Québec Guide to Improving Practices in the Management of Opioid Use Disorder (OUD)

IUD INSTITUT UNIVERSITAIRE SUR LES DÉPENDANCES

Québec

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BACKGROUND

This guide was developed using a method that was transparently communicated and is described in detail in the "Methodology" section of the *Rapport de recherche* (research report) document. The content is based on scientific data, clinical guides, interviews conducted in various regions of Québec with people who use opioids, clinical teams, program managers, and community groups working with people who use opioids. The content of the guide is the result of a reflection process conducted with an expert group and two advisory committees composed of people with OUD experience. Competent experts were consulted in order to ensure the most accurate content possible.

However, it must be noted that this guide is not prescriptive and that the authors **cannot be held accountable** for the clinical practices of professionals. Clinicians are expected to assume the responsibility for being adequately trained and qualified. They must exercise clinical judgment when providing care and services in compliance with the professional standards and the code of ethics to which they are subject.

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LIST OF INITIALISMS AND ACRONYMS

CISSS	French for *Centre intégré de santé et de services sociaux* (Integrated Health and Social Services Centres)
CIUSSS	French for *Centre intégré universitaire de santé et de services sociaux* (Integrated University Health and Social Services Centre)
CLSC	French for *Centre local de services communautaires* (Local Community Service Centre)
CMQ	French for *Collège des médecins du Québec* (College of Physicians of Québec)
COWS	Clinical Opiate Withdrawal Scale
CRD	French for *Centre de réadaptation pour les personnes ayant une dépendance* (Addiction Rehabilitation Centre)
CRISM	Canadian Research Initiative in Substance Misuse
DSM	Diagnostic and Statistical Manual of Mental Disorders
FMG	Family Medicine Group
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HSSS	Health and social services system
MSSS	French for *Ministère de la Santé et des Services sociaux* (Department of Health and Social Services)
NID-EM	French for *Niveaux de désintoxication – Évaluation par les intervenants médicaux* (Medical Withdrawal Level Assessment Tool)
NID-EP	French for *Niveaux de désintoxication – Évaluation par les intervenants psychosociaux* (Psychosocial Withdrawal Assessment Tool)
OAT	Opioid agonist treatment
OIIQ	French for *Ordre des infirmières et infirmiers du Québec* (Québec Order of Nurses)
OPQ	French for *Ordre des pharmaciens du Québec* (Order of Pharmacists of Québec)
OUD	Opioid use disorder
PrEP/PEP	Pre-exposure and Post-exposure prophylaxis
RHD	French for *Ressource d'hébergement en dépendance* (Addiction Recovery Housing Resources)
STI & BBI	Sexually transmitted infection and blood-borne infection

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GLOSSARY

Buprenorphine-naloxone

Has a 4:1 concentration of buprenorphine and naloxone and is available in sublingual tablets in Canada. Naloxone is a low bioavailable opioid antagonist when swallowed or taken sublingually and is used to discourage misuse and non-medical injections. When buprenorphine-naloxone is taken directly under the tongue, the naloxone component has negligible effects while the therapeutic effect of buprenorphine predominates. However, if misused by way of subcutaneous, intramuscular, or intravenous injection, a sufficient amount of naloxone will be absorbed, causing some withdrawal symptoms in people who use opioids regularly. Buprenorphine-naloxone is usually taken once a day, but due to its high safety profile and pharmacological properties, it can also be prescribed at high doses on an alternating administration schedule. In Québec, any doctor can prescribe buprenorphine-naloxone. Prescriber training by the Institut national de santé publique du Québec is recommended.[1]

Clinical Opiate Withdrawal Scale (COWS)

Objective assessment scale of opioid withdrawal symptoms. Scoring: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal.[5]

Drugs designed for withdrawal symptom management

Any drug that can be used to reduce opioid withdrawal symptoms, excluding opioid agonists (e.g. benzodiazepines, antinauseants, anti-inflammatories, muscle relaxants, alpha-2 adrenergic agonists).

Essential harm reduction supplies

Essential harm reduction supplies include:

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

Harm reduction, philosophy, and services

Harm reduction usually refers to policies and programs aimed at reducing the immediate social, economic, and health effects (e.g. transmission of infectious diseases, death due to overdose, criminal activity) associated with the use of psychoactive substances, but they do not necessarily aim to reduce drug use or achieve abstinence.[15] Harm reduction encompasses a range of services, as well as several principles, which are grouped under the term *harm reduction philosophy*.

Harm reduction philosophy

Harm reduction philosophy focuses on reducing and preventing the risks and negative consequences associated with opioid use and other risk behaviours. Its aim is to improve the quality of life of people in care. This philosophy is implemented by ensuring a therapeutic alliance between the health care professional and the client based on non-judgment, flexibility, empowerment, and self-determination. This philosophy has a powerful influence on caregivers' values and soft skills, and on how the services offered are developed. Harm reduction-based care involves collaborative therapeutic positioning and structural conditions that provide adequate flexibility for the deployment of the necessary actions. Harm reduction services for people who use opioids cannot be dissociated from harm reduction philosophy; however, they should not be mistakenly considered synonymous.

Harm reduction services

Examples include needle and syringe exchange programs, take-home naloxone programs, supervised injection services, etc. The services to be systematically provided by teams offering OAT are the distribution of essential harm reduction supplies (see definition of essential harm reduction supplies), and health-related prevention and promotion activities, including training on and the promotion of, low-risk drug use practices. However, it is important to emphasize that simply implementing harm reduction services does not equate to compliance with its associated philosophy.

Hierarchy of OUD care treatment (stepped care model)

The hierarchy of care, or stepped care model, aims to adapt and structure the treatment intensity to the characteristics of the person in treatment, thus preventing the latter from being directed to the wrong place and providing access to the best available resources.[7] "The stepped care model [...] incorporates the separation between care and services depending on the severity of concomitance, while combining them with other aspects such as gradual service and system integration coupled with a simultaneous or sequential engagement of each care step [Rush and Nadeau, 2012]."[8]

Holistic vision

This vision involves above all recognizing the person as a complex human being, rather than reducing them to their use of psychoactive substances, their homelessness, or their mental health issues.[11,18] In other words, it is based on a broader consideration of the person, taking into account the complexity of their biological, psychological, and social characteristics.

Long-term treatment planning and support for OUD

The partner care team, in collaboration with the individual, plan for long-term OUD treatment. This treatment may include pharmacological treatment, assessments by and follow-ups with several professionals, as well as psychosocial interventions, and may be offered through inpatient (CRD or hospital) or outpatient services (e.g. community housing resources, living environments). The focus here is to avoid viewing opioid use disorder as a linear process or time-constrained issue and opting instead for a long-term vision.

Low threshold

The expression *"low threshold"* refers to the reduction of barriers and conditions that a person may encounter when seeking to obtain access to and receiving required care.[3,4]

Medically assisted withdrawal management

Use of pharmacological treatment (e.g. dose tapering using opioid agonists or alpha-2 adrenergic agonists) to alleviate withdrawal symptoms and related adverse effects when a person stops consuming opioids, with a goal of abstinence. This term reflects a voluntary distancing from the old terms "detox" and "detoxification" previously employed to describe medically supervised withdrawal.

Slow taper: Gradual dose reduction of opioid agonists, usually in an institution or in an outpatient setting, over the course of a month or longer.

Rapid taper: Rapid dose reduction of opioid agonists, usually in a hospital or dedicated inpatient withdrawal management facility, over the course of a week or less.[1]

Medical management of OUD

Refers to the medical component of OUD management, including pharmacological treatment, health and wellness assessments, support and advice, assessment of motivation and barriers to change, creation of a treatment plan, encouraging adherence to pharmaceutical treatment, dose optimization, support for treatment and prevention of relapse, and referral to appropriate health and social services.[1]

Methadone

Long-acting synthetic opioid that acts as a pure agonist of Mu (μ) opioid receptors. Its half-life is approximately 24 to 36 hours, and it is easily absorbed. In Canada, it is usually administered as an oral solution and generally in a single daily dose. Methadone tablets are also provided in limited contexts (e.g. for travel or chronic pain). In Canada, since May 2018, an exemption from Health Canada is no longer required for physicians to prescribe methadone. Physicians have the responsibility to acquire the necessary knowledge to prescribe methadone.[1,9]

Naloxone

Naloxone is a fast-acting opioid antagonist that temporarily counteracts the effects of an opioid overdose.[12]

No Wrong Door policy

A *No Wrong Door* policy facilitates access to the resources a person needs to deal with any issues they encounter, regardless of where the issue originates. This means that any point of entry is good and appropriate for accepting a support request.[14]

One-stop shop model

Provide a wide range of interventions and services from a single location.[10,11]

Opioids

Substances frequently prescribed to relieve pain; they bind to opioid receptors in the brain and activate them to reduce the capacity for experiencing pain. High doses of opioids can cause euphoria, dysphoria, and respiratory depression. Opioids can be prescribed or obtained illegally and are available in synthetic (e.g. fentanyl, methadone), semisynthetic (e.g. heroin, hydromorphone, oxycodone, buprenorphine), and natural (e.g. opium, morphine, codeine) forms. The term "opiate" is defined as a compound naturally derived from the poppy. Depending on the formulation and type of opioid, and according to personal preference, opioids are consumed transdermally, intrarectally, by ingestion, inhalation, snorting, or through subcutaneous, intramuscular, or intravenous injection.[1]

Opioid agonists

Any substance that, by binding to and activating Mu (μ) opioid receptors, results in relieving withdrawal symptoms and the state of withdrawal in people with OUD. Opioids also relieve pain when used for chronic pain management. Oral opioid agonists used to treat OUD include methadone, buprenorphine, and slow-release oral morphine.[1]

Opioid agonist treatment (OAT) or maintenance treatment

Opioid agonists prescribed to treat OUD. In this document, OAT is defined as the long-term maintenance treatment (> 6 months) using an opioid agonist whose use in application for OUD treatment is well documented. OAT is the term chosen as it reflects an intentional distancing from the terms *opioid substitution therapy (OST), opioid maintenance treatment (OMT), and opioid replacement therapy (ORT)*.[1] OAT is usually provided in conjunction with individual consultation, long-term monitoring of psychoactive substance use, comprehensive primary and preventive care, and referrals to psychosocial treatment, psychosocial support, and specialized care services, as applicable.

Opioid use disorder (OUD)

Problematic use of opioids that results in clinically significant distress or disability and that meets the DSM-5 diagnostic criteria for opioid disorders. OUD includes the use of synthetic, semisynthetic, or natural opioids, whether prescribed or illegally obtained.[1]

Partner care team

A care team focused on collaboration, complementarity, and knowledge sharing between the person in care and the health and social services network. This relationship promotes co-construction and knowledge sharing to develop a common understanding of a situation or problem, and the possible solutions.[6]

Peer support workers

People with lived experience who support other individuals who are living with a similar life experience.[13]

Precipitated withdrawal

Withdrawal symptoms may occur when an opioid antagonist or partial agonist, (buprenorphine, for example) is administered to a patient who recently consumed a pure opioid agonist. Due to buprenorphine's high binding affinity for and its low intrinsic activity at the Mu (μ) receptor, a partial agonist displaces the pure opioid agonists from the Mu (μ) receptors without activating the receptor at a consistent intensity, which creates a significant decrease in effect. Precipitated withdrawal is more intense and occurs faster than typical opioid withdrawal.[1]

Stabilization dose (or comfort dose)

Dose of opioid agonists that relieves withdrawal symptoms for 24 hours.

Trauma-informed care

According to SAMHSA, "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." [2] SAMHSA has identified 6 key principles to a trauma-informed approach: 1) Ensure a physically and psychologically safe setting; 2) promote trustworthiness and transparency; 3) use peer support workers; 4) establish collaboration and mutuality; 5) based on practices that promote empowerment and self-determination (empowerment, voice, and choice); 6) take into account the specific characteristics of the person (e.g. gender, culture, ethnicity, sexual orientation).

Telemedicine

The practice of providing remote health care using information and communication technology (ICTs). In this case, the concept of remote means that the doctor and patient are not in each other's presence. This definition includes the use of traditional landline telephone service, cellular technology and the Internet (e.g. use of virtual communication applications such as Zoom or Skype) but excludes fax service. By definition, postal communication is not included in the definition of telemedicine. Telemedicine includes teleconsultation, telehealth, tele-expertise, telemonitoring, and tele-assistance.[17]

Withdrawal

Withdrawal is the metabolic process by which toxic substances are removed from the body.[14] A state of withdrawal consists of a set of symptoms of varying severity that occur during cessation or reduction of the use of psychoactive substances that have been consumed repeatedly and usually over a long period of time.[16]

Withdrawal management services

Inpatient and outpatient services that provide withdrawal management, in response to an individual's voluntary request to taper off a substance, including opioids.[14]

INTRODUCTION

This document is based on data collected as part of two research projects:

- *Vers des meilleures pratiques pour les personnes en situation de précarité et dépendantes aux opioïdes : Optimiser l'accès et l'organisation des soins de santé et services sociaux au Québec*
- *La prise en charge médicale dans le cadre de la gestion du sevrage des troubles de l'usage d'opioïdes (TUO) dans les CRD au Québec : Documenter les meilleures pratiques par l'élaboration d'un guide pratique afin de soutenir le déploiement et l'organisation des services*

This approach has resulted in development of 10 practice concepts to consider when addressing practice improvement related to the management of people who use opioids, and more specifically practices related to OUD treatment in Québec.

This guide includes an introductory preface on the principles and values underpinning the practice concepts. These elements are vital to offering and developing services for people who use opioids. Therefore, it is appropriate for the reader to assess the practice concepts in light of these ethical principles and values.

The need to reduce stigma toward people who use opioids, both in the community and within the health and social services system, is at the core of these ethical principles. The results of both research studies highlight the significant impact of the barriers and stigma surrounding access to care and the path of care for people who use opioids, including those in vulnerable situations. Given that the objective of these practice concepts is to improve the quality of life and the health of people who use opioids, it is essential to strive towards eliminating the stigma they experience.

The following 10 practice concepts have been developed with the goal of providing a continuum of services that are in line with the multiple experiences of people who use opioids. They will allow different stakeholders to modify the structuring of services, to apply best practices in the field and to provide quality services to people who use opioids. Similarly, the practice concepts aim to provide a smooth and individualized organization of OUD services in Québec. They reflect a cross-sectional and broad vision that enables each region to implement them while taking into account their specific characteristics and population needs.

Each practice concept is introduced within a context and then discussed according to its significance for three key stakeholders: (1) Partner care teams; (2) Health and social services; and (3) Decision makers. Each of these stakeholders has a specific role in improving services intended for people who use opioids, and it is essential that changes be applied across different levels to develop best practices throughout the province.

PARTNER CARE TEAMS

This designation refers to the interdisciplinary team that closely supports the person in OUD treatment, i.e. doctor, nurse, psychosocial worker, *peer support workers,* and community pharmacist. Team members are part of the same department or collaborate through official partnerships. Based on the level of support required and the overall health and well-being of the person who uses opioids, the team may be expanded or reduced.

HEALTH AND SOCIAL SERVICES

This designation refers to the institution providing OUD treatment services, i.e. partner care team program managers and institutions responsible for providing services.

DECISION MAKERS

This designation refers to the individuals or entities responsible for organizing care and services in Québec, i.e. the Ministère de la Santé et des Services sociaux and its various branches and interdepartmental partners. The colleges and professional orders of each interdisciplinary team member involved are also included in this category.

ETHICAL PRINCIPLES AND VALUES

By Any Brouillette and Isabelle Fournier

Justice, equity, solidarity, and benevolence are the core values of best practices for managing opioid use disorder. In keeping with the ethical principle of vulnerability, they are also a *sine qua non* to ensuring respect for people with opioid use disorder's autonomy, integrity, and dignity. Therefore, they support each of the practice concepts in this guide.

Justice and equity

Justice and equity are closely connected; one cannot be respected without ensuring respect of the other. Justice is due to all affected individuals and represents an obligation to fairly distribute the resources and the benefits of our health care interventions. Justice is intrinsically linked to the concepts of impartiality, equity, and non-discrimination: it demands the righteous sharing between individuals or groups, and thus to "give each their due."[19]

Equity focuses on the individual's specific circumstances and the intent of the law. It strives to correct the concrete injustices[19] that the law can generate in order to identify what is appropriate in individual situations and thus ensure equal opportunities in the end. Its aim is not to eliminate the natural inequalities and differences among people, but to correct injustices produced and exacerbated by social, cultural, and political mechanisms. By providing adaptive responses, equity helps to address social inequality.[20] Equity is not targeted in the provision of service, but rather in the expected end result.

In the health sector, equity and justice refer to our collective responsibility and call on our solidarity to ensure a fair distribution of access to care among individuals.[21] Equity allows for a more egalitarian ideal with respect to justice and solidarity. It calls for acceptance without judgment.

Integrity and dignity

Dignity is defined by the intrinsic worthiness and thus the right to be respected, *of every person,* by simply being human and belonging to *humanity*, which is composed of many interwoven connections.[19] Human dignity means that a person can feel respect, self-esteem, and a sense of personal ownership,[22] which allows them to defend their integrity.

Ethically speaking, integrity is defined as a coherent integration of a person's characteristics, including their emotions, aspirations, knowledge, and how they understand the meaning of their life. It is the cohabitation of these elements that allows the person to be faithful to their moral values and to defend them when threatened. True autonomy is difficult to achieve without a minimum of integrity and dignity.

Solidarity

Solidarity "results from adequate reflection on what social justice requires."[23] In its quest to promote a better life for all, solidarity is based on acceptable and reasonable parameters that are devoid of judgment based on what is right or wrong and that enable everyone to participate. In this sense, society demonstrates its solidarity by preventing what appears iniquitous or is experienced as an injustice by people who are unknown to us or not necessarily part of our immediate social circle. A society's strength rests on the collective effort focused on ensuring equal respect given by and to its members, and also on their understanding that each person's individual freedom, autonomy, security, and well-being depend on it. Interdependence gives the group the power to effect change, to transform its world through the capacity to work together towards a common goal. Solidarity also recognizes and upholds the importance of expressed values and the implicit mutual obligations required by a decent society.[24]

Solidarity is closely linked to the duty of non-abandonment,[25] i.e. it urges us to identify our social compass, our points of reference in order to resist indifference. In this perspective, we assume our main responsibility as caregivers through the solidarity expressed during a person's most lonely and isolated moments.

Autonomy

Autonomy refers to the ability to freely think, decide, and act on one's own initiative. This implies a double capacity,[26] to firstly have desires, and secondly being able to recognize, assess and prioritize them. As such, real autonomy is not possible without the minimum conditions allowing for the respect of the person's dignity and integrity, and a minimum level of human solidarity. This provides options that will enable a person to make certain choices. Respecting the autonomy of others is not only about self-determination. It is about helping others develop their full potential by supporting them as they explore and make decisions while respecting their dignity. It is no place for a complacent or "laissez-faire" attitude, but rather the implementation of conditions by caregivers for continuous decision-making processes that always enables free and informed consent. By adapting the services and terms of care, caregivers meet their responsibilities and help people assert who they are or want to be. They are more likely to respect the choices of people who use opioids, even when the decision seems wrong to them.

