

This tool is designed to support primary care providers in screening, diagnosing and implementing Opioid Agonist Therapy (OAT) for patients who have problems with opioid use. Sections A-C of this tool can be helpful for all primary care providers in screening for and diagnosing an Opioid Use Disorder (OUD). Sections D-I focusing on OAT can be most useful for primary care providers who are or have engaged in additional continuing professional development activities focused on OAT.

SECTION A: Important considerations for OUD

- People with OUD must have integrated and concurrent management of their physical health and addiction treatment needs, as well as their mental health and social well-being ¹
- OUD is a chronic, relapsing condition that requires long-term chronic disease management ²³
- OAT is first-line treatment for OUDs and should be offered to all patients with OUD
- Providers can develop the skills in prescribing OAT through the support and assistance of the following resources:
 - For providers who want more education on how to initiate OAT confidently, courses are available to help (See [Courses for providers](#))
 - For providers who require assistance starting or maintaining OAT, there are [Rapid Access Addiction Medicine \(RAAM\) Clinics](#) ^{vii} and the [Medical Mentoring for Addictions and Pain \(MMAP\) network](#) ^{viii} available to help
- Engage patients with non-stigmatizing language (See [Resources to reduce stigma](#))
- Ensure that when you prescribe opioids to patients to also provide them with naloxone kits



People living with OUD must be provided with nonjudgmental and supportive care



Talking points

Motivational interviewing can help encourage patients to make personal changes that they already deem as important for reaching a particular goal. Principles of motivational interviewing are:

- Express empathy through reflective listening
- Explore the discrepancy between patient’s goals or values and their current behavior
- Avoid arguments and direct confrontation
- Adjust to patient resistance rather than opposing it directly
- Support self-efficacy and optimism ⁸

NALOXONE

Naloxone is a medication that is used to reverse effects of an opioid overdose. It is recommended to keep naloxone on hand in case of an accidental overdose. Naloxone should be recommended for all patients on opioids. This is particularly important for patients on doses of >50 morphine equivalent dose (MED)/day, and those with a history of overdose or concurrent benzodiazepine use.

Providers are to advise patients that after using naloxone in the case of an overdose, they should immediately call 911 as the effects of the naloxone wears off after about 30 minutes.

Advise patients that Ontarians do not require a health card or a prescription to be eligible for a free take-home naloxone kit.

Naloxone is available in nasal and injectable kits. Patients can receive these kits and training on their use from pharmacies.

SECTION B: Screening for OUD

OUD is a complex issue that can occur at any time in one’s life and presents differently for everyone. If you suspect that your patient may be at risk of struggling with OUD, use the Prescription Opioid Misuse Index (POMI). The POMI is a 6-point questionnaire with strong predictive abilities for OUD.²⁴

Question	YES	NO
1 Do you ever use more of your medication, that is, take a higher dose, than is prescribed for you?	<input type="checkbox"/>	<input type="checkbox"/>
2 Do you ever use your medication more often, that is, shorten the time between doses, than is prescribed for you?	<input type="checkbox"/>	<input type="checkbox"/>
3 Do you ever need early refills for your pain medication?	<input type="checkbox"/>	<input type="checkbox"/>
4 Do you ever feel high or get a buzz after using your pain medication?	<input type="checkbox"/>	<input type="checkbox"/>
5 Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?	<input type="checkbox"/>	<input type="checkbox"/>
6 Have you ever gone to multiple physicians, including emergency room doctors, seeking more of your pain medication?	<input type="checkbox"/>	<input type="checkbox"/>

Two 'yes' answers indicate a positive screen and a possible diagnosis of OUD.

SECTION C - Diagnosing OUD

Once you have identified that your patient might have OUD through using the POMI, the DSM-5 criteria is then used to diagnose your patient.

The DSM-5 OUD criteria defines opioid use disorder as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two out of the eleven criteria within a twelve month period.^{6,14}

All patients who meet the DSM-5 criteria for OUD should be offered first-line treatment: buprenorphine-naloxone.

