosing while incarcerated and upon release.

In recent years, I have gained significant insights from my patients regarding Bup XL, particularly in correctional settings. Many patients continue to use fentanyl while on BUP XL but remain alive and in relatively better health. Even if they have been using fentanyl, these individuals often report minimal to no withdrawal symptoms upon entering a correctional facility if they are also on BUP XL. When they are released from incarceration, for many reasons they don't necessarily immediately go to a pharmacy or clinic for (OAT) prescriptions - and BUP XL treatment offers more autonomy before release without the worry of prioritizing a pharmacy, while providing several weeks protection from overdose.

Interestingly, patients frequently express that BUP XL offers them a sense of choice. Unlike other treatments, it reduces the intensity of dope sickness, allowing them to wait until they have money to purchase fentanyl rather than engaging in criminal activities to obtain drugs. This sense of control enables them to use drugs on their terms, not because they are compelled by withdrawal symptoms.

The integration of Buprenorphine XL into my community practice and within correctional facilities has shown promise in mitigating the severe withdrawal symptoms associated with opioid use, reducing overdose risks, and improving the overall quality of life for incarcerated individuals. Continued research and adaptation of addiction treatment protocols in correctional settings are essential to address the ongoing opioid crisis effectively.

THOUGHTS FROM A SEMI-RETIRED ADDICTION DOCTOR

Empathy Improves Treatment Outcomes

Meldon Kahan MD CCFP FRCPC
Medical Director, META:PHI

Provider empathy may be an important factor in treatment success, especially for stigmatizing conditions such as chronic pain, mental illnesses and substance use disorders. In a remarkable study (Licciardone 2024), 1470 patients with chronic low back pain who were enrolled in a national US pain registry completed a standardized survey on their perception of their physicians' empathy at baseline and 12 months later. All patients had the same physician during the study period. The study found that patients who rated their physicians as "very empathic" had lower pain scores, better function and less pain disability than those who rated their physicians as slightly or non-empathic. The association between pain and empathy was modest, but stronger than the associations for opioids, surgery and non-pharmacological treatments.

Empathy was measured using the Consultation and Relational Empathy (CARE) scale, a 10 item scale that asks patients to rate their physician on items such as "really listening; fully understanding your concerns; showing care and compassion; explaining things clearly; helping you to take control; and making a plan of action with you".

The study's results are consistent with research in the addiction field. One review (Moyers 2013) concluded that "differences among therapists account for between 5 and 12% of the variance in a variety of client outcomes… a better relationship between the client and therapist is associated with higher levels of treatment engagement and retention in substance abuse programs". The review cites both observational studies and randomized trials, which suggests that association between empathy and outcome might be causal.

In my clinical experience, people who use substances often have few social supports, are pessimistic about their ability to change, and are deeply ashamed of their addiction. Having a non-judgmental, empathic care provider can relieve the burden of shame and guilt while giving them a sense of hope and empowerment. Empathy is not something that necessarily takes prolonged counselling visits; it can be embedded in every encounter, even brief ones. It can be difficult for clinicians and therapists to maintain empathy if they have a heavy patient load, or if they have patients who have relapsed or frequently miss appointments. One strategy that helped me maintain empathy was to remind myself what the patients have endured and overcome - traumatic childhoods, violence, loneliness, anxiety, multiple losses. And overcoming addiction can take great courage: to change relationships and activities, withstand prolonged withdrawal symptoms, and cope with the disappointment of relapses and setbacks.

Evidence suggests that physicians lose empathy as they go through their training. Addiction services can address this by offering rotations to medical students and trainees. Having trainees listen to patients' stories and observe addiction clinicians in action is a powerful way to generate empathy.

EVENTS

2024 Webinar Series - Session #5
Indigenous Culture as Healing with Carol Hopkins, CEO Thunderbird Partnership Foundation
Wed June 19, 7-8:30 pm Register HERE

RAAM Monthly Videoconference Dialogue Series
Psychiatric Care in a RAAM Clinic with Wiplove Lamba, MD, FRCPC Psychiatrist
Wed June 4, 8-8:45 am

Addiction NP Videoconference Discussion
Wed June 26, 12-1 pm
To join any of these events contact laurie.smith@wchospital.ca