BCCSU

2023 CLINICAL SUMMARY RESOURCE

Updates to the Opioid Use Disorder Guideline

This clinical summary resource document provides a high-level **overview of key clinical changes to the 2023 update** to A Guideline for the Clinical Management of Opioid Use Disorder (OUD Guideline).

Each section includes corresponding page numbers in the guideline to facilitate navigation. There is also a medication-specific package, which accompanies this resource.

Download this PDF from bccsu.ca/opioid-use-disorder

BCCSU

2023 CLINICAL SUMMARY RESOURCE *Updates to the Opioid Use Disorder Guideline*

Summary of Recommendations

	Recommendation	Quality of evidence	Strength of recommendation[a]
	Pharmacological Treatment		
1	Adults with opioid use disorder (OUD) should be offered opioid agonist treatment (OAT) as the standard of care.	High	Strong
2	Prescribers should work with each patient to determine which of the following OAT medications are most appropriate based on the patient's circumstances, goals, and previous treatment experiences.		
	• Buprenorphine/naloxone[b]	High	Strong
	• Methadone	High	Strong
	• Slow-release oral morphine	Moderate	Strong
3	Transition between OAT medications should be facilitated if indicated by clinical circumstances or patient preference.	Low	Strong
4	Patients stable on 8mg–24mg sublingual buprenorphine/naloxone may be offered the monthly extended-release formulation of buprenorphine if indicated by patient preference or circumstances.	Low	Strong

[a] GRADE criteria were used to ascertain and describe the quality of evidence (possible categories include: high, moderate, low, very low) and strength of recommendation. Possible designations for strength of recommendation include strong and weak (conditional).
- A strong recommendation implies that all patients in a specific situation would want the recommended course of action and that only a small proportion of the general patient population would not.
- A weak (conditional) recommendation suggests that most patients in specific situations would want the recommended course of action but many would not. In the context of this guideline, a weak (conditional) recommendation would be applicable in specific situations where factors such as strong patient preference, limiting circumstances, or contraindications would preclude the use of other generally preferable options.

[b] In the absence of patient preference or other patient-specific factors that would favour other medications, buprenorphine/naloxone may be considered as the favourable option due to its superior safety profile.

Summary of Recommendations

	Recommendation	Quality of evidence	Strength of recommendation
	Pharmacological Treatment		
5	Injectable OAT with diacetylmorphine or hydromorphone should be considered for adults with severe OUD and ongoing unregulated injection opioid use who have not benefitted from, or have declined, oral options for OAT.	Moderate	Weak (Conditional)©
6	Opioid agonist treatment should be viewed as an open-ended treatment. However, if a patient wishes to discontinue medication following a sustained period of stability on OAT (12 months or more), a slow taper should be offered.	Moderate	Strong
7	For adults who choose to discontinue OAT, a relapse prevention plan should be collaboratively developed and implemented after a discussion of both pharmacological and nonpharmacological options.	Low	Strong
8	Oral naltrexone is not a recommended treatment for adults with opioid use disorder. However, it may be offered to individuals who have declined or discontinued OAT and would prefer non-opioid treatment.	Low	Weak (Conditional)
9	While extended-release naltrexone is not currently available in Canada, it is an evidence-based treatment that may be considered for patients with opioid use disorder who are not interested in OAT.	Moderate	Weak (Conditional)

© Note: This recommendation is endorsed from the 2019 CRISM National iOAT Clinical Guideline, which used "conditional" for this recommendation. It is analogous to a "weak (conditional)" recommendation.