DSM-5 OUD CRITERIA To confirm a diagnosis of OUD, at least two of the following criteria should be observed within a 12-month period: ¹⁵	
<input type="checkbox"/>	Opioids are often taken in larger amounts or over a longer period than was intended
<input type="checkbox"/>	There is a persistent desire or unsuccessful efforts to cut down or control opioid use
<input type="checkbox"/>	A great deal of time is spent on activities necessary to obtain the opioid, use the opioid, or recover from its effects
<input type="checkbox"/>	Craving, or a strong desire or urge to use opioids
<input type="checkbox"/>	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
<input type="checkbox"/>	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
<input type="checkbox"/>	Important social, occupational, or recreational activities are given up or reduced because of opioid use
<input type="checkbox"/>	Recurrent opioid use in situations in which use is physically hazardous
<input type="checkbox"/>	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
	Exhibits tolerance*:
<input type="checkbox"/>	<ul style="list-style-type: none"> • Need for markedly increased amounts to achieve intoxication or desired effect¹⁹ • Markedly diminished effect with continued use of the same amount¹⁹
	Exhibits withdrawal*:
<input type="checkbox"/>	<ul style="list-style-type: none"> • Characteristic opioid withdrawal syndrome¹⁹ • Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms¹⁹
DSM-5 OUD criteria is not validated in youth ≤ 12 ⁹	
Youth ≤ 12 have special needs and clinicians should consult experts	
*With the exception of patients who are taking opioids for chronic pain (For more information see Section E: Prescribing considerations for buprenorphine-naloxone)	



Talking points

“Opioids change the brain and the body in ways that can make it hard to stop using.”⁵

“OUD has nothing to do with character, willpower, or morals. Many good and strong people have an alcohol or drug problem. People with OUD find that once they start using opioids, it is no longer about choice.”⁷

“You have been diagnosed with this disorder because you have repeatedly tried but have been unable to cut down or stop your opioid use. People with OUD have lost control over their use and regularly consume more than they intend to, despite knowing that it’s harmful to them.”⁷

Note: If patients are unable or uninterested in starting treatment at this time, keep the door open for future treatment and begin building a rapport. Identify and address patient-centred goals. Follow up on patient goals regularly and consider motivational interviewing and harm reduction counseling.⁹

“I know that you are not interested in starting treatment at this time, but how about we create some goals to work towards?”

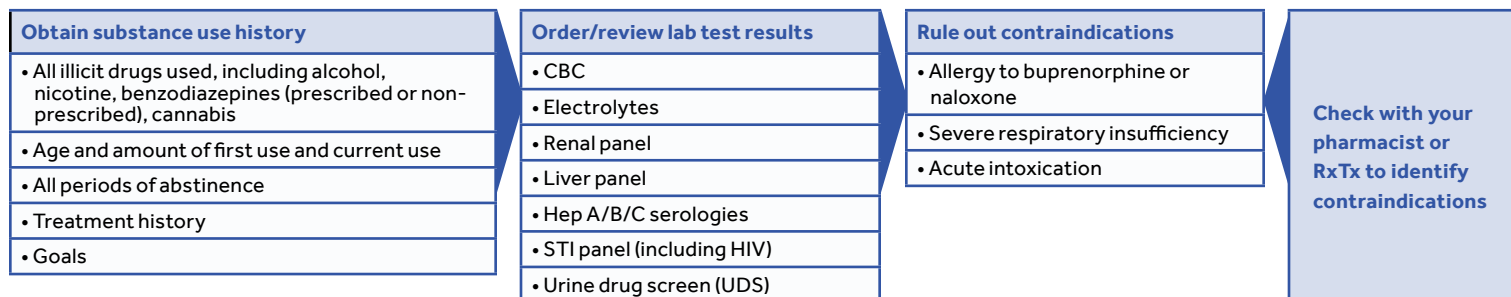
Severity of OUD

2to3 MILD
2 to 3 criteria

4to5 MODERATE
4 to 5 criteria

6+ SEVERE
6 or more criteria⁹

After confirming that your patient meets the DSM-5 criteria for OUD, consider conducting the following assessment to ensure that your patient will be an appropriate candidate for opioid agonist therapy (OAT). OAT involves treatment with opioid agonists and providers must have a clear understanding of their patient’s current substance use, physical health, and contraindications before initiating treatment:



SECTION D: Opioid agonist therapy (OAT)

OAT involves taking the opioid agonists buprenorphine-naloxone or methadone in order to prevent withdrawal and reduce cravings for opioids.²⁵

Buprenorphine-naloxone is considered first-line treatment for OUD. Buprenorphine-naloxone is a 4:1 mixture of buprenorphine to naloxone that is administered sublingually. Buprenorphine is a long-acting semi-synthetic partial opioid agonist that relieves opioid withdrawal symptoms and cravings. The inclusion of naloxone is intended to prevent diversion through injection.¹⁰ Naloxone is not absorbed orally. It does not contribute to the efficacy of buprenorphine-naloxone and does not cause withdrawal in people who take opioids while on buprenorphine-naloxone.