Benevolence and humility of the caregiver [1, 9, 10]

Benevolence is selfless and guides our actions in a compassionate manner. It evokes personal attention, concern, and empathy, and seeks the appropriate response to care by focusing on the specificity of the situation, its relational dimension, and the person in need of care as a whole; it attempts to explore their suffering, distress, and solitude. The combination of these two values helps determine fair and appropriate behaviour in situations where applying rules conflicts with the duty to respect a person under our care. They are thus aligned with the concept of equity by reaffirming that it is the person's interests that motivate our benevolent behaviour. The caregiver's humility offsets the risk of paternalism associated with these values. When the caregiver provides expertise to the person who uses opioids with a pragmatic and human approach, they acknowledge that the person is the expert of their unique situation.

The ethical principle of vulnerability

The ethical principle of vulnerability fosters respect, concern, and the protection of others, and calls for protecting life in a way that goes beyond simply protecting autonomy.[29] Vulnerability poses a risk for the person through the stifling of their ability to develop self-awareness.[30] Vulnerability is expressed through the difficulty of expressing one's self, and in the inability to give coherence to one's life through the telling of one's story. Free will and decision-making capacity are threatened, as the ability to make decisions beneficial to one's health and life rests on a person's awareness of their goals and of what they perceive as valuable or needing to be protected. The principle of free and informed consent is one of the tools that can mitigate vulnerability in the provision of health care services.

While managing opioid use disorder, both the person in treatment and the caregiver encounter this vulnerability. The path of care is rarely straight and unidirectional: everyone must acknowledge that starting over more than once is not a failure. The ethical principle of vulnerability reaffirms how this is an unavoidable intricacy of individual lives and human relations. Taking into account vulnerability is accepting that anyone may at some point lack the sufficient means or ability to protect themselves and preserve their health and well-being.

10 PRACTICE CONCEPTS SUMMARY

1

Practice Concept 1 – Anchor practice with people who use opioids in a holistic perspective and a harm reduction philosophy

People who use opioids are welcomed with respect and consideration; ongoing efforts are made to reduce their experience of stigma. The harm reduction philosophy guides interventions aimed at improving people's quality of life without considering abstinence as the ultimate objective. People who use opioids are perceived holistically and services are tailored to their needs.

2

Practice Concept 2 – Democratize access to OUD treatment

People who use opioids can easily access OUD treatment near their homes. Barriers to access and retention in treatment are minimized. All teams in Québec offering OUD treatment strive to make it flexible and individualized. Opioid agonist molecules are provided in a variety of locations, including specialized addiction services, but also emergency departments, psychiatric facilities, detention centres, and family medicine groups (FMGs).

3

Practice Concept 3 – Relax the regulatory framework for colleges and professional orders to enable the implementation of flexible and adapted OUD treatment modalities

Each person who uses opioids has flexible treatment modalities that are tailored to their individual situation. Such flexibility and adaptability imply relaxing the regulatory framework surrounding OUD treatment. The goal of this regulatory relaxation is to encourage the maximum number of people with OUD to start and continue treatment and to support clinical teams in the delivery of personalized services.

4

Practice Concept 4 – Welcome the initial request for services and ensure the safety of the person who uses opioids

The initial request for services submitted by a person who uses opioids, regardless of where it is received in the health and social services system, is routed directly and quickly to a team that provides OUD treatment. This team conducts a specialized evaluation. The person is systematically provided essential harm reduction supplies, including naloxone, throughout the process.

5

Practice Concept 5 – Make an adapted assessment, quickly start OAT, and choose the best care setting

People who use opioids are evaluated directly by a team that offers OUD treatment. This initial assessment is quick, adapted, and leads to the initiation of OAT within the shortest possible time span. This makes it possible to refer the person to inpatient or outpatient services from the outset as well as at any point during treatment.

Practice Concept 6 – Foster formal collaborations with key actors

Formal collaborations are established with key institutional and community partners in the region, providing optimal support to the person in OUD treatment. These collaborations facilitate access to services and foster continuity of care.

Practice Concept 7 – Incorporate requests for withdrawal management into a long-term treatment and support plan

Withdrawal management should be avoided for people with OUD. With this in mind, when a request for withdrawal management is received, the care team should have a comprehensive discussion with the person and inform them that withdrawal management is strongly discouraged because of the associated risks. If the person still wishes to initiate withdrawal management despite contraindications, the care team should put into place the necessary conditions to mitigate risks and facilitate transition at any time and without delay to a maintenance treatment program. A withdrawal management request should constitute a gateway to the HSSS and an opportunity to provide the person with access to resources that can provide long-term support.

Practice Concept 8 – Provide continuous OUD treatment based on the vulnerability of the person's situation

A minimal basket of services is provided by all teams providing OUD treatment. These services are provided on an ongoing basis and allow people who have stopped OAT to resume treatment quickly. The hierarchy of care for OUD treatment considers the vulnerability of the person's situation in order to determine the level of support they requires. This means that people in vulnerable situations have access to intensive support and, whenever possible, a broader range of services incorporated within a single institution *(one-stop shop)*.

Practice Concept 9 – Promote interventions by peer support workers in teams providing OUD treatment

People with experiential knowledge (peer support workers) are included and are involved in teams providing OUD treatment. The addition of peer support workers in services intended for people in vulnerable situations is to be favoured. These professionals are an integral part of interdisciplinary care teams and work in complementarity with the other members of these teams.

Practice Concept 10 – Support the stability of teams providing OUD treatment

To provide quality services to people who use opioids, teams providing OUD treatment have access to up-to-date trainings, guides, and clinical tools. A Québec OUD mentoring program, interdisciplinary team meetings, and clinical support spaces are implemented and formalized.

PRACTICE CONCEPT

1

Anchor practice with people who use opioids in a holistic perspective and a harm reduction philosophy

People who use opioids are welcomed with respect and consideration; ongoing efforts are made to reduce their experience of stigma. The harm reduction philosophy guides interventions aimed at improving people's quality of life without considering abstinence as the ultimate objective. People who use opioids are perceived holistically and services are tailored to their needs.

BACKGROUND

All services available to should adhere to the harm reduction philosophy, i.e. aim to reduce and prevent the risks and adverse consequences associated with risk behaviour, without considering abstinence as the final and absolute end goal.[31] The aim is thus to improve the quality of life for while respecting their individual choices.

Given that people who use opioids are frequently victims of stigmatization and discrimination, the humanistic values of harm reduction stress the importance of focusing primarily on establishing and maintaining a therapeutic alliance. Soft skills should be mandatory for working with these people, in order to offer a calm, authentic, judgment-free therapeutic setting that is conducive to providing support. The person should feel confident and accepted, regardless of their situation or condition.

Services provided to people who use opioids should be offered from a holistic perspective while fully taking into account not only their difficulties, resources, and needs, but also their strengths and aspirations. The person who uses opioids must be first and foremost acknowledged as a complex human being rather than being perceived solely through the lens of their psychoactive substance use. All of their dimensions: physical, mental, emotional, spiritual, and cultural must be considered. Similarly, services must be adapted to the individual's various characteristics such as gender, sexual orientation, parenthood, aging, and cultural or spiritual identity. Finally, trauma-informed care must be developed to provide services that integrate the need to feel physically and emotionally safe and to choose and control one's treatment.[32]

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

It is vital that people who use opioids be welcomed in a warm, respectful, sensitive, and stigma-free manner at all times. This humanistic approach must be adopted from the outset and maintained at all times throughout treatment to foster a therapeutic alliance. In congruence with a vision where the care team and people who use opioids are partners, it is imperative to understand what people who use opioids seek from treatment and guide them toward achieving these objectives, regardless of whether abstinence is part of the treatment plan. At all times, a person who uses opioids should be able to feel physically and emotionally safe with their care team and be able to choose and control their treatment. Assessing the physical, mental, emotional, spiritual, and cultural dimensions of the person who uses opioids and adapting the treatment plan and the physical premises to these considerations and needs, should be done as much as possible.

FOR HEALTH AND SOCIAL SERVICES

Institutions should ensure that teams working with people who use opioids respect the principles and values of the holistic harm reduction philosophy. To this end, these institutions must provide teams with the necessary tools for the practical implementation and concrete operationalization of the holistic perspective and the harm reduction philosophy. These tools would consist primarily of training, with emphasis on soft skills and may also take the form of consultations and clinical support for teams (see Practice Concept 10). Training should not be focused solely on theoretical knowledge, but also on the pragmatic application of the holistic perspective and the harm reduction philosophy. Special attention must be given to the physical layout of the premises to make people feel welcome.

The criteria for hiring and training staff working in OUD treatment services must be based on holistic perspective values and harm reduction philosophy. These criteria must take into account the ability of professionals to work from a partner care team perspective and to consider the person as a whole.

FOR DECISION MAKERS

To foster the development of OUD treatment services which integrate a harm reduction philosophy with a holistic view of the individual, it seems important to update the various documents providing a framework for these services (e.g. the regulatory framework for professional orders, the OUD clinical guide, and the ministerial reference framework). These updates would provide concrete guidance to teams by providing clear guidelines on how to implement the principles of the holistic perspective and the harm reduction philosophy.

Similarly, due consideration must be given to the incorporation of the harm reduction philosophy, holistic view, and related soft skills as well as to the initial and ongoing training of the various professionals working with people who use opioids. Moreover, the creation of spaces for facilitated dialogue and experience sharing in the various regions of Québec would be conducive to the application of such skills (see Practice Concept 10).

Finally, performance indicators must be established that take into account the complexity of the process and the time commitment necessary for implementing the holistic view and establishing a therapeutic alliance with people who use opioids, particularly those in situations of vulnerability.

The application of Practice Concept 1 would enable a person who uses opioid to say:

The services provided to me are in line with my goals, my reality, and my preferences and aim to improve my quality of life.

Abstinence is not a mandatory goal of my treatment unless I express such a desire.

I am welcomed with respect and without judgment, no matter where I seek services.

I feel physically and emotionally safe with my care team and feel that my choices are taken into account.

The support provided to me takes into account the many dimensions of my personality.

My strengths, aspirations, difficulties, and needs are at the heart of my interactions with my partner team.

PRACTICE CONCEPT

2

Democratize access to OUD treatment

People who use opioids can easily access OUD treatment near their homes. Barriers to access and retention in treatment are minimized. All teams in Québec offering OUD treatment strive to make it flexible and individualized. Opioid agonist molecules are provided in a variety of locations, including specialized addiction services, but also emergency departments, psychiatric facilities, detention centres, and family medicine groups (FMGs).

BACKGROUND

To limit barriers to access and retention in OUD treatment, it is important to always adapt services to people, not the other way around. Differentiation between so-called low-threshold services and regular services intended for people who use opioids should no longer be systematic in addiction treatment services in Québec. People using this type of service perceive the term *low threshold* as stigmatizing and condescending. In this sense, this term, frequently used to designate an organization providing services that are adapted, flexible, and personalized to the person's needs, should be discarded so that all OUD treatment teams in Québec incorporate these characteristics. Subsequently, the service basket and level of support provided should be adjusted based on the degree of vulnerability of the person's situation (see Practice Concept 8).

All services intended for people who use opioids should aim to minimize barriers to access, be adapted to the individual's reality, and be offered in a warm, flexible, and non-stigmatizing manner (see Practice Concept 1). Barriers at organizational, geographical, administrative, and relational levels must be considered. For example, all OUD treatment services should try to limit the criteria for admission and expulsion, as well as waiting times.

Geographical obstacles should also be limited as much as possible. In this regard, access to OUD-related services should be possible in proximity to the living environments of people who wish to obtain treatment. In cases where services may not be offered throughout the territory, remote care, such as telemedicine, should be put in place. In addition, outreach services should be established for people who are more isolated or who experience difficulties approaching health care institutions. Furthermore, a person should be able to access a pharmacy near their place of residence, where they can obtain opioid agonist molecules. In this regard, these molecules should be offered in all community pharmacies in Québec, in the same way as the majority of drugs for long-term treatment.

Any opportunity to initiate OAT should be seized at every level of the health and social services system. In this sense, all CRDs in Québec should have the capacity to initiate and monitor OAT. In addition, specific professional settings should, as a priority, be trained and equipped to initiate OAT, such as emergency departments,[A] psychiatric facilities, detention centres, and FMGs. Rapid initiation would limit the evolution of OUD-related issues, including overdoses, and prevent the situation of the person seeking care from deteriorating. After initiating OAT, the person should receive long-term support from a team able to provide services that are tailored to their needs and to the level of support that they require (see Practice Concept 8).

A See the results of project *SuboxED:* Retrospective case study: Evaluation of the implementation of naloxone dispensation and of a buprenorphine-naloxone prescription in three Québec emergency departments and satisfaction questionnaires. Report to the MSSS, March 31, 2020.

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

Caregiving for people who uses opioids should be flexible, warm, non-stigmatizing and tailored to their reality, not the other way around. As part of best care practice, efforts should be made to understand and reduce the barriers to access and retention in treatment that a person who uses opioids may face.

When a person who uses opioids expresses the wish to initiate OAT and meets the criteria for doing so, seize every opportunity to rapidly start treatment with the molecule before transferring the person to the most suitable institution for follow-up, if your team is not able to offer it. It is also important to establish outreach measures for the most vulnerable clients.

FOR HEALTH AND SOCIAL SERVICES

OUD services should be established on a broader scale to make them accessible no matter where the person who uses opioids resides. Formal collaborations should be established and maintained, in particular among teams that provide OUD treatment monitoring and teams that are likely to initiate OAT, such as emergency departments, psychiatric facilities, detention centres, and FMGs. Such regional collaborations would make it possible to provide each person with services adapted to the level of support they require for successful treatment. Moreover, rapid initiation of OAT would limit the evolution of OUD-related issues, including overdoses, while providing services to people who uses opioids before their situation deteriorates.

Due consideration should be given to the use of information technology, including telemedicine, to ensure easy access to OUD services to people living in remote areas or in the event of a lack of services in a given territory. Outreach services that support access to treatment should also be established to assist in supporting those most isolated or who experience difficulties approaching health care institutions.

A local assessment of barriers to access and retention should be conducted periodically to ensure that the services are in line with the needs of individuals.

FOR DECISION MAKERS

In order to provide rapid initiation of OAT for people who request it, resources should be allocated to increase the number of qualified OUD professionals, particularly with respect to the number of prescribing physicians. Similarly, efforts should be made to foster the initiation of OAT in various clinical settings, including emergency departments, psychiatric facilities, detention centres, and FMGs. This would make it easier to accommodate requests for care and would ensure that treatment could be initiated and monitored from various points of care within the health and social services system. In order to adequately and efficiently meet the different needs and treatment objectives of people who use opioids, it would be relevant to consider establishing a hierarchy of care for the treatment of OUD. This approach would clarify the roles of the various actors and assure that different levels of support and services are available.

Resources should also be provided to identify and expand the network of community-based partner pharmacies offering OAT. This would enable people in treatment to receive their treatment within their community. Measures should be put in place, including training and support, to ensure that the various molecules available for OAT in Québec are offered in all community pharmacies, affording the person in treatment with real choices.

Finally, in order to ensure equitable access to OUD treatment services, the analysis and establishment of various models for delivering services using information technology, including telemedicine, should be considered in regions that lack qualified personnel and where the territory is vast, causing lower coverage for OUD treatment.

The application of Practice Concept 2 would enable a person who uses opioid to say:

> The services are adapted to my needs and characteristics, not the other way round.

> These services are available near my home, including the pharmacy where I receive my OAT.

> I can quickly begin my treatment in different settings. Afterwards, my maintenance treatment is provided by the team that is best suited to my needs.

PRACTICE CONCEPT

3

Relax the regulatory framework for colleges and professional orders to enable the implementation of flexible and adapted OUD treatment modalities

Each person who uses opioids has flexible treatment modalities that are tailored to their individual situation. Such flexibility and adaptability imply relaxing the regulatory framework surrounding OUD treatment. The goal of this regulatory relaxation is to encourage the maximum number of people with OUD to start and continue treatment and to support clinical teams in the delivery of personalized services.

BACKGROUND

Traditionally, in Québec, the Collège des médecins (CMQ) and the Ordre des pharmaciens (OPQ) produced the guidelines governing both the clinical practice and the professional standards and legal aspects regarding the delivery of OAT. The latest guidelines, entitled *Utilisation de la méthadone dans le traitement de la toxicomanie aux opiacés,* were drafted in 1999 and amended in 2004, and the guideline *La buprénorphine dans le traitement de la dépendance aux opioïdes* was published in 2009. In the summer of 2019, the CMQ, OPQ, and l'*Ordre des infirmières et infirmiers du Québec* (OIIQ tabled a draft of a new guideline specific to professional practice in Québec related to the treatment of people with OUD. This new guideline no longer concerns the clinical component of practice, but only the regulatory context and ethical rules (herein referred to as the regulatory framework).

Updating this regulatory framework should be based on the harm reduction philosophy and a holistic view of the individual (see Practice Concept 1). This regulatory framework should allow for some flexibility in the professional approach in order to place adaptability and personalization of treatments at the forefront and thus promote access to and retention in treatment (see Practice Concept 2). Thus, clinical judgment should take precedence over unilaterally applied professional standards. Teams should be encouraged to use an approach in which the risks and benefits to the person in treatment are constantly being assessed and where their safety and that of others is at the heart of the interventions. An updated clinical guide should accompany the release of the regulatory framework. This joint effort would provide concrete support for professionals and ensure that their interventions and interpretations of the regulatory framework are based on the most recent and relevant data. More specifically, the therapeutic contract, urine drug screens, access to take-home doses, and the role of the pharmacist should be relaxed and updated according to the most recent and relevant scientific data and clinical guides (see Appendix 1).

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

In order to provide individualized care tailored to the reality of people who use opioids, it is important that you benefit from updated tools that emphasise your clinical judgment, such as a relaxed OAT regulatory framework of colleges and professional orders and an updated clinical guide. Beyond meeting the standards of practice established within the regulatory framework of colleges and professional orders, clinical judgment, and the safety of the individual and their social circle should guide your interventions. Thus, a risk-benefit approach should be adopted and constantly reassessed when making clinical decisions.

FOR HEALTH AND SOCIAL SERVICES

Professionals on partner care teams are governed by their relevant college and professional order's regulatory framework. These teams should therefore be familiar with this framework and know how to navigate it, but also know how to implement it in a suitable and flexible way. In this regard, providing continuing education and clinical support spaces will foster the use of clinical judgment for the individualization of treatment (see Practice Concept 10).

FOR DECISION MAKERS

Provincial college and professional order regulatory frameworks should be relaxed to make OUD treatment attractive and thus promote access to and retention in OAT while ensuring the safety of people who use opioids and their immediate social circle. Regulatory framework should be accompanied by an up-to-date clinical guide to support an approach based on the clinical judgment of care teams. In particular, regulatory framework should review the therapeutic contract, the use of urine drug screens, access to take-home doses, as well as the requirement for OAT to be administered under the surveillance of a pharmacist. These elements are considered to be restrictive by people in treatment and, therefore, reduce access to and retention in OAT (see Appendix 1).

The application of Practice Concept 3 would enable a person who uses opioid to say:

My care team provides me with a flexible and individualized treatment that is adapted to my situation. My treatment enables me to achieve my goals while ensuring my safety and that of my immediate social circle.

PRACTICE CONCEPT

4

Welcome the initial request for services and ensure the safety of the person who uses opioids

The initial request for services submitted by a person who uses opioids, regardless of where it is received in the health and social services system, is routed directly and quickly to a team that provides OUD treatment. This team conducts a specialized evaluation. The person is systematically provided essential harm reduction supplies, including naloxone, throughout the process.