Summary of Recommendations

	Recommendation	Quality of evidence	Strength of recommendation
	Non-Pharmacological Treatment		
10	Withdrawal management alone (including rapid opioid agonist tapers) without transition to OAT is not recommended.	Moderate	Strong
11	If the patient chooses to pursue withdrawal management (e.g., slow opioid agonist taper), this should be conducted in an outpatient setting, followed by a collaboratively developed relapse prevention plan and referral to long-term psychosocial treatment and support.	Moderate	Strong
12	Psychosocial treatment interventions and supports should be routinely offered to adults with OUD, in conjunction with pharmacological treatment.	Moderate	Strong
	Harm reduction		
13	Conversations about safer drug use, take-home naloxone, and referral to other harm reduction services should be routinely offered as part of standard care for individuals with OUD.	Moderate	Strong

OAT Medication Selection

Prescribers should work with each person to determine the most appropriate OAT medication based on:

- Individual circumstances
- Goals
- Previous treatment experiences

Three oral OAT options may be considered:

- Buprenorphine/naloxone
- Methadone
- Slow-release oral morphine (SROM)

Extended-release injectable buprenorphine may also be considered

Key changes

- No longer ranking oral OAT medications as first-, second-, or third-line treatment
  - Slow-release oral morphine is no longer considered a specialist-led option
  - Evidence on the safety and efficacy of SROM is limited in comparison to buprenorphine/naloxone and methadone
  - In the absence of individual preference or individual-specific factors that would favour other medications, buprenorphine/naloxone may be considered as the favourable option due to its superior safety profile
- Extended-release buprenorphine (brand name Sublocade)
  - Administered monthly via abdominal subcutaneous injection
  - Indicated for individuals who have been clinically stabilized on 8mg to 24mg of sublingual buprenorphine/naloxone for a minimum of 7 days (d)
  - Initial monthly doses of 300mg for 2 months, followed by monthly maintenance doses of 100mg
    - Some individuals may benefit from a maintenance dose of 300mg

(d) Individuals stabilized on >24mg of buprenorphine/naloxone or those who have been on buprenorphine/naloxone for fewer than 7 days may be candidates for extended-release buprenorphine; however, prescribing in these circumstances is outside of the indication specified in the product monograph.

Decision Support Tool for Selecting OAT

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	**Extended-release buprenorphine**		
Retention in treatment	May be slightly lower than methadone; retention improves at higher doses (above 16mg)	Substantially higher than placebo	Potentially slightly better treatment retention than buprenorphine/naloxone	Non-inferior to methadone
Initiation				
Requires withdrawal prior to induction	**Traditional induction:** Yes. Requires moderate withdrawal prior to induction **Low-dose induction:** No. Does not require prior withdrawal, allowing for comfortable start	No. Does not require a period of withdrawal, but requires prior stabilization on sublingual buprenorphine/naloxone	No. Does not require a period of withdrawal. May be easier to initiate	No. Does not require a period of withdrawal. Comparable process to methadone, with faster titration
Time to achieve therapeutic dose	**Traditional induction**: (1–3 days) Shorter time to achieve therapeutic dose **Low-dose induction**: (5–10 days) Takes longer to reach therapeutic dose	Two months on 300mg injections, followed by 100mg maintenance dose	(May take weeks) Longer time to achieve therapeutic dose	1-2 weeks
Requires stabilization on oral OAT prior to initiation	N/A	Requires stabilization on sublingual buprenorphine/naloxone prior to initiation	N/A	N/A
Side effects				
Side effects	Milder side effect profile	Medication adverse effects are similar to buprenorphine/ naloxone Injection site pain and pruritus	More severe dose-dependent side effect profile (e.g., sedation, weight gain, erectile dysfunction, cognitive blunting)	Comparable to methadone, though less well-described Possibly fewer subjective side effects

Decision Support Tool for Selecting OAT

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	**Extended-release buprenorphine**		
Safety				
Risk of overdose	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants	Low. Due to ceiling effect for respiratory depression in the absence of concurrent use of central nervous system (CNS) depressants	Higher. Particularly during treatment initiation	Comparable safety profile to methadone, though less well-described
Drug-drug interactions	Few	Few	Higher potential for adverse drug-drug interactions (e.g., antibiotics, antidepressants, antiretrovirals)	Fewer than methadone
Risk of precipitated withdrawal during initiation	Yes	No	No	No
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated
Rotation				
Rotation	Easier to rotate from buprenorphine/naloxone to methadone or SROM	Comparable to buprenorphine/naloxone	Risk of precipitated withdrawal when rotating to buprenorphine/naloxone May be rotated directly to SROM	Risk of precipitated withdrawal when rotating to buprenorphine/naloxone May be rotated directly to methadone