In conjunction to prescribing buprenorphine-naloxone, the risks and benefits of all of the treatment options are to be provided to patients.²⁰

Buprenorphine-naloxone is generally preferable to methadone because of its improved safety profile.²⁰ (See the chart below)

Initiating and maintaining OAT with buprenorphine-naloxone or methadone can be done in primary care, integrated care (primary care and addiction care), or specialized clinic settings.¹

PROVIDER RESOURCES FOR OAT
META:PHI has a list of RAAM clinics that are available to help ¹³
Consult specialists across the province to provide the best care possible for your patients at OTN eConsult ^v
Project ECHO for Chronic Pain/Opioid Stewardship ^{xx}
Medical Mentoring for Addictions and Pain (MMAP) Network ^{viii}
The Ontario Pharmacists Association (OPA) has an information line for professionals prescribing OAT 1-888-519-6069 ^{xi}

Buprenorphine-naloxone vs. methadone²¹

  BUPRENORPHINE-NALOXONE	VS.	  METHADONE
<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Lower risk of overdose <input checked="" type="checkbox"/> Shorter time to achieve an effective dose <input checked="" type="checkbox"/> Milder side effect profile <input checked="" type="checkbox"/> More flexible dosing schedules and take-home doses <input checked="" type="checkbox"/> Feasible for rural and remote locations <input checked="" type="checkbox"/> Easier to transition from buprenorphine-naloxone to methadone <input checked="" type="checkbox"/> Lower risk of harms (e.g. respiratory depression) 		<ul style="list-style-type: none">  May have higher treatment retention rates for those with higher intensity opioid use (e.g. heroin, those who inject opioids)  No withdrawal necessary to start treatment



Talking points

“At the right dose, buprenorphine-naloxone controls withdrawal symptoms for 24 hours so that you feel “normal” and not sick or high. Although some people think that this is just replacing one opioid with another, the idea is that by taking a medication as prescribed and getting rid of cravings, you will be able to break the patterns associated with misusing drugs and focus on getting healthy.”²⁰

INFORMATION FOR METHADONE PRESCRIBING

Methadone is to be used only if providers have the appropriate skills and training to do so, due to the risks and restrictions affiliated with prescribing methadone.*

- Consider methadone for OAT if treatment with buprenorphine-naloxone is contraindicated or not preferred⁹
- Discuss switching to methadone if buprenorphine-naloxone is not relieving the patient’s cravings⁷
- May be preferred treatment for individuals who cannot be stabilized on buprenorphine-naloxone⁹

Prescribing considerations for methadone

- Before prescribing methadone providers must discuss the risks and side effects of methadone, duration of treatment, and issues of accessibility and logistics (i.e. daily pharmacy visits for two months, potential impact on lifestyle and employment, and special considerations for traveling)
- Keep patient on methadone if they are already stable on the medication

*See the [CPSO Methadone Maintenance Program](#)¹⁰ and the [CAMH course Opioid Dependence Treatment](#)¹² for more instructions and support for methadone prescribing.

Methadone and generic buprenorphine-naloxone are both covered under Ontario Drug Benefits and most private plans.

SECTION E: Prescribing considerations for buprenorphine-naloxone

General approach

- Any patient that is considering OAT with buprenorphine-naloxone should sign a patient agreement form with their provider to ensure that the patient is aware of all of their roles and responsibilities during treatment: [Refer to the Machealth resource Buprenorphine Reference Guide](#)^{ix}
- Patients should be offered concurrent psychosocial treatment, support, and monitoring for at least six months while on treatment¹

For patients who refuse OAT

People with opioid use disorder who decline opioid agonist therapy should be offered an opioid taper, preferably using buprenorphine-naloxone, lasting longer than one month.¹

Prescribing considerations for OUD and patients living with chronic pain

Tell patients who are on morphine and have chronic pain, but are hesitant to switch to buprenorphine-naloxone, that buprenorphine-naloxone is an effective pain reliever with lower risks and fewer side effects.