BACKGROUND

There is currently a major issue in Québec regarding accessibility to OUD treatment services. Under the *Plan d'action interministériel en dépendance 2018-2028,* all services within the health and social services network have the responsibility to apply the *No Wrong Door* policy to facilitate the reception and referral of a request to obtain OUD treatment services. In addition, efforts should be made ensure that outreach teams encourage people who use opioids who are isolated or who experience difficulties approaching health care institutions to request treatment.

A harm reduction philosophy and a holistic perspective should be used to build a trusting relationship between people who use opioids and all health and social services (see Practice Concept 1). In the context of the current overdose health emergency, it is imperative that the health and social services system seize every opportunity to quickly refer people who use opioids wanting OUD treatment to teams providing OUD treatment. Immediate, effective, and direct referrals should be provided to spare the person who uses opioids from navigating the maze of the health care system. Teams that offer OUD treatment should be able to conduct a precise and adapted specialized assessment and then refer the person who uses opioids to the best context of care (see Practice Concept 5).

The department receiving the initial request for care should ensure that, pending this specialized assessment, a "safety net" for this person is put in place. This "safety net" would consist of providing the person with essential harm reduction supplies (Figure A). The provision of harm reduction supplies should be systematic and mandatory for all staff in the health care system in contact with people who use opioids, including workers who perform OUD screening.

Figure A: Essential harm reduction supplies

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

As a team offering OUD treatment, you will likely be referred requests from people who use opioids by various actors in the health and social services system. Upon contact with the referring service, it is important that you verify that the people who use opioids has been provided essential harm reduction supplies and is receiving proper support while waiting for your assessment.

During this first contact, an assessment appointment must be scheduled for the earliest available date. For people in vulnerable situations, this initial appointment would ideally be scheduled the same day. Some people may benefit from outreach efforts promoting the available OUD treatment services and generating interest in starting treatment.

FOR HEALTH AND SOCIAL SERVICES

Formal and sustainable service "corridors" should be established between non-specialized addiction treatment services (prioritizing 811 services, emergency departments, and CLSCs) and teams providing OUD treatment, which would allow for quick and direct referrals. In addition, outreach services should be established to provide access to treatment for people who use opioids who are isolated or who experience difficulties reaching out to health care institutions. Teams offering OUD treatment could be used to train and support health care workers who are not specialized in addiction and are in contact with people who use opioids. Coordination among the various stakeholders and knowledge of their respective services is essential in order to avoid a multiplication of steps for people requesting services and to apply the *No Wrong Door* policy.

FOR DECISION MAKERS

Health care staff, including those involved in OUD detection, should be able to transfer requests for services from people who use opioids directly to teams providing OUD treatment. In addition, clear instructions should be issued to these various stakeholders, starting with 811 services, emergency departments, and CLSCs, so that they can provide essential harm reduction supplies.

They should also be able to rely on updated training and tools that limit repetition of information during the service access process and that take into account the specific characteristics of people who use opioids.

In addition, it would be beneficial to create or reinforce outreach teams.

The application of Practice Concept 4 would enable a person who uses opioid to say:

> When I request services related to my opioid use, I am quickly referred to a team offering OUD treatment in my region. This team meets with me as soon as possible.

> In some situations, health and social services professionals can reach out to me and help me find the resources I need.

> The person receiving my request for services gives me harm reduction supplies, naloxone, and a list of resources from which I can get support.

PRACTICE CONCEPT

5

Make an adapted assessment, quickly start OAT, and choose the best care setting

People who use opioids are evaluated directly by a team that offers OUD treatment. This initial assessment is quick, adapted, and leads to the initiation of OAT within the shortest possible time span. This makes it possible to refer the person to inpatient or outpatient services from the outset as well as at any point during treatment.

BACKGROUND

People who use opioids should be assessed by a team offering OUD treatment so they can get quick and easy access to OAT. The assessment should be adapted to the reality of the person and split over more than one session if necessary, first prioritizing the key aspects required to initiate OAT. This assessment should be based on trauma-informed care, which implies that the person is under no obligation to recount traumatic experiences if they do not wish to. The delay between the assessment and initiation of OAT should be as short as possible, and ideally the person should be able to start the pharmacological part of their treatment on the day of the assessment. When immediate medical management is not possible, the team ensures that the person is supported during the waiting period.

This assessment should also be used to refer the person with OUD to inpatient or outpatient services based on their needs, request, and situation (physical health, psychological health, psychosocial situation, risk of withdrawal, type of opioid use, personal preferences, social circle, fear of relapse, etc.). Inpatient services, both in hospitals and in CRDs, should be accessible when deemed appropriate for the person, both at the initiation of and during treatment.

Following the assessment, the people who use opioids should be referred to a team that is able to provide services that are tailored to their needs and to the level of support their circumstances and overall health and well-being require (see Practice Concept 8). From the initial assessment appointment and at each subsequent contact, the person should be provided essential harm reduction supplies.

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

The assessment of the person referred to your services should be quick and adapted to their reality. This assessment may be split over more than one session according to the person's desire or your clinical judgment. The key aspects required to initiate OAT should be prioritized in order not to delay the initiation of treatment. If the assessment is split over more than one session, it should be done in such a way as to limit redundancies and to avoid having the person recount their narrative multiple times. In addition, this assessment should be based on trauma-informed care, which implies that the person is under no obligation to recount traumatic experiences if they do not wish to. A welcoming and non-judgemental reception of the person and ensuring their well-being should be the focus of this first contact.

During the assessment, you will have to collaborate with the people who used opioids to choose the care setting that best meets their needs and circumstances. Identification of the best care setting should be based on a specialized assessment of the person (physical health, psychological health, psychosocial situation, risk of withdrawal, type of opioid use, personal preferences, social circle, fear of relapse, etc.). Inpatient services should be available to the individual, where appropriate, both at the beginning (initiation) and over the course of treatment (stabilization of the person, management at the end of treatment, etc.).

OAT should be initiated as soon as possible following the assessment, ideally on the same day. If your team is unable to initiate treatment immediately, you should ensure that the person is supported during the waiting time. Following assessment, you should be able to refer the person to a team that is able to provide services that are tailored to that person's needs and the level of support they require (see Practice Concept 8).

At the end of each assessment, you should provide essential harm reduction supplies.

FOR HEALTH AND SOCIAL SERVICES

Services should be organized in such a way as to reduce the delay between the assessment and initiation of OAT. In addition, they should allow people in treatment to benefit from outpatient or inpatient services as needed, both initially and over the course of treatment. For example, care paths for early inpatient treatment should be implemented, both in hospitals and in CRDs when required. Spaces for consultation and fluid service "corridors" between inpatient and outpatient service teams should be established.

Seamless collaboration between the various treatment service points would ensure that once OAT has been initiated, the person is directed to a team that is able to provide them with services that meet their needs and the level of support they require (see Practice Concept 8). Care teams should be trained in the use of essential harm reduction supplies and have this equipment on site at all times in order to provide it to people seeking services and their immediate social circle.

FOR DECISION MAKERS

The assessment tools currently used should be reviewed to further reflect the realities of people who use opioids and the details specific to OUD treatment services. It seems particularly important that changes be made in terms of their duration and their ability to be split while identifying the key aspects that must be assessed before initiating pharmacological treatment.

The criteria for referral and the function of inpatient or outpatient services for people who use opioids should also be reviewed to provide a care setting tailored to the needs of each people who use opioids. To this end, the roles and services offered by each stakeholder, especially those from the inpatient services of hospitals and CRDs, should be clarified.

If efforts are made to have people who use opioids assessed directly by teams providing OUD treatment, we can expect that the number of assessments carried out by these teams will increase.

With regard to OUD management, performance indicators should be reviewed to now assess the delay between the initial service request and the initiation of OAT in order to reduce it to a minimum. Ideally, it should be possible to provide access to OAT on the day of the request.

The application of Practice Concept 5 would enable a person who uses opioid to say:

When I request services related to my opioid use, I have quick access to an assessment by a team that offers OUD treatment.

I can quickly start medication, when appropriate, the assessment is short and can be split over several appointments.

I have no obligation to disclose painful elements of my life if I do not wish to do so.

At each appointment, I am given naloxone and instructions on how to use it, as well as harm reduction supplies. I am also given a list of resources that can support me during the steps ahead.

The person who conducts my assessment helps me choose the care setting that best suits my needs. I can start treatment in an inpatient setting, i.e. have access to a resource that will provide me with temporary accommodations. Otherwise, I can opt for an outpatient setting and begin treatment in my living environment.

I was informed that, over the course of treatment, I can ask to use inpatient services if I feel the need.

PRACTICE CONCEPT

6

Foster formal collaborations with key actors

Formal collaborations are established with key institutional and community partners in the region, providing optimal support to the person in OUD treatment. These collaborations facilitate access to services and foster continuity of care.

BACKGROUND

Formal collaborations are important in order to support people who use opioids, limit barriers to access to OUD treatment, and foster continuity of care. The characteristics and needs of people in treatment and regional aspects could influence the nature of the collaborations to be established. However, in all cases, it would be crucial that partnerships be at least formalized between care teams and community pharmacies, community organizations, RHDs, hospitals, detention centres, and psychiatric facilities in each region.

With regard to partnerships with community pharmacies, awareness and clinical support should be provided to pharmacists so that they can benefit from up-to-date information on OUD best practices, the harm reduction approach, and the molecules used in OAT. In addition, given that pharmacists play an essential role in the partner care team, it is important to consider them as part of the team and to ensure the transmission of information, with the consent of the person in treatment.

Community organizations are also important actors in facilitating access to care for people who use opioids, particularly those in vulnerable situations. They also provide the person with support to achieve their goals and address their psychosocial situation. In Québec, the valuable field work carried out by community organizations with people in vulnerable situations involves providing connection, referrals, support, accompaniment, prevention, harm reduction, advocacy, and empowerment. In addition, community community workers have skills, knowledge, and advice that may complement those of clinical teams. In this sense, it would be wise for clinical teams and community organizations to establish formal collaboration agreements and spaces for consultation in order to clarify roles, enhance skills, and facilitate access to care and follow-up for people who use opioids.

It would be beneficial that these same partnerships be formalized with addiction recovery housing resources (RHD) to facilitate access to accommodation before, during, and after OUD treatment. These close collaborations would provide a secure framework for the person in treatment. It would also provide people who use opioids information on the regional resources available to assist them in improving their quality of life. In this regard, a clear and regularly updated list of RHDs that can accommodate people who have started OAT should be available in all regions of Québec.

Given that the democratization of access to OUD treatment is rooted in the rapid increase of stakeholders able to initiate OAT (emergency departments, psychiatric facilities, detention centres, and FMGs), coordination among these key actors is essential to provide optimal, continuous, adapted support to the person in OUD treatment (see Practice Concept 2).

A variety of environments would also be likely to be leveraged to create formal collaborations to support people in OUD treatment in achieving their goals. Examples include police departments, the employment assistance network, front-line services, services for people in vulnerable situations, and different housing resources.

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

Positive collaborations with key stakeholders in the health and social services system and the community network, including community pharmacies that offer OAT, community organizations, RHDs, hospitals, detention centres, and psychiatric facilities should be established, strengthened, formalized, and maintained. In this sense, you should make sure that you are aware of the resources available in your region, in terms of their service offerings, admission criteria, and approach to intervention, to foster these partnerships. These resources should be regarded as partners that can provide support to people in treatment through complementary services. In other words, the expertise and skills of these stakeholders should receive greater recognition and be taken into account within your team. In more complex situations and with the consent of the person in treatment, individualized collaborative service plans could be developed.

FOR HEALTH AND SOCIAL SERVICES

Formal collaborations with the various aforementioned stakeholders should be encouraged, created, and maintained on a regular basis. Ultimately, these formalized collaborations should enable the establishment of effective and sustainable service "corridors" for people with OUD, and in some complex cases even encourage collaborative intervention and task sharing as part of an individualized service plan.

Knowledge transfer activities and spaces for consultation involving the various organizations that may be in contact with people who use opioids should be established. These spaces would allow various professionals to coordinate their actions with the aim of facilitating access to OUD treatment, ensuring continuity of care, and enhancing support for people in treatment.

FOR DECISION MAKERS

A model should be developed to establish hierarchical care paths for people who use opioids to clarify the partnerships to be created, as well as the roles and responsibilities of each partner.

In addition, spaces for consultation and knowledge sharing should be established to facilitate coordination among the various partners, including hospitals, front-line services, detention centres, community organizations, RHDs, and police departments. These spaces would also ensure stronger relationships and close collaborations among stakeholders.

A regularly updated list of RHDs that can accommodate people who have started OAT should be available in all regions of Québec.

The valuable contribution of community organizations, particularly to people in vulnerable situations, should be recognized and reinforced.

The application of Practice Concept 6 would enable a person who uses opioid to say:

> My care team works with me to create collaborations with various community organizations and professionals that can support me in my efforts.

PRACTICE CONCEPT

7

Incorporate requests for withdrawal management into a long-term treatment and support plan

Withdrawal management should be avoided for people with OUD. With this in mind, when a request for withdrawal management is received, the care team should have a comprehensive discussion with the person and inform them that withdrawal management is strongly discouraged because of the associated risks. If the person still wishes to initiate withdrawal management despite contraindications, the care team should put into place the necessary conditions to mitigate risks and facilitate transition at any time and without delay to a maintenance treatment program. A withdrawal management request should constitute a gateway to the HSSS and an opportunity to provide the person with access to resources that can provide long-term support.

BACKGROUND

Due to the associated risk of treatment drop-out, relapse, overdose, morbidity, and mortality, withdrawal management should never be recommended for people with OUD. When a request for withdrawal management is received, the care team should have a comprehensive discussion with the person (see Appendix 2). During this discussion, the risks associated with withdrawal management and standards for best OUD treatment, i.e. a maintenance treatment, should be clearly communicated to the person (see Appendix 3).

If a person wants to start withdrawal management despite contraindications, the care team should respect their choice (see Appendix 4) and ensure that the person can continue to receive support and withdrawal management under the least harmful conditions possible (see Appendix 5). Cold turkey withdrawal and the sole use of withdrawal symptoms management drugs without an opioid agonist (e.g. clonidine, benzodiazepines, dimenhydrinate, loperamide) are considered high-risk and are to be completely prohibited. The same applies to a rapid taper of the opioid agonist molecule (less than 30 days).

When a person begins treatment with an opioid agonist molecule in an inpatient service (with an aim toward maintenance treatment or with a persistent request for withdrawal management), monitoring and re-evaluation of their pharmacological treatment should be ensured until the person is put in contact with a long-term care team.

It should also be recalled that opioid use disorder is not a linear process and is rarely a problem with a circumscribed timeline. A request for withdrawal management should therefore be considered as a gateway to the HSSS and an opportunity to connect the person with resources that can provide long-term support.

In addition, harm reduction supplies, particularly the distribution and instruction on the use of naloxone, should be systematically given to the person and their immediate social circle, given the increased risk of overdose following withdrawal management.

Since withdrawal management is not a recommended practice, the inpatient withdrawal management services traditionally used for this purpose may be used as a starting point for treatment using an opioid agonist molecule (regardless of the intended duration of treatment). Inpatient services could also allow for the integration of people in maintenance treatment who need time to stabilize their situation.

When a person already stabilized with OAT wants to terminate their treatment, a gradual taper over several months or even years should be implemented. This should be accompanied by long-term follow-up (psychosocial interventions, stay in CRD or RHD, resuming OAT if necessary, etc.) and access to essential harm reduction supplies.

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

Withdrawal management should be avoided, and maintenance treatment should always be encouraged. Quitting cold turkey and the sole use of withdrawal symptoms management drugs without an opioid agonist are considered high-risk and are to be completely prohibited. The same applies to a rapid taper of the opioid agonist molecule (less than 30 days). When a request for withdrawal management is received, the care team should have a comprehensive discussion with the person to provide them the necessary information so they can make an informed decision regarding their treatment (e.g. risks associated with withdrawal, preferred treatment, treatment modalities) (see Appendices 2 and 3).

When a person persists in their request for withdrawal management, your team should fill out the consent form (see Appendix 4) and accompany the person so that they can continue to receive support, taper off under the least harmful conditions possible (see Appendix 5) and have the opportunity to transition to a maintenance treatment at any time. In any case, you will have the responsibility to ensure ongoing monitoring and re-assessments of their pharmacological treatment until they are put in contact with a long-term team able to provide services that meet their needs and the level of care they require (see Practice Concept 8). Harm reduction supplies, particularly the distribution and instruction on the use of naloxone, should be systematically given to the person and their immediate social circle, given the increased risk of overdose following withdrawal management.

Requests for withdrawal management should be an opportunity to inform the person about the various services available, establish a relationship, and discuss how to meet all of their needs based on a holistic perspective and a harm reduction philosophy. Thus, the information collected during the specialized assessment (see Practice Concept 5) should be used to ensure that all requests for withdrawal management are incorporated into a plan for treatment and long-term support for the person with OUD.

FOR HEALTH AND SOCIAL SERVICES

Given that withdrawal management is not a recommended practice, it would be important to engage in a reflection concerning the name and mandate of inpatient withdrawal management services, which are traditionally used in this objective. These services could thus be used as a place for induction using an opioid agonist molecule, regardless of the intended duration of treatment. Services could also allow for the integration of people in maintenance treatment who need time to stabilize their situation. In this sense, a reassessment of the criteria for referral to inpatient services should ensure access to people with OUD at various points of their care path, such as the initiation or termination of their treatment, or in the event of psychosocial instability.

Cold turkey withdrawal and the sole use of withdrawal symptoms management drugs without an opioid agonist (e.g. clonidine, benzodiazepines, dimenhydrinate, loperamide) are considered high-risk and should be completely prohibited. In addition, inpatient services should no longer allow for rapid tapering (less than 30 days) for a person with OUD, as this practice is dangerous. Considering these changes, teams should master the tools annexed to this proposal in order to provide sound support to decision-making by people requesting withdrawal management and to encourage the best choice of treatment, i.e. OAT.

Despite contraindications, some people may persist in their request for withdrawal management. In such a case, teams should follow the clinical recommendations to begin tapering with the least harmful conditions possible (see Appendix 5) and encourage the person to transition to a maintenance treatment at any time. No matter the situation, teams should be able to ensure the continuity and reassessments of pharmacological treatment until the person has been put in contact with a team able to provide the level of services and the support that meet their needs (see Practice Concept 8). Inpatient services should thus be able to coordinate the extension of care on an outpatient basis, with addiction recovery housing resources, or rehabilitation centres. In this sense, systematic and close collaborations between teams providing maintenance treatments and inpatient service teams should be established and maintained to enable better continuity of OUD services.

In addition, inpatient service teams should have detailed knowledge of the service offerings of partner organizations in the region (see Practice Concept 6). Thus, coordinated planning with the different key actors would ensure long-term management of the person's needs. Essential harm reduction supplies, including the distribution of and instruction in the use of naloxone, should be available on site for people requesting withdrawal management and their immediate social circle.