Decision Support Tool for Selecting OAT

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	**Extended-release buprenorphine**		
Tapering off				
Tapering off	Milder withdrawal symptoms; easier to discontinue. May be a better option for individuals with lower-intensity physical opioid dependence	Milder withdrawal symptoms Buprenorphine concentrations are decreased slowly over time following the last injection and may take months for buprenorphine to leave the system completely	More severe withdrawal symptoms	Comparable to methadone
Dosing				
Dosing	Health Canada-approved maximum dose of 24mg, but higher doses (up to 32mg) may be necessary for some people Alternate day dosing possible May be suboptimal for individuals with very high opioid tolerance	First two months: Monthly dose of 300mg Maintenance dose: Monthly dose of 100mg (though some patients may benefit from remaining at a 300mg maintenance dose)	No maximum dose specified in the product monograph	No maximum dose specified in the product monograph
Take-home doses	Suitable for immediate take-home doses, including take-home initiation when indicated, which may contribute to increased people autonomy and cost savings Advantageous for rural and remote locations	N/A	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with DWI • Clinical and psychosocial stability	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with DWI • Clinical and psychosocial stability

Dosing and Titration
Low-dose Buprenorphine/naloxone Induction

Low-dose buprenorphine/naloxone inductions reduce barriers to successful inductions, as they do not require that individuals reach moderate withdrawal prior to induction.

Low-dose induction dosing will depend on the individual's particular circumstances (e.g., opioids used, time since last use, preferences). Protocols for 7- and 8-day low-dose inductions should be combined with individualized assessment.

Key changes

Low-dose buprenorphine/naloxone induction is an induction method that slowly up-titrates low doses of buprenorphine/naloxone without cessation of all other opioids until a therapeutic dose has been reached

- May be preferred induction method for people who currently use fentanyl or other intermediate- and long-acting opioids, depending on individual preference
- Does not require a period of withdrawal
- Can be co-prescribed with a full-agonist to reduce reliance on the unregulated drug supply during induction

Low-dose induction dosing will depend on the individual's particular circumstances (e.g., opioids used, time since last use, preferences). Protocols for low-dose inductions should be combined with individualized assessment.

Table 1. Sample 7-day low-dose induction protocol

Day	Buprenorphine /naloxone Dose	Number of times a day	Other opioids
1	0.5mg/0.125mg	2	Continue full agonist use
2	0.5mg/0.125mg	3	Continue full agonist use
3	1mg/0.25mg	2	Continue full agonist use
4	2mg/0.5mg	2	Continue full agonist use
5	2mg/0.5mg	3	Continue full agonist use
6	4mg/1mg	3	Continue full agonist use
7	12mg/3mg	1	Stop other use

A BID 8-day induction protocol may be preferable for some individuals due to consistent dosing.

Dosing and Titration

Dosing and titration protocols for OAT medications have been updated based on new literature and clinical experience. These include modified starting doses, titration protocols, and maximum daily doses that address increased opioid tolerance due to the presence of fentanyl in the unregulated drug supply.

Starting Doses

Starting doses depend on factors that affect the person's risk of toxicity, including:

- Known opioid tolerance
- Current opioid use
- Co-occurring substance use patterns

Buprenorphine/naloxone

- No change from 2017 guideline
- Starting dose of 2mg/0.5mg to 4mg/1mg, based on risk of precipitated withdrawal

Methadone

Key change:
A starting dose of 30mg–40mg for individuals who currently use fentanyl and have previous experience with methadone