Precipitated withdrawal

- Precipitated withdrawal is a sudden onset of severe withdrawal symptoms that occurs when the first dose of buprenorphine-naloxone is taken while other opioids are still present in the body¹⁰
- Precipitated withdrawal can be avoided by allowing sufficient time to pass between the last use of opioids and starting buprenorphine-naloxone treatment

Determining withdrawal for treatment

In order to avoid precipitated withdrawal, the following scales can help determine opioid withdrawal symptoms:

[The Clinical Opiate Withdrawal Scale \(COWS\)](#) is an 11-item scale designed to be administered by a provider. This tool can be used in both inpatient and outpatient settings to rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.²⁶

[The Subjective Opiate Withdrawal Scale \(SOWS\)](#) is self-administered by a patient for grading opioid withdrawal symptoms. It contains 16 symptoms whose intensity the patient rates on a scale of 0 (not at all) to 4 (extremely), and takes less than 10 minutes to complete.²⁷

Buprenorphine-naloxone prescription

If you have never written a prescription for buprenorphine-naloxone before, refer to the [Machealth resource Buprenorphine Reference Guide](#), which provides guidance on how to prescribe buprenorphine-naloxone.^{ix}



Talking points

Patients living with chronic pain

"I know that you have pain and no one is questioning that. But I am worried that the risks of opioids are now outweighing the benefits for you."

"Your OUD is probably making your pain worse. This is because you go through withdrawal every day as the opioid wears off, and withdrawal greatly increases your perception of pain. If you treat your OUD with buprenorphine-naloxone, you will likely experience a decrease in your chronic pain as well as an improvement in your daily life."⁷

"If you are on opioids and are worried about switching to another treatment because of your pain, you should know that other options such as buprenorphine-naloxone will effectively relieve your pain."

Preparing the patient to start treatment on buprenorphine-naloxone

"You will need to stop all opioids at least 12-24 hours before starting buprenorphine-naloxone."

"When your opioids begin to wear off, you will experience withdrawal. Symptoms of withdrawal include muscle aches, nausea and vomiting, cramps, chills, sweating, yawning, and goosebumps. People also experience insomnia, anxiety, fatigue, and powerful cravings."

"To help with withdrawal symptoms, you may take:

- Clonidine 0.1 mg every 8 hours (by prescription)—many people do not need this
- Ibuprofen up to 600 mg every 8 hours
- Acetaminophen up to 1000 mg (2 Extra Strength) every 6 hours
- Dimenhydrinate 50 mg every 6 hours
- Walking, resting, hot baths or showers can help (but not right after taking clonidine)"

"It is important to be in withdrawal before you start buprenorphine-naloxone in order to avoid precipitated withdrawal, which is like the worst flu of your life."¹⁸

Handling patient concerns

"Let's talk about your questions and concerns so that you will understand the benefits and drawbacks to this treatment. I understand that you are worried about starting buprenorphine-naloxone but know that most people feel significantly better."

Stopping treatment suddenly

"It is important not to stop taking buprenorphine-naloxone suddenly or you will experience withdrawal."²⁰

SECTION F: Office treatment



OFFICE TREATMENT PROTOCOL

Office treatment is the preferred method of treatment to ensure that patients do not go into precipitated withdrawal. ⁷

PLANNING FOR TREATMENT

- Plan treatment for a weekday morning, allowing for reassessment later the same day ¹⁸
 - Monday mornings are the most optimal ¹⁸
- Refer to the [Machealth resource Buprenorphine Reference Guide](#) on how to prescribe buprenorphine-naloxone ^{ix}
- Identify the pharmacy to be used:
 - Confirm that they stock buprenorphine-naloxone Rx for 6x2 mg buprenorphine-naloxone tablets ²⁰ and that doses will be dispensed daily at the pharmacy
- Determine whether the patient will take their first dose at the pharmacy or bring their medication to the office for witnessed dosing
- Advise your patient that the first dose of buprenorphine-naloxone is to be taken at least 12 hours since the last oral immediate release (IR) dose, and 24 hours since the last oral controlled release (CR) dose ²⁹
 - Ensure patient is aware that treatment cannot take place if they are intoxicated OR if they are not in withdrawal ²⁰
- Remind the patient not to drive or operate heavy machinery during the first day of treatment ²⁰
 - Watch for signs of sedation whenever the dose of buprenorphine-naloxone is increased and gage whether to tell patient to refrain from driving or operating heavy machinery accordingly
- Inform the patient that they will be taking their medication at the pharmacy daily for the first 1-2 weeks

! CAUTION: If the patient is not in withdrawal then treatment must be postponed to avoid precipitated withdrawal.