FOR DECISION MAKERS

Clear instructions should be issued should be issued to all HSSS teams that provide services to people with OUD, stating that withdrawal management is to be avoided. Moreover, democratized access to adaptive, flexible, and individualized maintenance treatment (see Practice Concept 2) would very likely limit the number of requests for withdrawal management. Considering this, the traditional distinction between withdrawal management and maintenance services should be abolished, given that in the presence of an OUD, the use of opioid agonists is indispensable. Inpatient withdrawal management services could thus be used as a place for induction using an opioid agonist molecule (regardless of the intended duration of treatment). They could also allow for the integration of people in maintenance treatment who need time to stabilize their situation.

When a request for withdrawal management is submitted, specialized tools to determine the level and context of care required (e.g. NID-EP and NID-EM) should be updated to reflect the particularities of OUD and to provide an appropriate care setting. In addition, rehabilitation services and addiction recovery housing should be part of the continuum of services to enable that people who insist on withdrawal management may do so by tapering an opioid agonist molecule over more than 30 days.

Finally, a clinical guide should be drafted to address the management of withdrawal management and its multiple scenarios (end-of-treatment tapering for people stabilized with OAT, opioid tapering for people not stabilized with OAT, for people who do not meet DSM-5 diagnostic criteria, for people with chronic pain, etc.).

The application of Practice Concept 7 would enable a person who uses opioid to say:

When I submit a request for withdrawal management, I am advised that this practice is dangerous and carries risks to my health. My team helps me make an informed decision by giving me up-to-date information.

If I wish to go ahead with withdrawal management despite the associated risks, my care team respects my will and suggests the least harmful conditions possible to do so.

My care team monitors and adjusts my medication if I feel uncomfortable..

At any time, I can stop tapering and resume a comfort dose. I may change my mind at any time and opt for maintenance treatment.

Because of the significant risk of mortality resulting from an overdose associated with withdrawal management, I and my immediate social circle have access to naloxone, instruction on its use, and all essential harm reduction supplies.

PRACTICE CONCEPT

8

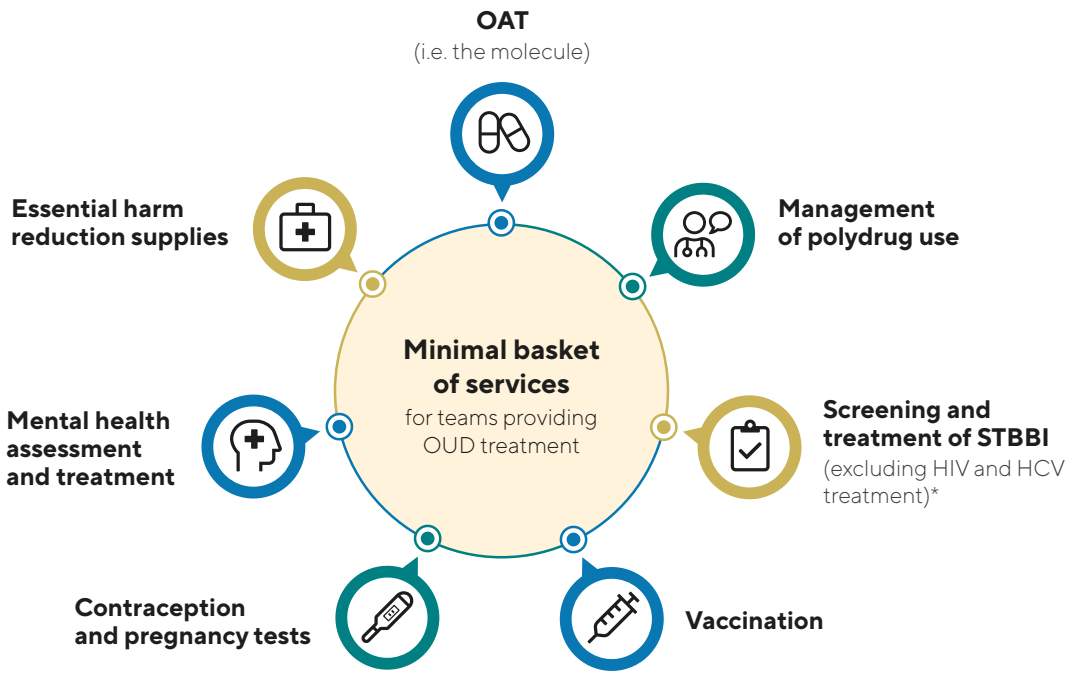
Provide continuous OUD treatment based on the vulnerability of the person's situation

A minimal basket of services is provided by all teams providing OUD treatment. These services are provided on an ongoing basis and allow people who have stopped OAT to resume treatment quickly. The hierarchy of care for OUD treatment considers the vulnerability of the person's situation in order to determine the level of support they requires. This means that people in vulnerable situations have access to intensive support and, whenever possible, a broader range of services incorporated within a single institution *(one-stop shop)*.

BACKGROUND

Some components seem essential to ensure quality of care for anyone in OUD treatment in Québec. First, the team that accompanies a person in treatment should provide a minimal basket of services related to OUD. This service offering should include the components listed in the figure below.

Figure B : Minimal basket of services for teams providing OUD treatment



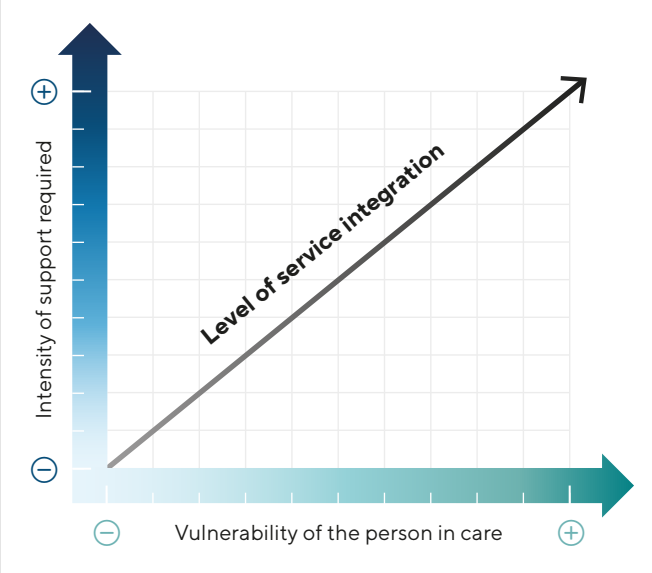
* HIV and HCV treatment are not included in the minimal basket however they should be strongly encouraged, specifically for HCV treatment as it is short and time-limited.

Interdisciplinarity is also a guarantee of quality and makes it possible to use an approach based on a holistic view of the person, whether through teams working in a single location or in partnership.

With the objective of long-term treatment and support of people with OUD, it would be important to maintain a relationship with those who quit OAT and not to delay resumption of pharmacological treatment when necessary, since many people drop in and out of treatment. In no case should a person in OUD treatment be subjected at any time to an involuntary interruption of the care and services they receive, for example, during hospitalization or incarceration.

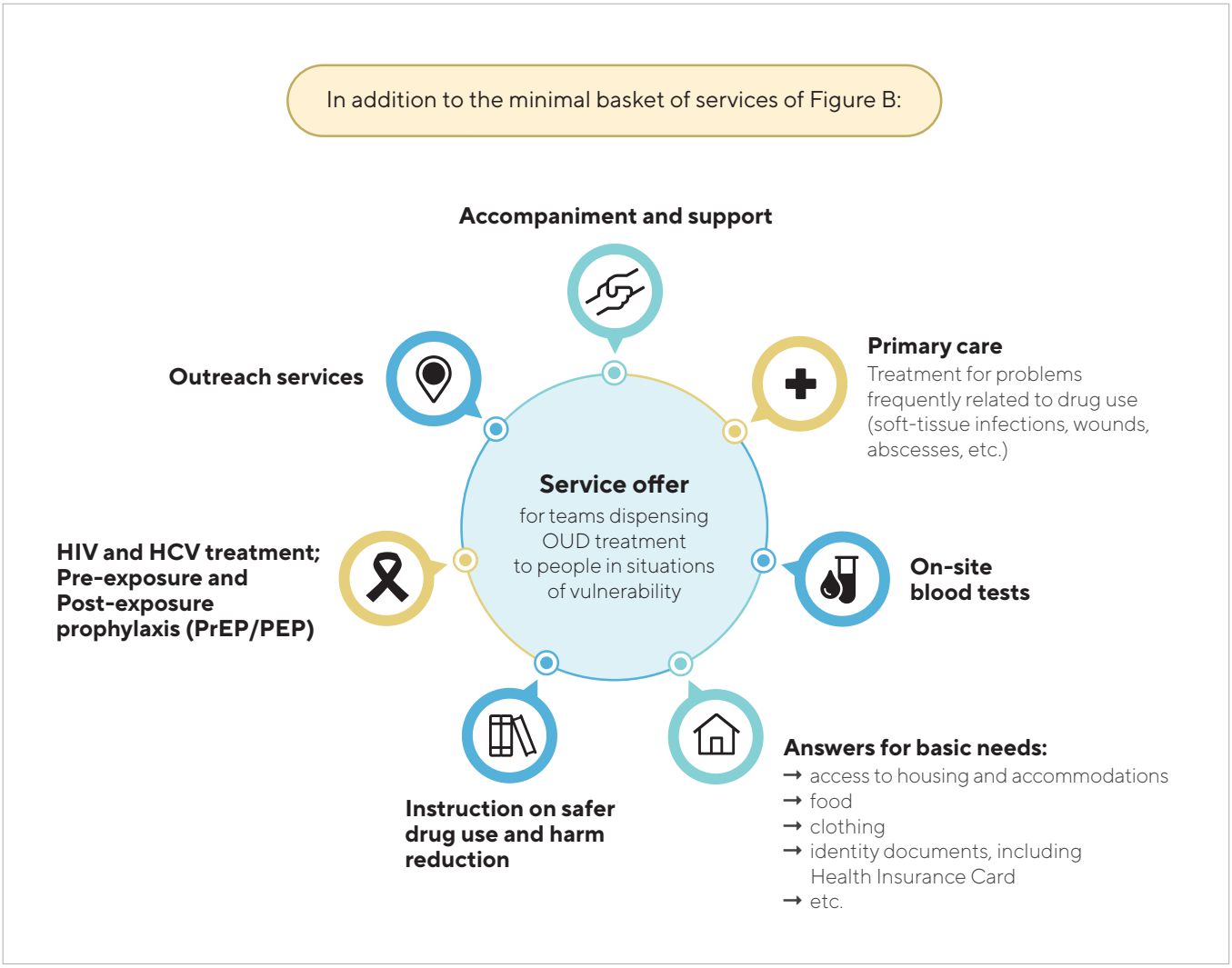
However, it is important to recognize that people who use opioids do not constitute a homogeneous group. Each person has a myriad of characteristics and needs that should be considered during OUD treatment. In order to provide OUD treatment adapted to the reality of each person, it would be important that the level of support offered be based on the degree of vulnerability of the person's situation.

Figure C : Level of service integration



People in vulnerable situations, i.e. those with many vulnerability factors as well as complex and often concomitant physical and mental health issues, should be able to receive intensive support from their teams. They should also be able to benefit from a more extensive offering of services incorporated within a single institution *(one stop shop),* to the extent possible. These services should systematically include outreach services, as well as accompaniment and support, in cases where it is not possible to offer certain services on site. Furthermore, formal collaborations with the major institutional and community partners would foster this more comprehensive response to the various needs of the person (see Practice Concept 6). In addition, peer support workers should be systematically integrated into these teams (see Practice Concept 9) and it would be essential to use a harm reduction philosophy and a trauma-informed care approach (see Practice Concept 1). The criteria for a person to have access to these teams or remain under their care should therefore be based on their degree of vulnerability (OUD being only one of many criteria) and the level of support they need, rather than the presence of a specific diagnosis or the willingness to use OAT or not. These people will require more time and support from such a team as well as a high degree of flexibility, adaptability, and individualization of services. Barriers to access and retention in services should be reduced for these people; these include requiring identity or health insurance documents, the obligation to attend appointments at scheduled times, waiting times, complex administrative procedures, and rigid intervention plans and frameworks that are not divided into multiple steps.

Figure D : Service offer for teams dispensing OUD treatment to people in situations of vulnerability



People whose situation is relatively stable could use teams providing low- to moderate-intensity OUD support and be referred to other services when these are not available on site. However, accompaniment and support should be considered as needed. In all cases, the minimal basket of services (Figure B) described above should always be available on site.

People who are gradually becoming stable should be able to transition to less intensive support in a fluid manner. Coordination should also be established between teams offering different levels of support to enable adequate accompaniment and support for people experiencing a situation of temporary instability without immediately referring them to another team. Such flexibility regarding levels of support would allow the person in treatment to continue being accompanied as much as possible by the care team with which they have established a relationship and thereby avoid the frequently experienced, sense of failure.

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

You should be able to rely on an interdisciplinary team, either within your own institution or through the implementation of strong partnerships. In conjunction with OUD treatment, you should be able to provide a minimal basket of care and services to any person in treatment (Figure B). You may also be required to offer several other services depending on the vulnerability of the person's situation and their needs. If you are unable to provide all the necessary services on site, formal collaborations with your partners, as well as accompaniment and support when necessary, would enable you to meet the person's various needs. To the extent possible, people in vulnerable situations should be able to benefit from more extensive service offerings which are integrated within a single institution *(one-stop shop),* (Figure D). People in vulnerable situations require more time and support from your team, as well as a higher degree of flexibility, adaptability, along with individualization of services to assist with limiting barriers where possible.

When a person in OUD treatment is experiencing a situation of temporary instability from a biopsychosocial perspective, you should be able to increase the level of the support so as to avoid referring that person too quickly to another team. You should then be able to rely on teams offering a higher level of support to help you as needed.

Given that OUD does not follow a linear process, many people will drop in and out of treatment. You should be able to allow people who have stopped OAT to resume treatment quickly.

FOR HEALTH AND SOCIAL SERVICES

It would be beneficial to foster interdisciplinarity, either directly or through strong partnerships, within all teams providing OUD treatment. In addition, collaborations with key regional institutional and community partners should be formalized and maintained to encourage a more comprehensive response to the various needs of individuals. Administrative procedures should be simplified as much as possible to allow people who have stopped treatment to resume it quickly.

A minimal basket of common care and services should be provided by all OUD treatment teams (Figure B). Clinical teams should have the necessary equipment to provide care and the required services. To ensure the provision of services to all people with OUD within the territory, the level of support should be adapted to the vulnerability of the situation of the person receiving services.

With regard to the organization of services for people in vulnerable situations, they should be able to count on teams with the capacity to provide a high level of support (including outreach services) and integrate as much as possible a more extensive offering of services within a single institution *(one stop shop)* (Figure D). If it is impossible to provide on-site care and services, formal collaborations with various stakeholders should be established, including with community organizations, and accompaniment and support should be provided. Peer support workers should be systematically integrated into these teams. As for trauma-informed care, while useful for any person with OUD, it should be considered essential in this setting. The organization of services for these people should address the different barriers to access and retention they face.

FOR DECISION MAKERS

Clarifying the minimal basket of services that should be provided by any OUD treatment team would ensure consistency, uniformity, and quality across teams, in addition to outlining the training and equipment necessary to roll out such services.

The continuity of OUD treatment should be ensured through the participation of multiple stakeholders, including detention centres and hospitals.

Developing a hierarchy of care for OUD treatment would make it possible to provide services to all people with OUD based on their needs. This development would also help to clarify the roles of the different stakeholders. This future hierarchy of care could be based on the level of support required by the person receiving services.

New models for the organization of de-compartmentalized services should be considered for people in vulnerable situations whether they struggle with addiction, mental health disorders, homelessness, etc. These models should no longer be based on the presence of a specific diagnosis or the willingness or unwillingness to follow specific treatment, but rather on the level of support the person requires to meet their needs. These models should include an integrated *(one-stop shop)* and interdisciplinary service offering within a single location, to the extent possible.

The application of Practice Concept 8 would enable a person who uses opioid to say:

My follow-up is without interruptions, even in the event of hospitalization or incarceration.

If I decide to end my treatment, I can stay in touch with my team. Should I decide to resume treatment, I can do so quickly.

My personal characteristics and needs are considered in determining which team can offer me the best help.

If I am in a vulnerable situation, I have access to intensive support from my team. My team can meet most of my needs in a single location. I do not have to navigate through numerous services to get the help I need.

If my situation is rather stable, I can receive less intensive support. If necessary, I am referred to other professionals and I am offered accompaniment and support through the process should I need it.

When I experience a temporarily difficult situation, my team acts in coordination with other professionals to support me. I continue my follow-up as much as possible with the team that knows me and with which I have established a relationship of trust.

PRACTICE CONCEPT

9

Promote interventions by peer support workers in teams providing OUD treatment

People with experiential knowledge (peer support workers) are included and are involved in teams providing OUD treatment. The addition of peer support workers in services intended for people in vulnerable situations is to be favoured. These professionals are an integral part of interdisciplinary care teams and work in complementarity with the other members of these teams.

BACKGROUND

Interventions by peer support workers are based on the principle that people who have personally experienced a situation, such as OAT, could offer emotional and practical support to other people going through similar situations. Although informal support may be offered among people who use opioids, interventions by peer support workers formalize this relationship and confer institutional legitimacy to this type of support by utilising experiential knowledge.

Peer support workers should be part of partner care teams, with priority given to teams supporting people in vulnerable situations, and work with other professionals in these teams in a spirit of complementarity. Thus, peer support workers could provide safe and adapted support that would help people with OUD better understand their treatment and achieve their care goals. These peer support workers could also help change the attitudes, language, and habits of teams and help reduce the stigma surrounding people who use opioids.

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

Including a person with experiential knowledge into your team could be beneficial to your practice. This person would work in complementarity with other professionals in the partner care team to contribute skills and knowledge related to their experiences. This role should be acknowledged and valued by all team members. The team should seek to collaborate with the peer support worker and incorporate them into the various aspects of the team's work. Like the other professionals in the team, the peer support worker should have a voice in decision-making, clinical discussion, and service improvement.

FOR HEALTH AND SOCIAL SERVICES

Peer support worker positions should be created within teams providing OUD treatment in the different regions of Québec, with priority given to teams supporting people in vulnerable situations. The peer support workers should be hired based on having experienced OUD treatment and having a life path similar to that of the people using the services provided by the team. Continuing education and supervisory opportunities should be provided to peer support workers as part of their mandate. Similarly, the role and task definition of these professionals should be clearly defined to foster effective collaboration with the team and to provide a specific framework for intervention. Employers should also ensure that people in these positions are paid fairly and that peer support workers benefit from the same employee benefits and union rights as the rest of the team.

FOR DECISION MAKERS

Resources should be allocated to support the creation of positions for peer support workers in teams providing OUD treatment, with priority given to teams supporting people in vulnerable situations. Guidelines should also be established to supervise the practice and training of peer support workers in the field of addiction[B].

B Guidelines for peer support in mental health were published in 2013 by the Mental Health Commission of Canada. Although they are very relevant to the implementation of interventions by peers, they do not provide specific guidance on interventions with opioid-dependant individuals.[33]

The application of Practice Concept 9 would enable a person who uses opioid to say:

I have the opportunity to benefit from the support and accompaniment of a peer support worker who is part of my OUD care team.

The peer support worker helps me understand the treatments that are offered to me, listens to me if I need to speak with someone who went through a similar experience, and accompanies me through the various steps associated with the treatment.

The peer support worker can help me better understand my rights and ensure that they are respected throughout my care path.