DAY OF TREATMENT

- Confirm the patient's intention to start buprenorphine-naloxone and review questions and risks/benefits
- Ask when the patient last used opioids, including which, how much and how
- Assess withdrawal using the [COWS](#). Treatment may be started if the score is 12+ ^{9,23}
- Patients may pick up their Day 1 prescription and bring it to the office for witnessed ingestion by a primary care team member after assessment of withdrawal ⁹
- The first dose of buprenorphine-naloxone will be 4 mg SL (2mg if elderly or on high dose of benzodiazepines)**
- Ensure that the patient allows the buprenorphine-naloxone tablet to dissolve under their tongue completely; this should take about 5-10 minutes ²¹
- Ask the patient to lift their tongue after 3-5 minutes to show the tablet dissolving ²¹
- Reassess in 2 hours. If the patient has improved but is still in withdrawal, give another 4 mg to take in the office or at home. **Maximum dose for the first day is 12 mg** ²⁹
- Patients are not required to wait in the office between doses

FOLLOW-UP ASSESSMENTS

Patients should be reassessed within the week of treatment (ideally Day 2-5), and then weekly after that

- Day 2** maximum dose 16 mg
- Days 3-4** maximum dose 24 mg
- Ask specific questions at each visit: ¹⁸
 - How long did the dose last?
 - What time did the dose wear off?
 - What were the specific withdrawal symptoms?
 - Did they use additional opioids?
 - Was there sedation? Side effects?

If withdrawal symptoms are present, give previous dose + additional 2-4 mg. If no withdrawal symptoms, continue previous day's dose. ¹⁸

ONGOING FOLLOW-UP ASSESSMENT

- Review the same questions in "Follow-Up Assessments" in the following weeks
- At each assessment, write prescription for the appropriate quantity of tablets until the next visit
- After two to four weeks, if you deem that the patient is stable on buprenorphine-naloxone, the patient can take their medication at home. Patients typically start with one dose per week and increase by one dose every one to two weeks
- One urine sample per month or at every visit. See [Section H](#) for more information



SECTION G: Home treatment**HOME TREATMENT PROTOCOL**

Home treatment is not the preferred method but may be necessary for certain situations. ²⁹

CAUTION: Home treatment is not appropriate for patients with complicated histories of comorbid substance use (i.e. alcohol use disorder or other substance use disorders).

CAUTION: If the patient is not in withdrawal then the treatment must be postponed to avoid precipitated withdrawal.

PLANNING FOR TREATMENT

- It is required that the provider has experience and comfort with buprenorphine-naloxone treatment before recommending a home treatment ⁹
- Refer to the [Machealth resource Buprenorphine Reference Guide](#) on how to prescribe buprenorphine-naloxone ^{1x}
- Write a prescription for Day 1 2 mg x 6 tablets SL and have the patient pick up the medication

Primary care providers should provide the following information to their patients if considering home treatment:

- Access to nurses, physicians, or support
 - Practitioner contact information including after-hours advice if needed and the contact information of closest pharmacies
 - Instruct patients to call 911 in case of emergencies and to obtain naloxone kits
- Written instructions for home treatment dosing and timing that has been carefully reviewed with the patient and their caregiver (if applicable) in advance
- Provide your patient with the form, [BC OUD subjective opiate withdrawal scale \(SOWS\) patient handout](#), to ensure that they know what withdrawal looks and feels like ²⁸
 - Ask your patient to repeat instructions back to you in their own words to see if they understand what the process is going to look like
- Advise your patient that the first dose of buprenorphine-naloxone is to be taken at least 12 hours since the last oral immediate release (IR) dose, and before 24 hours since last oral controlled release (CR) dose ²⁹
 - Ensure your patient is aware that treatment cannot take place if they are intoxicated OR if they are not in withdrawal ²⁰
 - Remind the patient not to drive or operate heavy machinery during the first day of treatment ²⁰
 - Watch for signs of sedation whenever the dose of buprenorphine-naloxone is increased and gage whether to tell patient to refrain from driving or operating heavy machinery accordingly
- Ensure that your patient knows to allow the buprenorphine-naloxone tablet to dissolve under their tongue completely; this should take about 10 minutes ²¹
- Schedule follow-ups by phone or in office ⁹
 - Set up specific times that the patient can call you

DAY OF TREATMENT

- Advise the patient to use [SOWS](#). If withdrawal score is 17+ then they may take their first dose of buprenorphine-naloxone ⁹
- Patient is to take 2 mg x 2 tabs SL ²⁹
 - If the patient is still in withdrawal after 2 hours, they may take another 2 mg x 2 tabs SL. Maximum total dose is 12 mg (6 tablets) in 24 hours
 - If the patient is still in withdrawal after another 4 hours, they may take 1-2 tabs
- Patients following home treatment instructions should be logging the total dose taken (number of tablets). **The total dose taken on Day 1 is the Day 2 starting dose** ⁹

DAY TWO OF TREATMENT

- Day 2** maximum dose 16 mg
- Plan to check-in by phone in the morning so that the prescription can be sent to the pharmacy ⁹
- Ask specific questions:¹⁸
 - How long did the dose last?
 - What time did the dose wear off?
 - What were the specific withdrawal symptoms?
 - Did the patient use additional opioids?
 - Was there sedation? Side effects?
- It is recommended that the patient come in for an office visit on Day Three ⁹

ONGOING FOLLOW-UP ASSESSMENT

- Days 3-4** maximum dose 24 mg
- Review the same questions in "Day Two of Treatment" in the following weeks. Reassess the patient on days two to four. Increase dose by 2-4 mg at each visit if the patient reports withdrawal symptoms or cravings towards the end of a dosing interval. Each dose increase should increase the duration of the patient's relief from withdrawal and cravings ²⁹
- One urine sample per month or at every visit. See [Section H](#) for more information

SECTION H: Follow-up visits and maintenance

- After two to four weeks, stable patients can take their medication at home. Consider if your patient is stable on buprenorphine-naloxone:
 - Patients are considered stable if they are attending appointments, getting their dose regularly, and there is no ongoing opioid use, verified by UDS
- Take home doses are typically increased every one to two weeks to a maximum of six for three to six months, and can then be increased to two to four weeks of take home doses at a time
- Take home doses are usually reduced if there is a recurrence of problematic substance use
- Arrange frequent office visits for counseling.
 - Frequency of office visits should be proportionate to the patient’s level of stability
 - In the early stabilization stage, visits are typically weekly
 - Later stabilization every two weeks
 - Maintenance stage typically every four weeks

Urine Drug Screening (UDS)

- Stable patients should provide at least one urine sample per month or at every visit (typically monthly for patients who are stabilizing or in the earlier phase of maintenance)
 - A minimum of four urine drug screens (24 hour notice) is recommended in the first year for patients who are very stable and are seen less frequently⁹
- Review unexpected results with the patient and, if necessary, with an addiction physician
 - If your patient’s UDS results are positive with signs of opioids and/or other drug use, it is essential to understand why the test results are positive. Identify if the patient is experiencing withdrawal symptoms or cravings, if they are in need of strategies for dealing with cravings and triggers, and if there is another substance use issue. Use non-stigmatizing language, and discuss the primary cause before taking action
 - Create a plan with your patient if they come back with multiple positive UDS results. If it is a continuous issue, refer to a specialist to get a second opinion
- Consider lab testing UDS over point-of-care test
 - Point-of-care tests are more costly, and must be interpreted with caution because of false positives and false negatives¹¹
 - Lab test results are more accurate and can indicate additional substances and metabolites¹¹
- Practitioners may request random urine drug screens UDS and random pill counts to reduce the risk of diversion



Talking points

Ask about withdrawal symptoms or cravings; sometimes patients require minor dose adjustments of 2–4 mg/day

“Have you had any withdrawal symptoms?”
 “Have you had any cravings lately?”

Ask about any substance use

“Have you been using any substances to cope with withdrawal?”

Ask about overall mood and functioning

“How have you been feeling?”
 “Are you able to complete chores and tasks during the day?”
 “Are you attending work?”

UDS that show signs of opioids and/or other drug use

“Your UDS results show that you have been using opioids. Why is that? Are you using opioids to cope with withdrawal symptoms? Are you feeling pain? It is normal to feel pain, and we want to understand why you are experiencing this discomfort. As your provider, I am here for you.”

“Your UDS results show continuous substance use, and I think we should talk to a specialist to discuss adjusting your OAT to address the issues that you are facing. I will help you every step of the way.”