PRACTICE CONCEPT

10

Support the stability of teams providing OUD treatment

To provide quality services to people who use opioids, teams providing OUD treatment have access to up-to-date trainings, guides, and clinical tools. A Québec OUD mentoring program, interdisciplinary team meetings, and clinical support spaces are implemented and formalized.

BACKGROUND

In order to ensure a high-quality OUD service offering, several forms of support for team practice should be put in place and encouraged. These different forms of support would also improve team stability.

First, continuing education sessions should be developed and made available to all members of the interdisciplinary teams. These trainings should be based on the latest scientific data and address a variety of themes related to OUD best practices. It would be beneficial to quickly set up continuing education sessions on a few important topics, including relational and soft skills, trauma-informed care, OUD adaptability and individualization, and best practices regarding requests for withdrawal management. A clinical guide and related tools should also be provided to teams in order to support clinical judgment consistent with the holistic perspective and the harm reduction philosophy. In addition, a provincial mentoring program should be established to help teams deal with complex situations, enhance their knowledge, and familiarize them with such situations. The creation of a mentoring program would also formalize an interdisciplinary network of OUD experts in Québec.[C]

Teams should regularly hold interdisciplinary meetings to support their decisions and foster team cohesion. These meetings would enable team members to address complex cases, new issues, crisis management, service improvement, etc. The discussions held in these meetings would ensure flexible, adapted, and individualized practices.

Lastly, special attention should be given to the creation of clinical support spaces for individuals and groups. The objective of these spaces would be to help teams maintain a balance despite the difficult realities they face. They would be particularly important for teams providing a high level of support to people in vulnerable situations.

C Outside of this project, further work has been carried out to determine the training needs related to OUD in Québec. For additional information, you may consult the following report: Perreault, M., Archambault, L., Gabet, M., Ponsot, A.S., Cohen, J., Artunduaga, A. 2019. *"Rapport sur les besoins de développement des compétences en matière de traitement du trouble lié à l'utilisation d'opioïdes"*, 69 p.

IMPLICATIONS OF THIS PRACTICE CONCEPT

FOR PARTNER CARE TEAMS

Implementing a set of support measures in your practice should enable you to ensure the provision of flexible, adapted, and individualized interventions with people who use opioids. An up-to-date clinical guide and tools, mentoring, continuing education, regular interdisciplinary meetings, and clinical support spaces for individuals and groups should be provided. These measures should provide you with the necessary support to operate your practice. They should also be updated regularly to ensure your practice is based on the most up-to-date data.

FOR HEALTH AND SOCIAL SERVICES

Given the specificity and complexity of working with people who use opioids, teams should be able to rely on a set of measures to ensure quality interventions in OUD services. Therefore, all team members should be given time to pursue continuing education based on up-to-date data and practices. In addition, interdisciplinary meetings should be held on a regular basis to foster team cohesion and to enhance flexibility, adaptability, and individualization of treatment.

It would also be important to encourage the establishment of a Québec OUD mentoring program to leverage knowledge sharing. Such a program would help teams feel more comfortable when handling complex situations. Clinical support spaces for individuals and groups should also be provided to support team members in their practices.

FOR DECISION MAKERS

It would be important to prioritize the development of clinical tools adapted to the specific characteristics of OUD, the creation of a clinical guide, and the development of continuing education to ensure the provision of services based on up-to-date data and best practices. The creation of an official interdisciplinary mentoring program in Québec should also be considered. Teams providing OUD treatment, particularly those that provide a high level of support to people in vulnerable situations, must be realistic about the difficult realities experienced by people in treatment. It would be important to recognize that appropriate support is essential to the efficient functioning and stability of these teams.

The application of Practice Concept 10 would enable a person who uses opioid to say:

My care team provides me with treatment based on best practices.

If complex and specific situations arise, my team may have to discuss my situation with experts in order to find the best solutions. This process will always be anonymous and confidential.

PRACTICE CONCEPTS SUMMARY GRAPH

Request for support
in a specialized or non-specialized addiction treatment service

PRACTICE CONCEPT 4

Quickly

Specialized assessment
conducted by an OUD expert

PRACTICE CONCEPT 5

Begin treatment with an opioid agonist molecule quickly, ideally the same day

At all times, ensure the application of the **holistic perspective** and **the harm reduction philosophy**

PRACTICE CONCEPT 1

The service offer is **flexible, adapted** and **individualized**

PRACTICE CONCEPT 2+3

Interventions by **peer support workers**

PRACTICE CONCEPT 9

Provision of essential harm reduction materials at all stages of the process

Distribution of naloxone and instructions for use

Distribution of safer injecting, safer smoking and safer sex supplies

A list of available community resources including supervised injection services when available and accessible

If OUD: Propose an opioid agonist treatment (OAT)

A

Begin the OAT as quickly as possible
buprenorphine-naloxone (1st choice), methadone or slow-release oral morphine

PRACTICE CONCEPT 2

Possible induction sites:
CRD, emergency departments, psychiatric facilities, detention centres, and FMG

PRACTICE CONCEPT 2

B

Determine the best care setting
Inpatient or outpatient service

PRACTICE CONCEPT 5

C

Choose the best long-term care team
to offer the intensity of support required

PRACTICE CONCEPT 5

Key partners:
Pharmacies, community organizations, front-line services, employment assistance network, services for people in vulnerable situations and different housing resources

PRACTICE CONCEPT 6

Plan for treatment and long-term support
based on the intensity of support required and the degree of vulnerability of the person's situation

PRACTICE CONCEPT 8

Avoid opioid withdrawal management

PRACTICE CONCEPT 7

If the person wish to begin opioid tapering:
- → Detailed explanation of risks involved (appendix 2+3)
- → Signature of the consent form (appendix 4)
- → Frequent reassessments and transfer to OAT at any time

After the consultation, if the person persists in their request for withdrawal management:
- → Reduce the risks associated with withdrawal management (appendix 5)

If the person is ending a maintenance treatment:
- → Slowly taper the dosage over several months or even years

A maintenance treatment is indefinite and long-term
It is important to maintain contact with the person since many people drop in and out of treatment.

Support the stability of care teams

PRACTICE CONCEPT 10

CRD French for *Centre de réadaptation pour les personnes ayant une dépendance* (Addiction Rehabilitation Centre)

FMG Family Medecine Group

PRACTICE CONCEPTS SUMMARY GRAPH

SELECTED REFERENCES

1. Initiative Canadienne de Recherche en Abus de Substance (ICRAS-CRISM). Lignes Directrices Nationales de L'Initiative Canadienne de Recherche sur L'Abus de Substances sur la Prise en Charge Clinique du trouble lié à l'usage d'opioïdes [web]. Initiative canadienne de recherche sur l'abus de substances (ICRAS-CRISM); 2018 [cited Jan. 9, 2020]. Available at: https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-FRENCH.pdf

2. Substance Abuse and Mental Health Administration (SAMHSA). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach | SAMHSA Publications [web]. U.S. Department of Health and Human Services; 2014 [cited Jan. 7, 2020]. Available at: https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.html

3. Edland-Gryt M, Skatvedt AH. "Thresholds in a low-threshold setting: an empirical study of barriers in a centre for people with drug problems and mental health disorders." *Int J Drug Policy.* 2013;24(3):257-64.

4. Islam M, Topp L, Conigrave KM, Day CA. "Defining a service for people who use drugs as 'low-threshold': what should be the criteria?" *Int J Drug Policy.* 2013;24(3):220-2.

5. Wesson DR, Ling W. "The Clinical Opiate Withdrawal Scale (COWS)." *J Psychoactive Drugs.* 2003;35(2):253-9.

6. Ministère de la Santé et des Services sociaux. *Cadre de référence de l'approche de partenariat entre les usagers, leurs proches et les acteurs en santé et en services sociaux — Publications du ministère de la Santé et des Services sociaux* [web]. 2018 [cited Jan. 7, 2020]. Available at: https://publications.msss.gouv.qc.ca/msss/document-002061/

7. Uchtenhagen A. *Stepped Care Models in Addiction Treatment. Textbook of addiction treatment: International perspectives.* 2015;

8. Institut national d'excellence en santé et services sociaux (INESSS). *Modèles de dispensation des soins et services aux personnes présentant des troubles concomitants de santé mentale et de dépendance* [web]. 2016 [cited Feb. 3, 2020]. Available at: https://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/ServicesSociaux/INESSS_Avis_Dispensation_soins_services_troubles_concomitants.pdf

9. Collège des médecins du Québec (CMQ). *Retrait de l'exemption pour le traitement par la méthadone à compter du 19 mai* [web]. 2018 juin [cited Feb. 5, 2020]. Available at: http://www.cmq.org/nouvelle/fr/retrait-exemption-methadone.aspx

10. Van Beek I. "Case study: Accessible primary health care—A foundation to improve health outcomes for people who inject drugs." *Int J Drug Policy.* 2007;18(4):329-32.

11. Wood S, Austin S. "Building Bridges in Bridgeport for HIV-Positive Substance Abusers." *Journal of HIV/AIDS & Social Services.* 2009;8(1):20-34.

12. Institut national d'excellence en santé et services sociaux (INESSS). *La réanimation cardiorespiratoire (RCR) dans le contexte de l'administration de naloxone pour surdose d'opioïdes dans la communauté* [web]. 2018 [cited Feb. 5, 2020]. Available at: https://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/Medicaments/INESSS_Avis_naloxone_RCR.pdf

13. Substance Abuse and Mental Health Administration (SAMHSA). *Value of Peers,* 2017 [web]. Substance Abuse and Mental Health Administration (SAMHSA); 2017 [cited Jan. 17, 2020]. Available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf

14. Ministère de la Santé et des Services sociaux. *Plan d'action interministériel en dépendance 2018-2028 : Prévenir, réduire et traiter les conséquences associées à la consommation de substances psychoactives, à la pratique des jeux de hasard et d'argent et à l'utilisation d'Internet* [web]. Québec; 2018 [cited Oct. 31, 2018]. Available at: http://publications.msss.gouv.qc.ca/msss/fichiers/2018/18-804-02W.pdf

15. International Harm Reduction Association. *What is Harm Reduction ? A position statement from the International Harm Reduction Association* [web]. London; 2009 [cited Feb. 5, 2020]. Available at: https://www.hri.global/files/2010/05/31/IHRA_HRStatement.pdf

16. World Health Organization (WHO) - Organisation mondiale de la santé (OMS). *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* [web]. Geneva; 2009 [cited Jan. 9, 2020]. Available at: https://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

17. Collège des médecins du Québec (CMQ). *Le médecin, la télémédecince et les technologies de l'information et de la communication* [web]. 2015 [cited Feb. 5, 2020]. Available at: http://www.cmq.org/publications-pdf/p-1-2015-02-01-fr-medecin-telemedecine-et-tic.pdf?t=1579444839879

18. Sorsa MA, Kiikkala I, Åstedt-Kurki P. "Engagement in help-seeking of dual diagnosed mothers at a low-threshold service: grasping life through co-created opportunities." *Advances in Dual Diagnosis.* Apr. 23, 2018;11(2):88-100.

19. Durand, Guy. *Introduction générale à la bioéthique: Histoire, concepts et outils* [web]. Paris: Fides-Cerf; 1999 [cited Dec. 20, 2019]. Available at: http://www.editionsfides.com/fr/ouvrages-de-reference.aspx?id2=143&id3=120&catalogue=false

20. Association des établissements de réadaptation en déficience physique du Québec. *Valeurs phares en réadaptation* [web]. 2006 [cited Dec. 20, 2019]. Available at: http://aerdpq.reseaut.net/fichiers/publications/valeurs_phares.pdf

21. Tauber A. "A philosophical approach to rationing." *The Medical journal of Australia.* 2003;178:454-6.

22. *Law c. Canada (Ministre de l'Emploi et de l'Immigration)* [web]. 1 RCS 497 1999. Available at: https://scc-csc.lexum.com/scc-csc/scc-csc/fr/item/1691/index.do?site_preference=normal

23. Nadeau, Christian. *Liberté, égalité, solidarité* [web]. Montréal (Québec): Éditions Boréal; 2013 [cited Dec. 20, 2019]. Available at: https://www.editionsboreal.qc.ca/catalogue/livres/liberte-egalite-solidarite-2330.html

24. ter Meulen R, Wright K. "Family solidarity and informal care: the case of care for people with dementia." *Bioethics.* 2012;26(7):361-8.

25. Hirsch, Emmanuel. *Le Devoir de non-abandon* [web]. Paris: Les Editions du cerf; 2004 [cited Dec. 20, 2019]. Available at: https://www.editionsducerf.fr/librairie/livre/8341/le-devoir-de-non-abandon

26. Pelluchon, Corine. "Du principe d'autonomie à une éthique de la vulnérabilité." In: *Actes du colloque du 29 novembre 2009* [web]. Centre Sèvres, Paris; 2009 [cited Dec. 20, 2019]. Available at: http://corine-pelluchon.fr/wp-content/uploads/2013/07/article-pour-CS%C3%A8vres.pdf

27. CSSS Pierre Boucher. *Cadre de référence en éthique.* May 2013.

28. Sautereau C. "Répondre à la vulnérabilité: Paul Ricœur et les éthiques du care en dialogue." *Journal of French and Francophone Philosophy.* 2015;23:1.

29. Duplantie A. "Étude de cas. Éthique et responsabilité professionnelle face à la vulnérabilité d'autrui. Dossier soins àdomicile." *Perspective infirmière,* OIIQ. 2009;6(5):47-51.

30. Straehle C. "Vulnerability, Health Agency and Capability to Health." *Bioethics.* 2016;30(1):34-40.

31. Evans J. "Exploring the (bio)political dimensions of voluntarism and care in the city: The case of a 'low barrier' emergency shelter." *Health & Place.* 2011;17(1):24-32.

32. Centre canadien sur les dépendances et l'usage de substances (CCSA). *Trousse pour soin sensibles au traumatisme* [web]. 2014 [cited Feb. 4, 2020]. (Série *Les principes de base de...*). Available at: https://www.ccsa.ca/fr/trousse-pour-soin-sensibles-au-traumatisme-serie-les-principes-de-base-de

33. Commission de la santé mentale du Canada. *Lignes directrices relatives à la pratique du soutien par les pairs et à la formation de pairs aidants | Commission de la santé mentale du Canada* [web]. 2013 [cited Dec. 20, 2019]. Available at: https://www.mentalhealthcommission.ca/sites/default/files/Peer_Support_Guidelines_FRE_0.pdf

APPENDICES

Appendix 1

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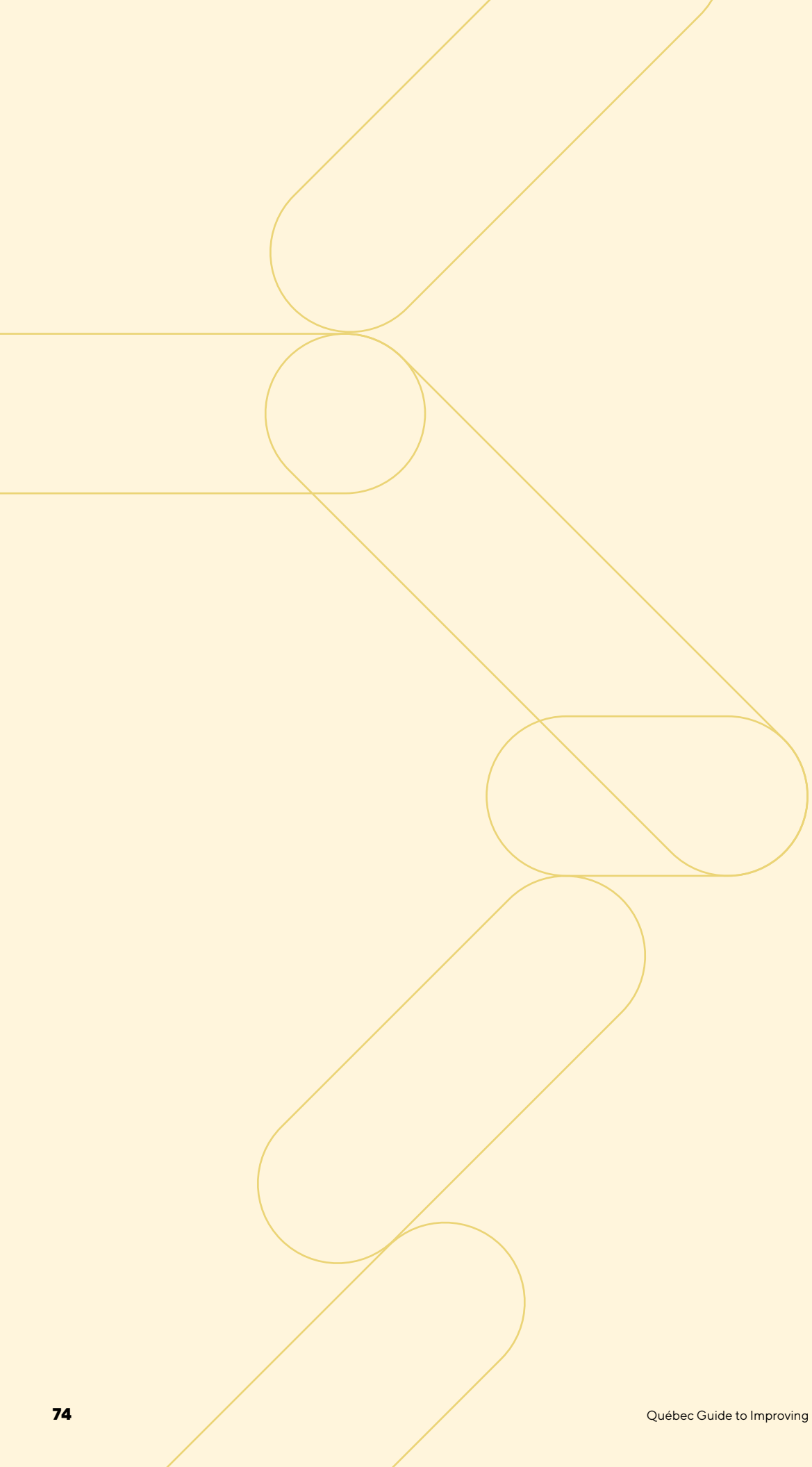


APPENDIX 1

Request for Adaptation of the Proposed Regulatory Framework for the Treatment of Opioid Use Disorder (OUD)

Excerpt from the document submitted to the Inter-Professional Order Committee (CMQ, OPQ, OIIQ) on September 24, 2019.

In the summer of 2019, the CMQ, OPQ, and OIIQ presented a draft version of forthcoming new guidelines on the regulatory context and ethical rules (regulatory framework) based on professional practice in Québec in terms of the treatment of people with OUD. The research team was asked to comment on this draft version.

The team used the preliminary results of the research projects *Vers de meilleures pratiques pour les personnes en situation de précarité et dépendantes aux opioïdes : optimiser l'accès et l'organisation des soins de santé et services sociaux au Québec* and *La prise en charge médicale dans le cadre de la gestion du sevrage des troubles de l'usage d'opioïdes (TUO) dans les centres de réadaptation en dépendance du Québec* and sought the opinion of the working group (comprised of experts in the treatment of OUD in Québec) from the first project. The presentation of the preliminary results to the working group resulted in proposals to amend certain recommendations regarding the regulatory framework. These proposals are based on up-to-date data from scientific articles, clinical guides, and the results of interviews conducted with the different populations, during the two research projects. On September 24, 2019, the research team met with representatives of the Inter-Professional Order Committee to table and present these proposals.