For patients who do not stabilize on buprenorphine-naloxone

- If a patient fails to stabilize on buprenorphine-naloxone, try to identify if there are other mental health issues going on
 - Ask: “How is your mood?” “Are you experiencing a lot of anxiety?”
- Consider the Patient Health Questionnaire (PHQ-9)³⁰ and the Generalized Anxiety Disorder 7-item (GAD-7) scale³¹ for further screening
- Also consider having a discussion with the patient about an alternative in treatment modalities:¹¹
 - This could include remaining on buprenorphine-naloxone and referring the patient for more intensive counseling or to a residential treatment program¹¹
 - It could involve referring the patient to a physician experienced in addiction medicine for consideration of a switch from buprenorphine-naloxone to methadone maintenance treatment.¹¹

Consider the following screening questions to identify the cause of the patient not stabilizing²⁰

Is the dose adequate?	Ask “Are you experiencing withdrawal symptoms?”
Is the patient using other illicit substances?	Ask “Are you taking any substances to cope with your withdrawal?”
Is the patient experiencing perceived withdrawal symptoms?	Ask “Are you experiencing pain? shakiness? sweats?”
Are there other active health issues present in the patient?	Ask “Do you have any chronic conditions?”
Are there factors present in the patients life that is putting them at risk?	Ask “Are you able to access your pharmacy easily?” Ask “How are things at home?”



Missed doses: If six or more daily consecutive doses are missed, a loss of tolerance to buprenorphine-naloxone may have occurred and patients may require re-stabilization.⁹

Refer to this chart if six or more daily consecutive doses are missed:

Dose	Suggested Dose Adjustment
2 mg/0.5 mg - 4 mg/1 mg	No change
6 mg/1.5 mg - 8 mg/2 mg	Restart at 4 mg/1mg
> 8 mg/2mg	Restart at 8 mg/2 mg



If the patient displays persistent, problematic use of non-opioid substances, consideration should be given to refer the patient for intensive psychosocial treatment or consulting with a physician experienced in addiction medicine for the management of these disorders.¹¹

If treatment is not effective or patient is not able to tolerate buprenorphine-naloxone, try consulting experts and specialists through [OTN eConsult^v](#), [MMAP^{viii}](#), and [Project ECHO for Chronic Pain/Opioid Stewardship^{xx}](#) to pinpoint the cause, before putting your patient on second-line therapy of methadone²⁰

SECTION I: Tapering off buprenorphine-naloxone

It is important to acknowledge that treatment failure and success does not rely on the duration of a patient being on OAT. OUD is a chronic, relapsing condition that requires a life-long dedication to its management. The end goal of every OAT is to not necessarily taper off of the medication, as every patient's journey is unique and individual to their own needs. Providers must discuss at length how long their patients should remain on treatment and how treatment should be managed.

This section is relevant for patients who have been identified as appropriate candidates for tapering off of buprenorphine-naloxone.



When to taper buprenorphine-naloxone

Ultimately, it is the patient's choice if and when they want to taper off buprenorphine-naloxone. However, it is important to inform all patients inquiring about tapering that longer term (>6-12 months) treatment generally is associated with better outcomes.⁹



Indications for buprenorphine-naloxone tapering¹

The decision to taper should be individualized and patient-centred, based on factors such as:

- Prescriber evaluation of patient's clinical and social stability;
- High visit attendance/adherence;
- Continued abstinence from non-medical opioid use;
- Re-entry into school, work, and volunteering;
- Housing stability;
- Family stability and the presence of a support system;
- Patient insight into triggers and well-developed relapse prevention plan;
- Existing physical and mental health issues are addressed and well-controlled; and
- Patient's desire to taper treatment is not due to outside pressures or circumstances.⁹



Talking points

"How long you stay on these medications is up to you. However, you are much less likely to relapse if you taper off of these medications gradually once your life becomes more stable, and you have not used nonprescribed opioids for at least six months. In general, the longer you have been addicted to opioids, the longer you should stay on buprenorphine-naloxone."⁷

"You will be told how to taper the medication slowly and safely. This decreases the risk of going through withdrawal symptoms. If you have very strong urges, or if you relapse, you should go back on the medication."⁷



Example of buprenorphine-naloxone tapering protocol

- Decrease dose by small amounts, e.g. 2 mg or even 1 mg at doses less than 6 mg at a time.
- Leave at least two weeks, preferably longer, between dose decreases.
- Put the taper on hold at the patient's request, or if the patient experiences withdrawal symptoms or cravings.
- Return to the original dose if the patient begins using opioids again, even in small amounts or intermittently.
- Provide regular support and encouragement.
- Emphasize that it is not a "failure" if the taper has to be held or reversed, and it is safe and acceptable to remain on buprenorphine-naloxone for long periods when necessary.