1. Use of urinary tests

1.1. Original wording of the regulatory framework

"Like the patient questionnaire, urine drug or substance testing should be seen as a tool to enhance patient safety and improve the patient's treatment plan. The frequency at which urine tests are to be performed varies, depending on the patient's treatment phase and clinical progress."

"In the event of suspected falsification of urine tests, urine samples may be collected under direct supervision."

"Urine screening tests, where available, are conducted randomly."

1.2. Proposed amendment

Urine tests are a clinical tool that can be useful to complement anamnesis or to help the person who uses opioids concede to uncertain use when there is fear of contamination. They may be used if anamnesis does not reflect clinical outcomes or if there is reason to suspect misuse. Frequent and systematic use of urine tests is not recommended. In addition, they should not be used as a punitive recourse, such as through direct correlation with the number of take-home doses. To foster a relationship of trust, the person in treatment should also be informed that the test has an informative and non-coercive value. The frequency of urine tests, if used, must not affect the rehabilitation of the person or the continuation of treatment. The person in treatment has the right to refuse to be tested. Urine tests under direct supervision are incompatible with respect for the privacy of the person and should be avoided. A person in treatment also has the right to be informed that a test will be requested. The majority of people should not require frequent and regular testing during treatment.

2. Take-home doses

2.1. Original wording of the regulatory framework

"No take-home dose, save for few exceptions (recorded on file), shall be given to a new patient during the first three (3) months of methadone treatment."

"Take-home doses should not be allowed or continued if the patient in treatment: (...) – has relapsed. (...) – has recently been released from a prison setting."

"The granting of take-home additional doses is to be gradually introduced for medication based on the timetable proposed in Appendix 5, up to a maximum of 6 doses (...)"

"Moreover, it should be noted that lost, stolen, or destroyed doses will not be replaced."

2.2. Proposed amendment

Take-home doses require more flexibility based on the physician's judgment and the minimum requirements and anchored in international best practices.

For example:
From the beginning of treatment, take-home doses may be given for weekends if necessary for practical reasons (pharmacies closed on weekends or no available means of transportation). The safety profile of buprenorphine-naloxone allows for greater flexibility in the provision of take-home doses right from the beginning of treatment. It is also possible to give up to 1 month of take-home doses if the person has been clinically stable.

For workers with atypical schedules (seasonal, contract, on call, weather dependant, etc.), people experiencing difficulties making it to their appointments, or anyone who can benefit from it, some flexibility may also be given regarding the doses taken under supervision in a pharmacy by asking the person to bring the doses that are at home.

The provision of take-home doses should be reassessed in the following cases:

- → inability to store doses in a safe place;
- → risk of black-market diversion;
- → suicidal ideations, cognitive impairment, psychosis, or risk of misuse;
- → significant psychosocial instability.

3. Initiation of treatment with buprenorphine-naloxone

3.1. Original wording of the regulatory framework

No mention of the possibility of initiating treatment at home.

3.2. Proposition de modification

It is also possible to give the patient additional doses of buprenorphine-naloxone to complete treatment initiation at home if withdrawal symptoms occur before the regular dose scheduled for the next day. Alternatively, each additional dose required to complete initiation may be given by the community pharmacist.

Take-home doses as part of initiation are distinct from take-home doses given during long-term treatment.

4. Therapeutic contract

4.1. Original wording of the regulatory framework

"It is recommended that a therapeutic contract with the patient be signed as soon as they begin treatment."

4.2. Proposed amendment

The treatment plan should be discussed with the person requesting care to fully understand their objectives and obtain their free and informed consent. The clinician may decide to use a written document with no legal value as an information medium for the patient. In no case should this document contain rules or threats that impede access to health care (e.g. expulsion in the event of non-compliance), except in cases of danger, for example in the presence of violent behaviour or threats to the care team.

5. Programme Alerte (Drug monitoring program)

5.1. Original wording of the regulatory framework

"It is therefore strongly recommended that the patient be introduced to and offered the program and that their consent to enroll in the program be obtained as soon as possible."

5.2. Proposed amendment

The systematic application of this security measure for all people under OAT is discriminatory and restrictive.

The Alert program should only be used if the physician has a significant doubt about the misuse of drug prescriptions.

6. Role of the pharmacist

6.1. Original wording of the regulatory framework

"The pharmacist who chooses to provide this service must, in addition to monitoring drug therapy, organize the pharmaceutical service and implement reasonable measures to prevent black-market diversion."
"(...) verify that the tablets are completely dissolved before discharging the patient, including a visual inspection under the patient's tongue."

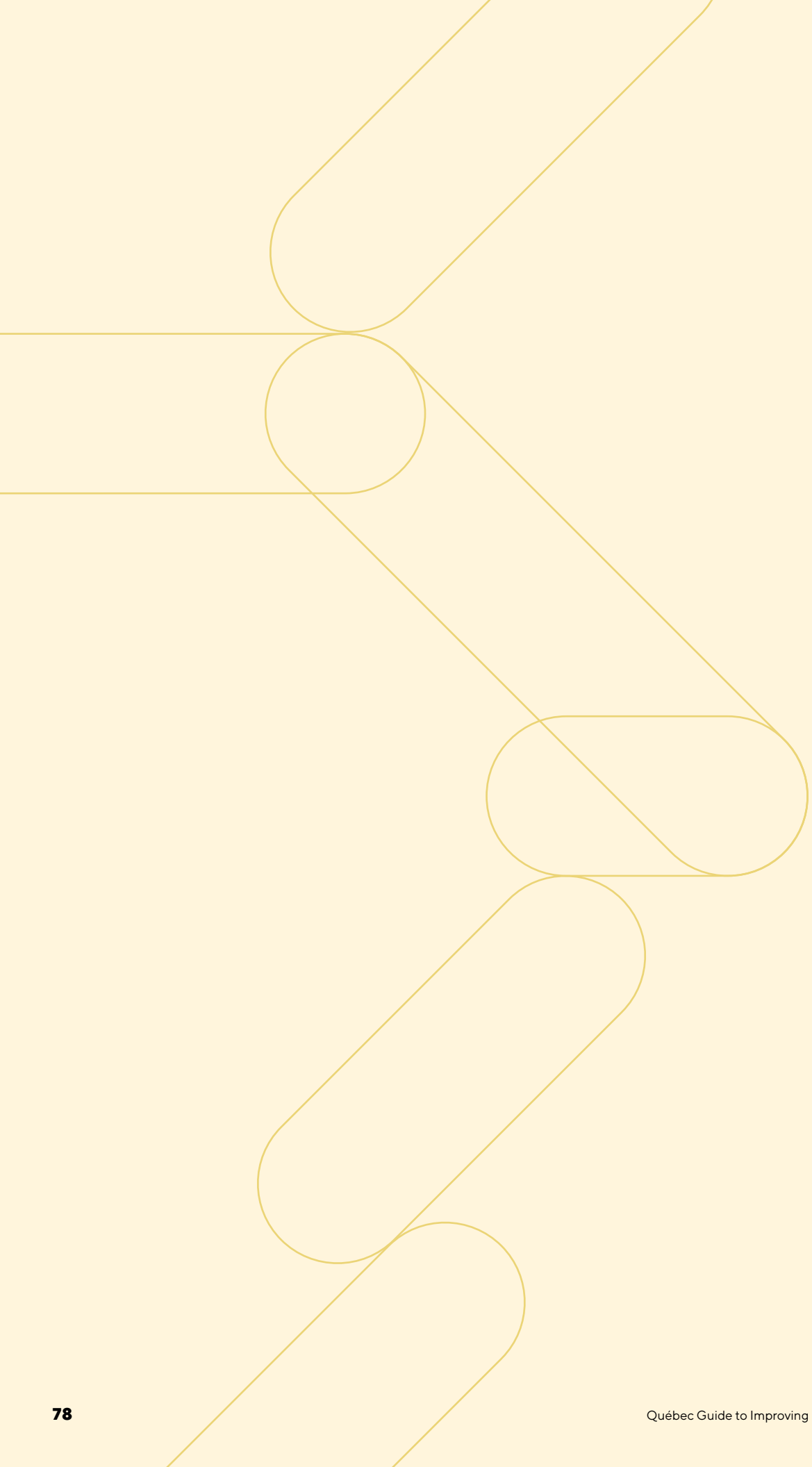
6.2. Proposed amendment

The pharmacist is a health care professional who is an integral part of a care team whose work is based on the patient partner principle.

The emphasis on the pharmacist's monitoring role should be reviewed and refocused on ensuring the well-being of the person under OAT.

Pharmacists play an important therapeutic role in OAT. They are the members of the care team who are most frequently in contact with the person under OAT. Therefore, they have the potential to exert a positive influence on improving the person's health and quality of life.

Monitoring of the dissolution or intake of OAT should only be carried out when there is doubt about possible diversion.



APPENDIX 2
Making an Informed Choice Regarding Opioid Addiction

This document has been designed to demystify opioid addiction and highlight the various components to consider in order to make a safe choice regarding the long-term planning of each person's specific addiction treatment.

What are opioids?

Opioids are substances in the depressants category that act on the brain to relieve pain and that may also create euphoria. They may be prescribed or purchased on the illicit market. Currently in Canada, several psychoactive substances produced on the illicit market, including heroin, are contaminated by very powerful opioids such as fentanyl and its analogues. This contamination significantly increases the risk of overdose and mortality in people who use opioids.

One of the characteristics of opioids is that regular use rapidly develops tolerance and withdrawal symptoms.

Are there effective treatments?

When a person develops an opioid addiction, now known as opioid use disorder (OUD), and their use of opioids results in impaired functioning or considerable suffering, scientific evidence has shown that long-term opioid agonist treatment (OAT) is the most effective and safe treatment.

OAT is described as a "maintenance" treatment supported by the administration of a drug that alleviates withdrawal symptoms, decreases the urge to use, and causes little sleepiness or euphoria. In Québec, the drugs usually offered to people in treatment include buprenorphine-naloxone (SuboxoneTM), methadone, or slow-release oral morphine (KadianTM). In addition, when a person begins OAT, psychosocial support is offered and encouraged. This adapted support provides help in reorganizing certain aspects of everyday life that may require changes.

OAT has been demonstrated to improve the living conditions of people with OUD. OAT has several beneficial effects, including reducing:

- opioid use;
- criminalization of people who use opioids;
- mortality;
- infections associated with intravenous opioid use (e.g. HIV, HCV);
- infections such as endocarditis, abscesses, etc.

What is opioid withdrawal?

Withdrawal is defined as "the metabolic process by which toxins are removed from the body."[1] In this context, this term refers to the rapid and complete cessation of opioid use in a person who has been using these substances repeatedly and usually over a long period of time. These opioids may have been obtained through a prescription or on the illicit market.

Is withdrawal management recommended for individuals who are addicted?

No! It is important to note that up-to-date scientific data shows that withdrawal management is dangerous for people with opioid use disorder. It exposes the person to a **high risk of relapse and overdose** as their opioid tolerance diminishes. An overdose may cause serious harm, including brain damage, coma, or even death.

Indeed, studies show that withdrawal management alone without other interventions leads to significant health risks:

- **High rate of relapse** — A rapid process of decreasing opioid intake results, in the vast majority of cases, in a relapse, i.e. rapid resumption[2–12] of use.
- **High risk of overdose and mortality** — People who relapse after withdrawal management are at an increased risk of overdosing given the rapid decrease in their opioid tolerance.[13–17]
- **Increased risk of infection** — People who use intravenous drugs and who attempt withdrawal management are more likely to contract viruses such as HIV or hepatitis C because of the increase in risk behaviours following a relapse.[18,19]

In addition, it has been shown that people who wish to end OAT, even those who have been in treatment for a long period of time, must do so slowly and on a planned basis, with the support of a competent team. This approach will reduce the risks mentioned above.

The "least harmful" withdrawal management approach: Slow tapering using a decreasing dose of opioid agonist

Scientific evidence indicates that cold turkey withdrawal in combination with drugs to relieve symptoms of withdrawal (e.g. clonidine, Gravol™, Imodium™, Ativan™) should be prohibited. The same data indicate that if a person insists on withdrawal management after having properly understood the risks, the recommended approach is to use opioid agonists.

Buprenorphine-naloxone should be the primary molecule used, given its numerous benefits in terms of safety, rapid initiation, and flexibility (e.g. easy transition to methadone, faster take-away doses). However, if the person prefers methadone, this option may also be considered if there is no contraindication.

Once treatment with the molecule has begun and the comfort dose has been reached with the chosen opioid agonist, the person should be allowed to remain on that dose for as long as they wish before tapering. This period allows the person to become accustomed to a comfort dose and better understand the benefits of an opioid agonist. If the person still decides to begin tapering, **this should always be done slowly, over a period of more than 30 days and using a decreasing dose of opioid agonist.** During tapering, the person should have the option of changing their mind and returning to the comfort dose, stopping the withdrawal management, and transitioning to a maintenance treatment.

People who ask for withdrawal management and aim for complete abstinence from opioids will often reconsider their choice when faced with the intensity and severity of withdrawal symptoms. This is not a failure, but rather an opportunity to transition to a maintenance treatment, which is the safest and most effective approach.

Psychosocial interventions should also be included with this process to provide appropriate support to the person and enable their long-term management of opioid use disorder. Indeed, opioid addiction should be seen not as an isolated problem that will be resolved after withdrawal management, but rather over the long term. People with opioid use disorder must therefore be monitored over time, taking into account both the risk of relapse and their changing needs.

Choosing the appropriate care setting

When a person has given their free and informed consent to treatment for their opioid use disorder, the next step is to determine the care setting in which they will be treated. There are several possible options, including inpatient services such as in a hospital or rehabilitation centre, or outpatient services (in the person's living environment). This choice should be made based on a specialized assessment of the person (physical and psychological health, psychosocial situation, preferences, environment, fear of relapse, etc.).

For people who decide to begin maintenance treatment, inpatient services may also be used for the treatment initiation period. This option provides a safe place to stay where qualified staff is present to support the person at the start of treatment. However, most people are able to go through this period in an outpatient setting. In addition, inpatient services may be offered to a person under OAT after the initiation period, which would provide them, for example, with the necessary support should they experience moments of vulnerability.

Naloxone and harm reduction supplies: Everywhere, always, and for everyone!

Regardless of the treatment that the person chooses, at the first assessment and at each subsequent appointment they should be offered essential harm reduction supplies, including naloxone and instruction on how to use it. Naloxone saves lives by reversing the effects of an opioid overdose. It is therefore important that the immediate social circle of the person in treatment be involved in the provision and instruction of naloxone use. Providing safer injecting, safer smoking and safer sex supplies also reduces the increased risk of infection.

Health and social services institutions can now distribute naloxone to specific populations through their own services. People in treatment and their immediate social circle may also receive naloxone at a pharmacy and from certain community organizations.

To find a place to get naloxone, please consult: https://sante.gouv.qc.ca/en/repertoire-ressources/naloxone/

To better understand naloxone: https://www.quebec.ca/en/health/advice-and-prevention/alcohol-drugs-gambling/rescuing-a-person-from-a-possible-opioid-overdose/

To better understand the risks associated with opioid use: https://www.quebec.ca/en/health/advice-and-prevention/alcohol-drugs-gambling/risks-of-opioid-use/

For information on drugs: https://publications.msss.gouv.qc.ca/msss/fichiers/2019/19-804-03A.pdf

APPENDIX 2

Document based on::
British Columbia Centre on Substance Use (BCCSU), British Columbia Ministry of Health. *A Guideline for the Clinical Management of Opiod Use Disorder,* [online]. Vancouver, BC, 2017 [accessed Jan. 9, 2020]. Available at: http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf.

References

1. Ministère de la Santé et des Services sociaux. *Plan d'action interministériel en dépendance 2018-2028 : Prévenir, réduire et traiter les conséquences associées à la consommation de substances psychoactives, à la pratique des jeux de hasard et d'argent et à l'utilisation d'Internet* [web]. Québec; 2018 [accessed Oct. 31, 2018]. Available at: http://publications.msss.gouv.qc.ca/msss/fichiers/2018/18-804-02W.pdf

2. Gowing L, Ali R, White J, Mbewe D. "Buprenorphine for managing opioid withdrawal." *Cochrane Database Syst Rev.* 2017;2017(2):CD002025.

3. Fiellin DA, Schottenfeld RS, Cutter CJ, Moore BA, Barry DT, O'Connor PG. "Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: a randomized clinical trial." *JAMA Intern Med.* 2014;174(12):1947-54.

4. Amato L, Davoli M, Minozzi S, Ali R, Ferri M. "Methadone at tapered doses for the management of opioid withdrawal." *Cochrane Database Syst Rev.* 2005;(3):CD003409.

5. Nielsen S, Hillhouse M, Weiss RD, Mooney L, Sharpe Potter J, Lee J, et al. "The relationship between primary prescription opioid and buprenorphine-naloxone induction outcomes in a prescription opioid dependent sample." *Am J Addict.* 2014;23(4):343-8.

6. Hopper JA, Wu J, Martus W, Pierre JD. "A randomized trial of one-day vs. three-day buprenorphine inpatient detoxification protocols for heroin dependence." *J Opioid Manag.* 2005;1(1):31-5.

7. Ling W, Hillhouse M, Domier C, Doraimani G, Hunter J, Thomas C, et al. "Buprenorphine tapering schedule and illicit opioid use." *Addiction.* 2009;104(2):256-65.

8. Sigmon S, Dunn K, Saulsgiver K, Patrick M, Badger G, Heil S, et al. "A randomized, double-blind evaluation of buprenorphine taper duration in primary prescription opioid abusers." J*AMA Psychiatry.* 2013;70(12):1347-54.

9. Sigmon SC, Dunn KE, Badger GJ, Heil SH, Higgins ST. "Brief buprenorphine detoxification for the treatment of prescription opioid dependence: a pilot study." *Addict Behav.* 2009;34(3):304-11.

10. Marsch LA, Moore SK, Borodovsky JT, Solhkhah R, Badger GJ, Semino S, et al. "A randomized controlled trial of buprenorphine taper duration among opioid-dependent adolescents and young adults." *Addiction.* 2016;111(8):1406-15.

11. Breen CL, Harris SJ, Lintzeris N, Mattick RP, Hawken L, Bell J, et al. "Cessation of methadone maintenance treatment using buprenorphine: transfer from methadone to buprenorphine and subsequent buprenorphine reductions." *Drug Alcohol Depend.* 2003;71(1):49-55.

12. Amass L, Ling W, Freese TE, Reiber C, Annon JJ, Cohen AJ, et al. "Bringing buprenorphine-naloxone detoxification to community treatment providers: the NIDA Clinical Trials Network field experience." *Am J Addict.* 2004;13 Suppl 1:S42-66.

13. Strang J. "Death matters: understanding heroin/opiate overdose risk and testing potential to prevent deaths." *Addiction.* 2015;110 Suppl 2:27-35.

14. Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S, et al. "Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study." *BMJ.* 2003;326(7396):959-60.