Provider resources

- i. Canadian Medical Association Journal (CMAJ) Management of opioid use disorders: a national clinical practice guideline <https://link.cep.health/oud14>
- ii. DSM-5 OUD criteria <https://link.cep.health/oud15>
- iii. Clinical Opiate Withdrawal Scale (COWS) <https://link.cep.health/oud9>
- iv. Subjective Opiate Withdrawal Scale (SOWS) <https://link.cep.health/oud10>
- v. Ontario Telemedicine Network (OTN) eConsult <https://link.cep.health/oud3>
- vi. The Centre for Addiction and Mental Health (CAMH) Opioid Dependence Treatment (ODT) Certificate Program <https://link.cep.health/oud7>
- vii. META:PHI RAAM Clinics <https://link.cep.health/oud1>
- viii. Ontario College of Family Physicians (OCFP) Medical Mentoring for Addictions and Pain (MMAP) <https://link.cep.health/oud2>
- ix. Machealth Buprenorphine Reference Guide <https://link.cep.health/oud8>
- x. Women's College Hospital (WCH) Safe opioid prescribing and managing opioid use disorder: A pocket reference for primary care providers <https://link.cep.health/oud16>
- xi. Ontario Pharmacists Association (OPA) OTA line <https://link.cep.health/oud5>
- xii. Ontario College of Family Physicians (OCFP) Opioid Management <https://link.cep.health/oud17>
- xiii. Substance Abuse and Mental Health Services Administration (SAMHSA) TIP 63: Medications for Opioid Use Disorder <https://link.cep.health/oud18>
- xiv. National Institute on Drug Abuse (NIH) Talking to Patients About Sensitive Topics: Communication and Screening Techniques for Increasing the Reliability of Patient Self-Report <https://link.cep.health/oud19>
- xv. The College of Physicians and Surgeons of Ontario Methadone Program <https://link.cep.health/oud6>
- xvi. BC Guidelines Opioid Use Disorder: Diagnosis and Management in Primary Care <https://link.cep.health/oud20>
- xvii. CAMH Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline <https://link.cep.health/oud21>
- xviii. Government of Canada Awareness Resources for Opioids <https://link.cep.health/oud22>
- xix. Ontario Harm Reduction Distribution Program (OHRDP) Find a needle syringe program <https://link.cep.health/oud23>
- xx. Project ECHO for Chronic Pain/Opioid Stewardship <https://link.cep.health/oud4>

Patient resources

- xxi. Women's College Hospital Opioid Use Disorders A Guide for Patients <https://link.cep.health/oud24>
- xxii. eCouch Self Help <https://link.cep.health/oud25>
- xxiii. Subjective Opiate Withdrawal Scale (SOWS) <https://link.cep.health/oud10>

Mental health resources

- xxiv. Ontario 211 <https://link.cep.health/oud26>
- xxv. Ontario College of Family Physicians (OCFP) Collaborative Mental Health Network (CMHN) <https://link.cep.health/oud2>
- xxvi. CAMH Opioid Addiction <https://link.cep.health/oud27>

Addiction counseling, stress-management strategies and tools for preventing relapse

- xxvii. ConnexOntario <https://link.cep.health/oud28>
- xxviii. Women's College Hospital Substance Use Service/Addictions Medicine Resources <https://link.cep.health/oud29>

Resources for social needs such as housing and income support

- xxix. Poverty Tool [cep.health/poverty](https://link.cep.health/poverty)
- xxx. ConnexOntario <https://link.cep.health/oud28>
- xxxi. Ontario 211 <https://link.cep.health/oud26>

Chronic pain resources

- xxxii. Management of Chronic Non-Cancer Pain Tool [cep.health/cncp](https://link.cep.health/cncp)
- xxxiii. The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain <https://link.cep.health/oud31>

Resources to reduce stigma

- xxxiv. Changing how we talk about substance use a resource from the government of Canada <https://link.cep.health/oud32>
- xxxv. Substance Abuse and Mental Health Services Administration (SAMHSA) Words Matter: How Language Choice Can Reduce Stigma <https://link.cep.health/oud33>
- xxxvi. CAMH Understanding Stigma <https://link.cep.health/oud34>

Courses for providers

- xxxvii. The Centre for Addiction and Mental Health (CAMH) Opioid Dependence Treatment (ODT) Certificate Program <https://link.cep.health/oud7>
- xxxviii. The College of Physicians and Surgeons of Ontario Methadone Program <https://link.cep.health/oud6>
- xxxix. Machealth Opioids Clinical Primer <https://link.cep.health/oud35>

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