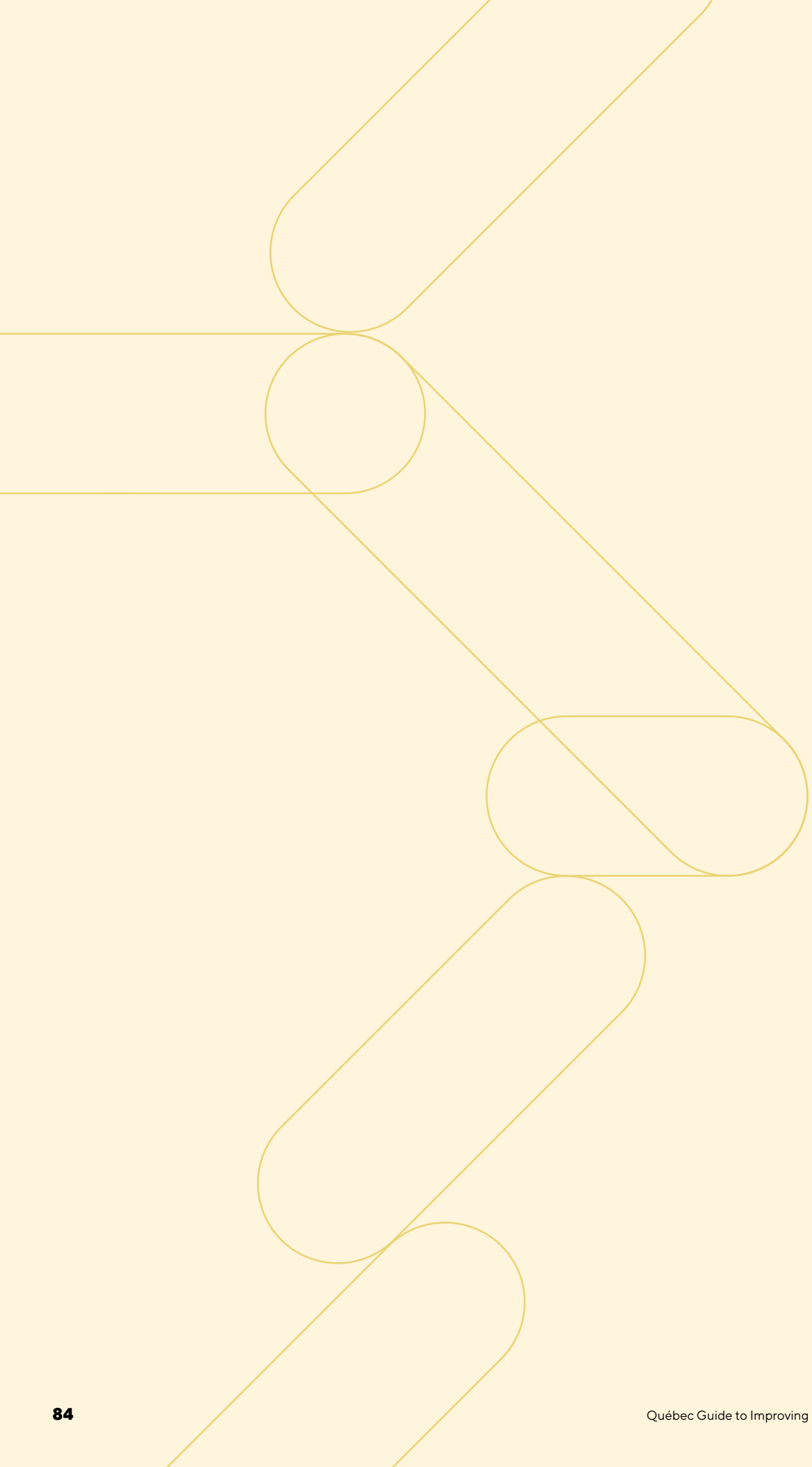
15. Wines JD, Saitz R, Horton NJ, Lloyd-Travaglini C, Samet JH. "Overdose after detoxification: a prospective study." *Drug Alcohol Depend.* 2007;89(2-3):161-9.

16. Chang DC, Klimas J, Wood E, Fairbairn N. A "Case of Opioid Overdose and Subsequent Death After Medically Supervised Withdrawal: The Problematic Role of Rapid Tapers for Opioid Use Disorder." *J Addict Med.* 2018;12(1):80-3.

17. Ravndal E, Amundsen EJ. "Mortality among drug users after discharge from inpatient treatment: an 8-year prospective study." *Drug Alcohol Depend.* 2010;108(1-2):65-9.

18. MacArthur GJ, Minozzi S, Martin N, Vickerman P, Deren S, Bruneau J, et al. "Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis." *BMJ.* 2012;345:e5945.

19. MacArthur GJ, van Velzen E, Palmateer N, Kimber J, Pharris A, Hope V, et al. "Interventions to prevent HIV and Hepatitis C in people who inject drugs: a review of reviews to assess evidence of effectiveness." *Int J Drug Policy.* 2014;25(1):34-52.



APPENDIX 3

List of Items to be Addressed When People Who Use Opioids Request Withdrawal Management

When a person who uses opioids requests withdrawal management, you must make sure to give them all of the following information. As a health and social services professional, it is your responsibility to ensure that the person understands the risks associated with opioid withdrawal management.

☐ 1. Explore the reasons behind the request for opioid withdrawal management.

☐ 2. Give them the document: *Making an Informed Choice Regarding Opioid Addiction.* Read the document *Making an informed choice regarding opioid addiction* with the person and answer their questions to ensure they understand the following:

☐ **A) What are opioids?**

Currently in Canada, several psychoactive substances produced on the illicit market, including heroin, are contaminated by very powerful opioids such as fentanyl and its analogues. This contamination significantly increases the risk of overdose and mortality for people using opioids.

☐ **B) Are there effective treatments?**

For opioid use disorders, opioid agonist treatment (OAT) is the most effective and safest treatment (improvement in the person's living conditions, decrease in opioid use, mortality, morbidity, and infections).

☐ **C) What is opioid withdrawal?**

As used here, this term refers to the rapid and complete cessation of opioid use in a person who has been using these substances repeatedly and usually over a long period of time.

☐ **D) Is opioid withdrawal management recommended?**

Opioid withdrawal management is to be avoided because of the significant risk of relapse, infection, overdose, and mortality.

☐ **E) The "least harmful" withdrawal management approach: Slow tapering using a decreasing dose of opioid agonist**

If the person still decides to begin opioid tapering, discuss withdrawal management using a gradual decrease in opioid agonist doses (30 days or more), while encouraging a transition to a maintenance treatment at any time and without delay. Cold turkey withdrawal or using drugs to reduce symptoms should be prohibited.

☐ **F) Choosing the appropriate care setting**

The person may choose to gradually taper off opioids in outpatient services or start tapering in inpatient services, depending on their needs and your assessment.

☐ **G) Preventing and responding to opioid overdose**

Give the person naloxone and instructions on how to use it before they leave your office (include the people who accompany them, if applicable).

Ask the person if they use alcohol, benzodiazepines, or GHB. If so, explain the increased risk of overdose associated with the combined use of these substances with opioids.

☐ **H) The importance of essential harm reduction supplies**

Make sure to offer safer injecting, safer smoking and safer sex supplies to the person before they leave your office.

☐ 3. Make sure you ask the person for a **telephone number** to reach them. If they do not have one, ask for the contact information of someone who can reach them (e.g. street worker, community organization, pharmacy, someone in their immediate social circle).

Remember...

- You should avoid opioid withdrawal management and encourage maintenance treatment with opioid agonists at all stages of the process.
- Upon reception of a request for opioid withdrawal management, the care team should have a comprehensive discussion with the person to provide them with the necessary information so they can consent to care in a free and informed manner. The risks associated with opioid withdrawal and the best treatment for OUD (i.e. OAT) should be addressed in this discussion.
- When a person persists in their request for opioid withdrawal management, your team should always begin treatment with an opioid agonist in a care setting that is appropriate to their situation in such a way as to facilitate transition to a maintenance treatment at any time.
- Buprenorphine-naloxone should be the first-line molecule, as it offers several advantages. Methadone may also be used if the person prefers this option and if no contraindications exist. Tapering should always take place over a period of more than 30 days, by gradually decreasing the dose and extending the stabilization periods. Treatment modalities should be flexible, i.e. adapted to the person's needs.
- One of the main objectives of withdrawal management services is to act as a bridge with long-term addiction services and to encourage the person's commitment to long-term addiction treatment.
- You should always provide access to essential harm reduction supplies, including naloxone and instruction on how to use it.

APPENDIX 4

Consent Form Associated with a Withdrawal Management Request Linked to an Opioid Use Disorder (OUD)

IDENTIFICATION LABEL

By checking the boxes below and signing at the bottom of this form, I acknowledge that I am making an informed choice and that I agree with the following statements:

- ☐ I understand that I have opioid use disorder (opioid addiction).
- ☐ I understand that, according to current scientific evidence, opioid agonist maintenance treatment (OAT) is the safest therapeutic option that maximises the chances of recovering from opioid use disorder. The recommended duration of OAT varies based on the specific circumstances and needs of each person but is always long-term.
- ☐ I understand that opioid withdrawal management is to be avoided, and that if I decide to opioid taper, I will be exposed to a high risk of relapse and overdose. Overdose may cause serious harm, including brain damage, coma, or even death.
- ☐ I understand that if I choose to begin withdrawal management, I should use an opioid agonist over a period longer than 30 days, and I should not attempt a withdrawal using other types of medication or cold turkey withdrawal.
- ☐ I understand that withdrawal management as a standalone therapeutic option is contraindicated.
- ☐ I understand that if I opt for a slow taper using an opioid agonist, I may change my mind and may be encouraged to do so in order to transition to opioid agonist maintenance treatment.
- ☐ I understand that withdrawal management will not cure my opioid use disorder. OUD requires long-term treatment and support.
- ☐ I acknowledge that I have had sufficient time and opportunity to ask questions regarding the items mentioned above and I also acknowledge that I have received satisfactory clarification and advice in this regard.

I hereby make the following decision today:

☐ **I want to undergo opioid agonist maintenance treatment (OAT).**
I agree to undergo opioid agonist maintenance treatment under the care of the partner team and have decided not to begin opioid withdrawal management.

☐ **I want to begin a slow taper using an opioid agonist over a period longer than 30 days.**
I acknowledge that this is not the best therapeutic option. I may change my mind at any time and I am encouraged to switch to opioid agonist maintenance treatment.

☐ **I want to begin withdrawal management using a different method.**

Please specify: _____
I understand that this is not the appropriate therapeutic option. I may change my mind at any time and I have been encouraged to switch to opioid agonist maintenance treatment.

Signature of the person making the request: _____

Date : _____

Signature of a health professional as witness: _____

Date : _____

APPENDIX 4

Document based on:
British Columbia Centre on Substance Use (BCCSU), British Columbia Ministry of Health. *A Guideline for the Clinical Management of Opiod Use Disorder*, [online]. Vancouver, BC, 2017 [accessed Jan. 9, 2020]. Available at: http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf.

APPENDIX 5

Conditions to Reduce the Risks Associated with Withdrawal management

Following a comprehensive discussion detailing the risks associated with withdrawal management and the best treatment for OUD (i.e. maintenance treatment), the person may still wish to begin opioid tapering despite contraindications (see appendices 2 and 3). It would be advisable for the team to fill out the consent form in Appendix 4 and to accompany the person to ensure they still receive support and begin tapering under the least harmful conditions possible.

Opioid agonist molecule and tapering period

The care team should then introduce an opioid agonist according to standard initiation methods (use buprenorphine-naloxone in first line, see Appendix 6). The opioid agonist molecule should be introduced to allow the person to attain a comfort dose and to enable them to experience a stable period. Then, if the person still wants to opioid taper, the agonist molecule doses may be gradually decreased. This decrease should take place over **at least 30 days**, but should ideally be spread over a longer period. At all of these stages, the person should be reassessed frequently and immediately switched to a maintenance treatment if they so desire.

The use of buprenorphine-naloxone during tapering offers many advantages over methadone, including rapid initiation (1-3 days), a safety and flexibility profile that makes it conducive to initiation in various locations and contexts, a quickly achieved comfort dose, ease of transition to maintenance treatment, and greater safety than methadone, especially at the start of treatment (lower risk of overdose). Cold turkey withdrawal and the sole use of withdrawal symptom management drugs without an opioid agonist (e.g. clonidine, benzodiazepines, dimenhydrinate, loperamide) are considered high risk and are to be completely prohibited. The same applies to rapid tapering of an opioid agonist molecule in under 30 days.

Treatment plan and long-term support

Withdrawal management should always be combined with immediate access to psychosocial interventions as well as the possibility of integrating addiction housing resources. In addition, withdrawal management should always be integrated in a long-term treatment and support plan for the person. It would therefore be important to maintain contact with the person, even after discontinued use of the agonist molecule, and to not delay resumption of pharmacological treatment when necessary, since many people drop in and out of treatment.

> **In addition, essential harm reduction supplies, particularly naloxone along with instruction on how to use it, should be systematically given to the person and their immediate social circle, given the increased risk of overdose following withdrawal.**

Appropriate care setting

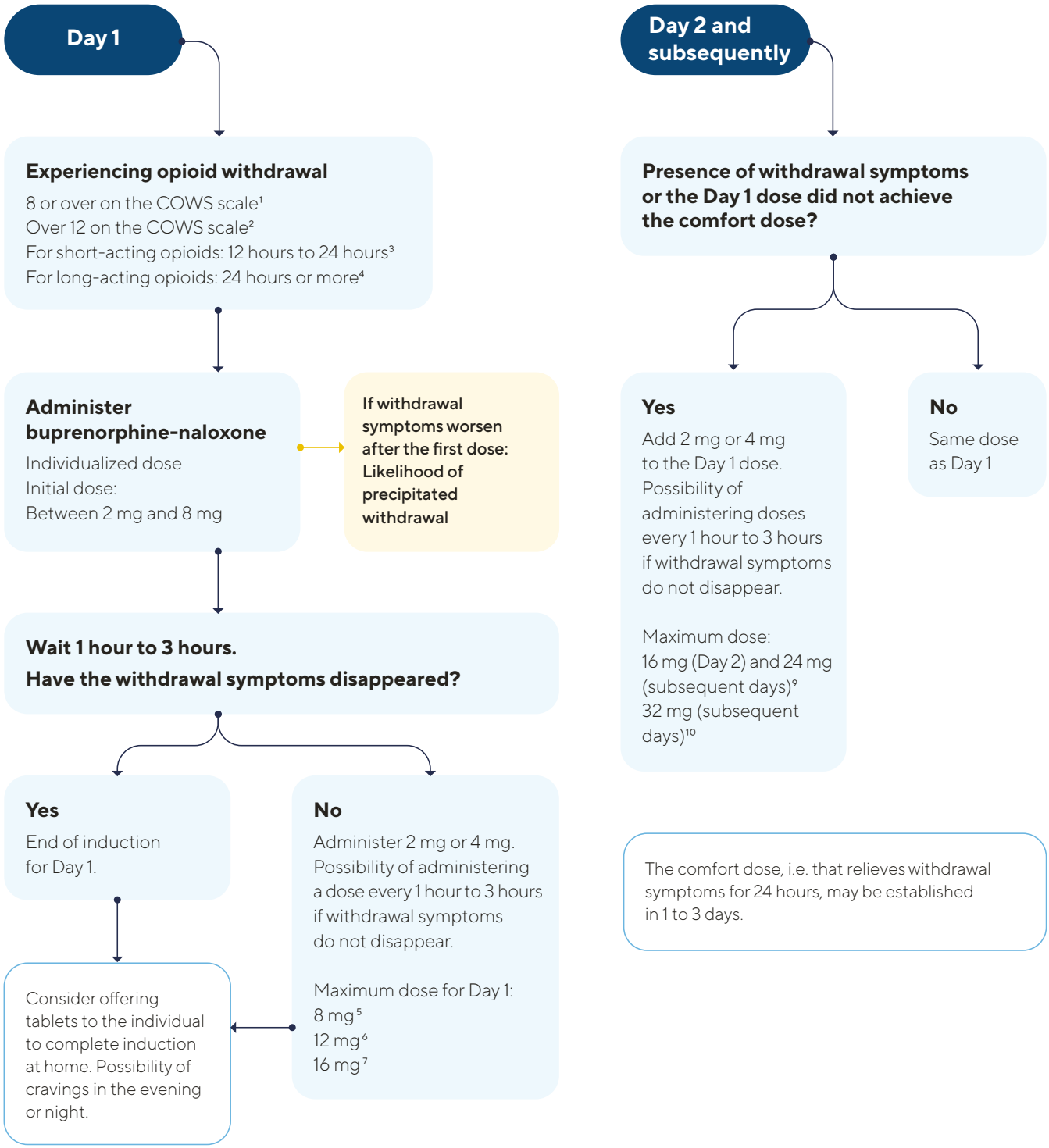
The choice of setting (inpatient or outpatient) for withdrawal management should be based on a specialized assessment of the person (physical health, psychological health, psychosocial situation, risk of withdrawal, type of opioid use, personal preferences, social circle, fear of relapse, etc.) (see Practice Concept 5). Opioid withdrawal management should not be directly associated with internal medical care, and may be offered through inpatient services (hospital or CRD institution) or outpatient services (e.g. living environments, addiction housing resources). Opioid withdrawal management in outpatient settings would have the advantage of allowing for a gradual decrease under a flexible, individualized protocol, therefore providing multiple opportunities to transition to maintenance treatment, which is the safest treatment. The management of opioid withdrawal in inpatient services would keep people under observation, ensure a more thorough management of symptoms, provide a drug-free environment, enable the person to experience a stable period while using an opioid agonist, and provide for the provision of appropriate care based on the person's needs.

When a person initiates treatment with an opioid agonist molecule in an inpatient service following a request for opioid withdrawal management, monitoring and reassessment of their pharmacological treatment should be ensured when necessary until they are put in contact with the long-term care team that is most suitable to meet their needs (see Practice Concept 8).

> **It should also be reminded that opioid use disorder is not a linear process and is rarely a problem with a circumscribed timeline. The request for opioid withdrawal management should thus constitute a gateway to the HSSS and an opportunity to connect the person with resources that may support them in the long term.**

APPENDIX 6

Summary of Data from the Literature on Buprenorphine-Naloxone Induction Procedures



* This figure reports data from the review of the literature of the research project on the medical management of opioid withdrawal: *Rapport combiné de recherches.* The doses indicated are for buprenorphine. The authors cannot provide any guarantees and cannot be held responsible for clinical practices of OAT. Care and service providers must ensure that they are properly trained and competent to provide care and services in accordance with their professional standards and codes of ethics.

References

1. Gunderson E, Wang X, Fiellin D, Bryan B, Levin F. "Unobserved versus observed office buprenorphine/naloxone induction: A pilot randomized clinical trial." *Addict Behav.* 2010;35(5):537-40. Hereinafter identified as "Gunderson."

   Jacobs P, Ang A, Hillhouse MP, Saxon AJ, Nielsen S, Wakim PG, et al. Treatment outcomes in opioid dependent patients with different buprenorphine/naloxone induction dosing patterns and trajectories. *Am J Addict.* 2015;24(7):667-75. Hereinafter "Jacobs."

   Nielsen S, Hillhouse M, Weiss RD, Mooney L, Sharpe Potter J, Lee J, et al. The relationship between primary prescription opioid and buprenorphine-naloxone induction outcomes in a prescription opioid dependent sample. *Am J Addict.* 2014;23(4):343-8. Hereinafter "Nielsen 2014."

   Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs.* 2003;35(2):253 9. Hereinafter "Wesson."

2. British Columbia Centre on Substance Use (BCCSU), British Columbia Ministry of Health. *A Guideline for the Clinical Management of Opiod Use Disorder* [web]. Vancouver, BC; 2017 [accessed Jan. 9, 2020]. Available at: http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf. Hereinafter "BCCSU."

   Center for Addiction and Mental Health (CAMH). *Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline* [web]. 2011 [accessed Jan. 9, 2020]. Available at: https://www.cfpc.ca/ProjectAssets/Templates/Resource.aspx?id=4345&langType=3084. Hereinafter "CAMH."

   Suboxone product monograph including patient medication information. Indivior UK Limited: Berkshire, UK. Control No. 195433. December 20, 2016. Disponible à: https://pdf.hres.ca/dpd_pm/00037755.PDF. Hereinafter "Suboxone monograph."

   Wesson, *op. cit.*

3. For heroin, morphine, hydrocodone, and fast-release oxycodone, 12 to 16 hours. For slow-release oral morphine, controlled-release hydromorphone, and extended-release oxycodone, 17 to 24 hours. (BCCSU, *op. cit.*)

   American Society of Addictions Medicine (ASAM). *The National Practice Guideline for the Use of Medication in the Treatment of Addiction Involving Opioid Use* [web]. 2015 [accessed Jan. 9, 2020]. Available at: https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf. Hereinafter "ASAM."

   Substance Abuse and Mental Health Administration (SAMHSA). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* [web]. 2004 [accessed Jan. 9, 2020]. Available at: https://www.ncbi.nlm.nih.gov/pubmed/22514846. Hereinafter SAMHSA.

   Gunderson, *op. cit.*

4. For methadone, 24 hours or more, but preferably 30 to 72 hours (BCCSU, *op. cit.*).

   Nielsen S, Hillhouse M, Mooney L, Fahey J, Ling W. "Comparing buprenorphine induction experience with heroin and prescription opioid users." *J Subst Abuse Treat.* 2012;43(3):285-90. Hereinafter "Nielsen 2012."

   Breen CL, Harris SJ, Lintzeris N, Mattick RP, Hawken L, Bell J, et al. "Cessation of methadone maintenance treatment using buprenorphine: transfer from methadone to buprenorphine and subsequent buprenorphine reductions." *Drug Alcohol Depend.* 2003;71(1):49-55. Hereinafter "Breen."

   Gunderson, *op. cit.;* Nielsen 2014, *op. cit.;* ASAM, *op. cit.;* SAMHSA, *op. cit.*

5. Collège des médecins du Québec, Ordre des pharmaciens du Québec. *La buprénorphine dans le traitement de la dépendance aux opioïdes* [web]. 2009 [accessed Jan. 9, 2020]. Available at: https://www.opq.org/doc/media/808_38_fr-ca_0_ld_buprenorphone.pdf. Hereinafter "CMQ" et "OPQ"

   CAMH, *op. cit.;* SAMHSA, *op. cit.*

6. Monographie Suboxone, *op. cit.*

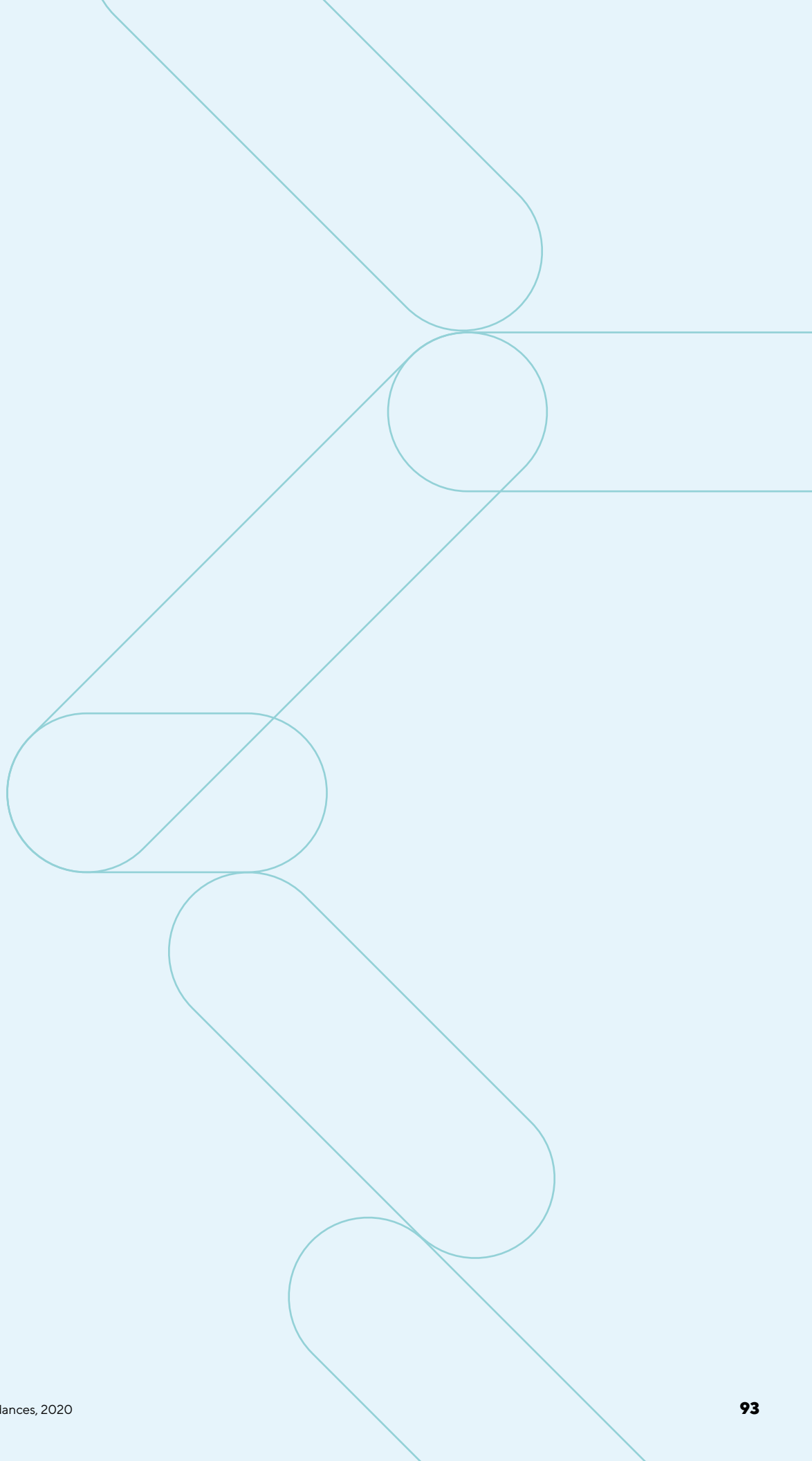
7. Marsch LA, Moore SK, Borodovsky JT, Solhkhah R, Badger GJ, Semino S, et al. "A randomized controlled trial of buprenorphine taper duration among opioid-dependent adolescents and young adults." *Addiction.* 2016;111(8):1406-15.

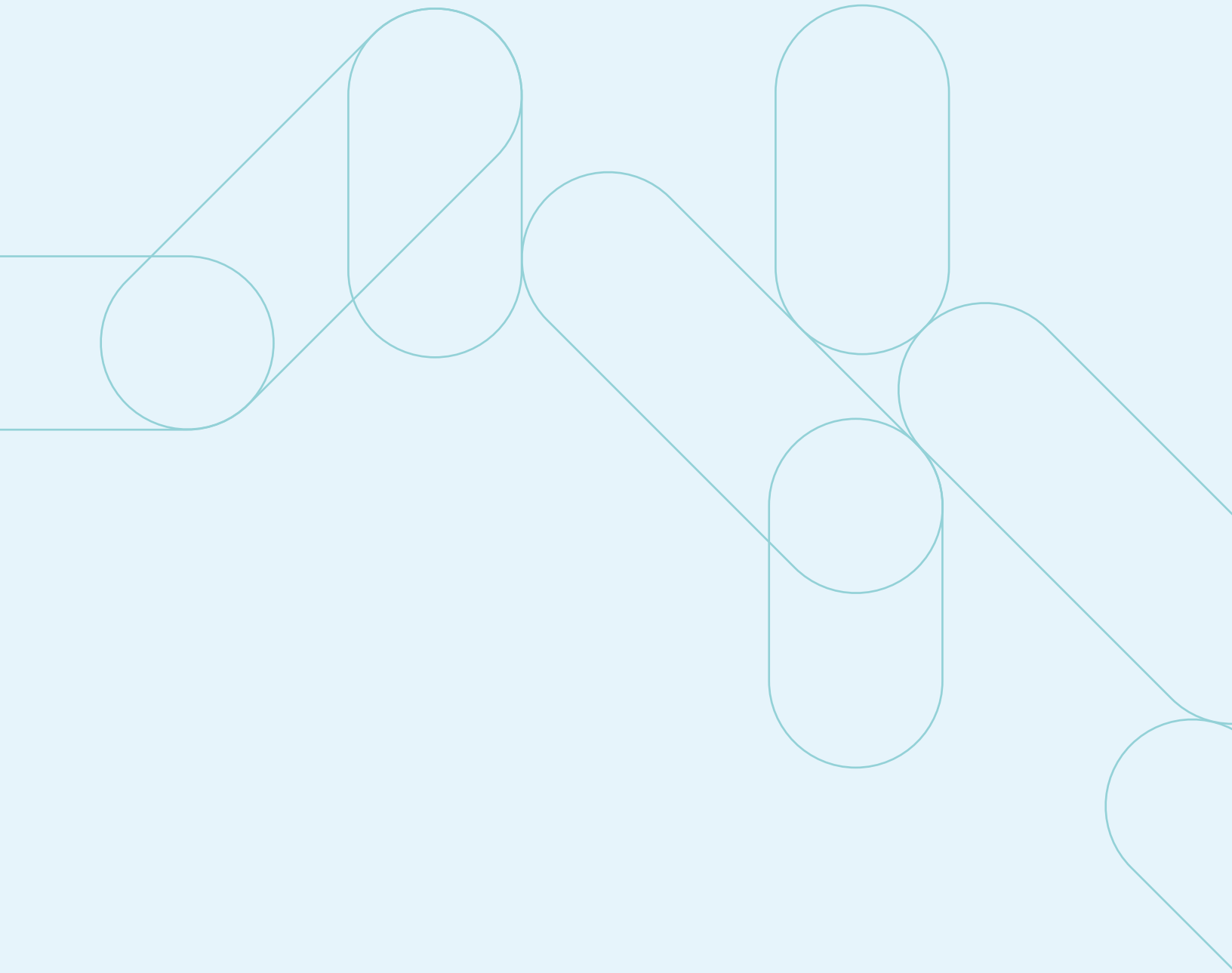
   Gunderson, *op. cit.;* Nielsen 2012, *op. cit.;* Jacobs, *op. cit.;* BCCSU, *op. cit.*

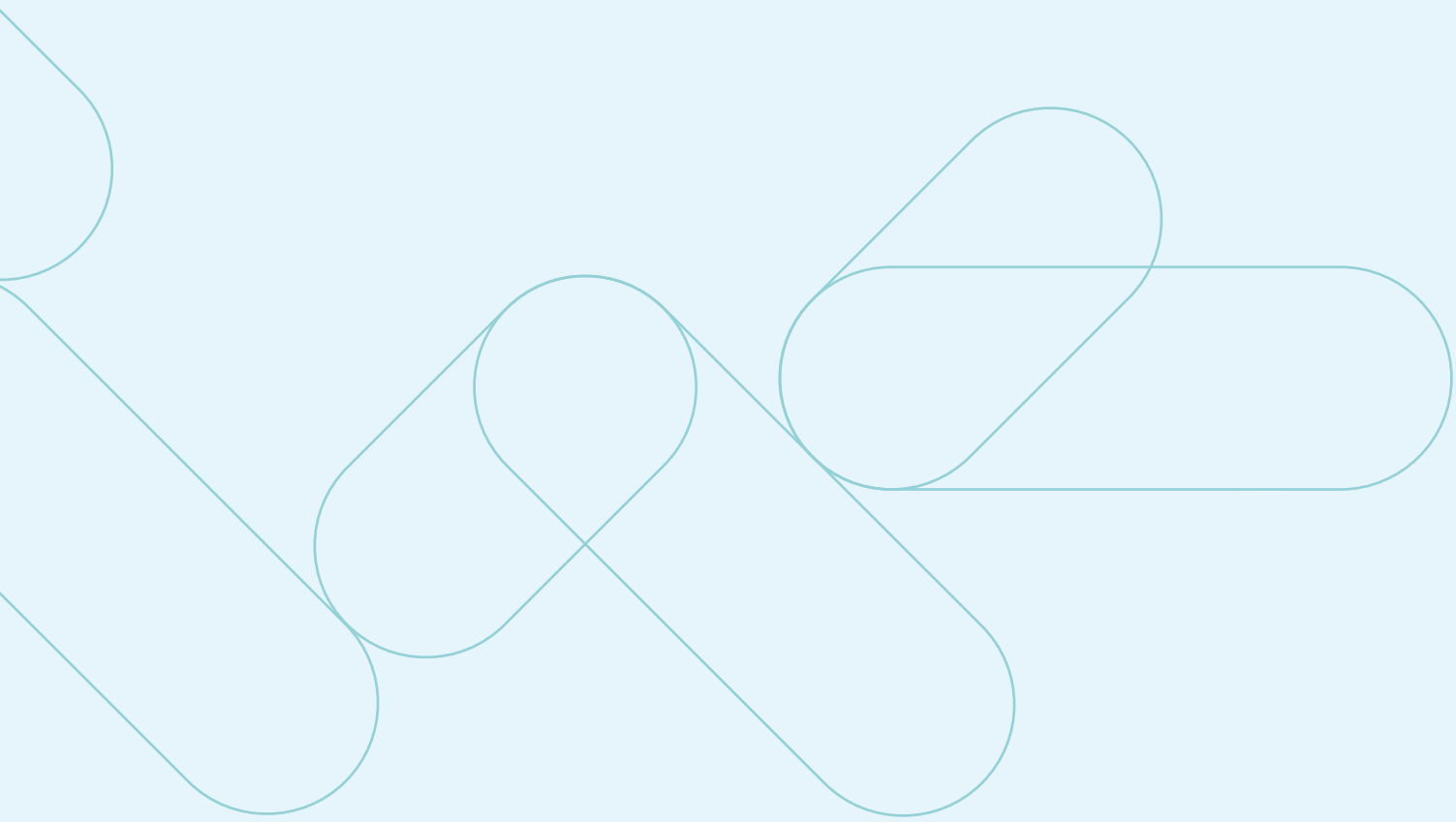
8. Several authors propose a maximum dose of 16 mg on day 2 and 24 mg on subsequent days: Gowing L, Ali R, Dunlop A, Farrell M, Lintzeris N. *National Guidelines for Medication-Assisted Treatment of Opioid Dependence* [web]. Government of Australia; 2014 [accessed Jan. 9, 2020]. Available at: https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence

   Suboxone monograph, *op. cit.;* Nielsen 2012, *op. cit.;* BCCSU, *op. cit.;* CMQ et OPQ, *op. cit.;* CAMH, *op. cit.;* Nielsen 2014, *op. cit.;* Breen, *op. cit.*

9. Some sources state that it is sometimes possible to stabilize a person on a dose of 32 mg buprenorphine per day: Jacobs, *op. cit.,* BCCSU, *op. cit.,* et World Health Organization (WHO). *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* [web]. Geneva; 2009 [accessed Jan. 9, 2020]. Available at: https://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf







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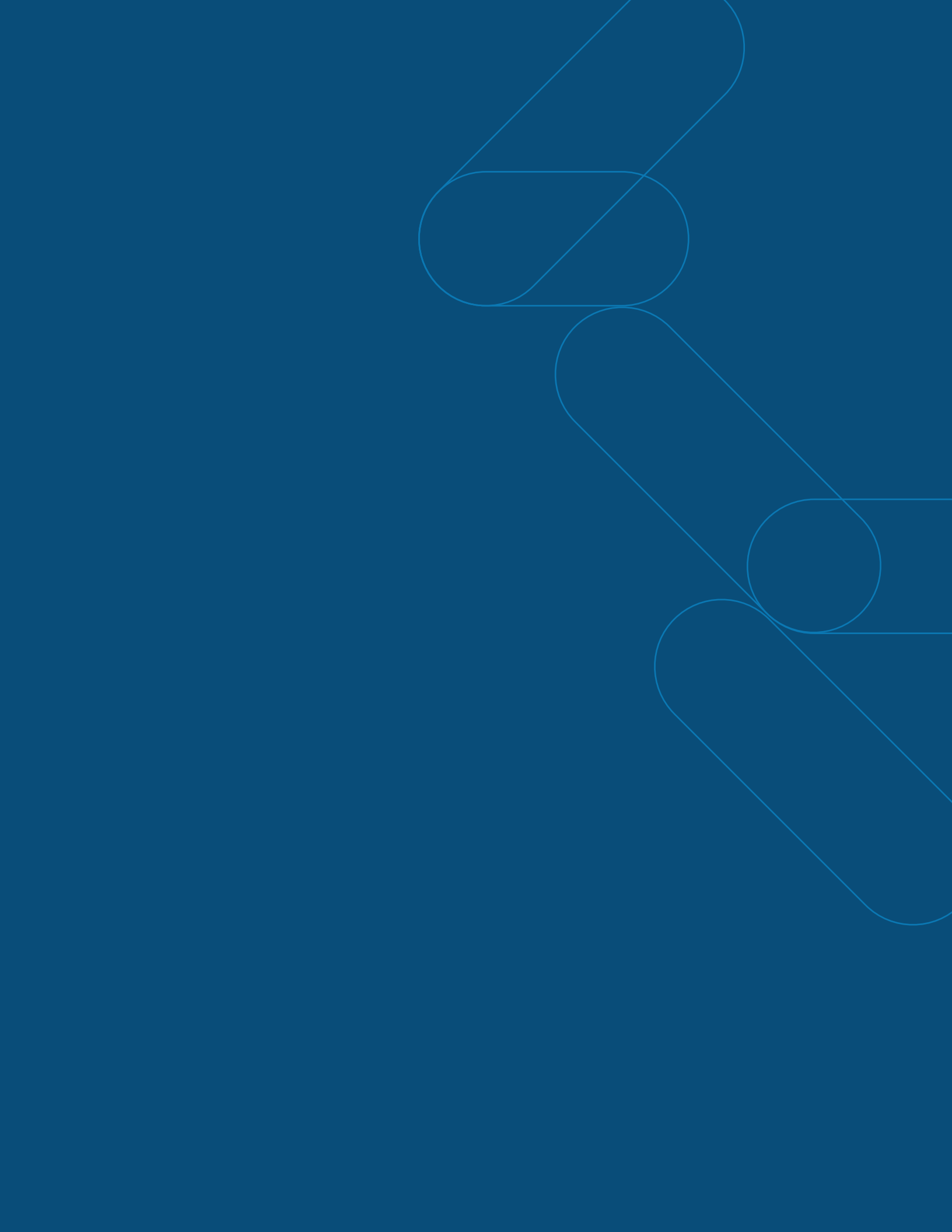

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