Table 1. Methadone starting doses based on individual's opioid tolerance

Level of tolerance	Suggested starting dose
No/low tolerance | opioid-naïve High risk of toxicity Individuals who do not use opioids regularly or those without any opioid tolerance Includes individuals who have completed withdrawal management, those not currently using opioids but at risk of return to use, individuals with heavy use of other sedating agents, and individuals with severe comorbidities that affect toxicity risks	5–10mg/day
Unknown/moderate tolerance Moderate risk of toxicity Includes individuals who use benzodiazepines or other sedatives (prescribed or unprescribed), individuals with alcohol use disorder	10–20mg/day
Known high tolerance Lower risk of toxicity Individuals actively using opioids (at least once per day, less than once per day at clinician discretion)	20–30mg/day
Known very high tolerance Very low risk of toxicity **Characterized specifically by previous methadone experience and current fentanyl use**	30–40mg/day

Dosing and Titration

Starting Doses

Slow-release Oral Morphine

Key changes:

- Starting doses range between 50–300mg based on individual tolerance
- Pharmacists will dispense SROM as a capsule to be swallowed whole. If clinically indicated or preferred by the person, the capsule may be opened and sprinkled for immediate ingestion

Table 2. Slow-release oral morphine starting doses based on individual's opioid tolerance

Level of tolerance	Suggested starting dose
No/low tolerance | opioid-naïve High risk of toxicity Individuals who do not use opioids regularly or those without any opioid tolerance. Includes individuals who have completed withdrawal management, those not currently using opioids but at risk of return to use, individuals with heavy use of other sedating agents, and individuals with severe comorbidities that affect toxicity risks.	50mg/day
Unknown/moderate tolerance Moderate risk of toxicity Includes individuals who use benzodiazepines or other sedatives (prescribed or unprescribed), individuals with alcohol use disorder.	100–150mg/day
Known high tolerance Lower risk of toxicity Individuals actively using opioids (at least once per day, less than once per day at clinician discretion).	200mg/day
Known very high tolerance Very low risk of toxicity **Characterized specifically by previous SROM experience and current fentanyl use**	300mg/day

Dosing and Titration

Dose Escalation

Titration on OAT should be guided by the individual's opioid tolerance and clinical discretion. Depending on individual circumstances, titration may be maintained, slowed, or sped up.

Buprenorphine/naloxone

- No change from 2017 guideline
- Traditional induction: additional 2mg/0.5mg to 4mg/1mg every 1–3 hours if withdrawal symptoms are not adequately relieved

Methadone

Key change:

Opioid Tolerance	Dose Increase
High opioid tolerance (i.e., documented history of fentanyl use) and experience with methadone	• Titrated by a maximum of 15mg every 3 days • Once the daily dose reaches approximately 85mg, the titration process should be slowed to a maximum of 10mg every 3–5 days
Lower or unknown tolerance, no active fentanyl use, or those who have no history of OAT with methadone	• Doses should be increased more cautiously (e.g., 5–10mg every 3–5 days)

Slow-release Oral Morphine

Key change:

- Increase dose by up to 100mg every 24–48 hours after the initial starting dose
  - Assess individual for sedation prior to dose increases

Dosing and Titration

Maximum and Stabilization Doses

The maximum dose for buprenorphine/naloxone has increased to address higher opioid tolerance due to the presence of fentanyl in the unregulated drug supply. While there is no evidence for higher stabilization doses of methadone or SROM, clinical experience indicates that higher doses may be needed.

Buprenorphine/naloxone

Key change:

A daily dose of up to 32mg/8mg may be reasonable and can be provided safely to address the high opioid tolerance of people who use fentanyl[1]

Methadone

Key change:

- No defined maximum dose
- A daily dose of 150mg or higher may be required to address the high opioid tolerance of people who use fentanyl

Slow-release Oral Morphine

Key change:

- No defined maximum dose
- The highest dose described in the literature to date is 1200mg
  - However, clinical experience indicates that doses above 1200mg are often required to address the high opioid tolerance of people who use fentanyl

References:

1. Herring AA, Vosooghi AA, Luftig J, et al. High-Dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder. JAMA Network Open. 2021;4(7):e2117128-e2117128. doi:10.1001/jamanetworkopen.2021.17128

Managing Precipitated Withdrawal

Precipitated withdrawal can occur when the first dose of buprenorphine/naloxone is administered to a person who has been using full agonist opioids before they have achieved a moderate stage of opioid withdrawal (Clinical Opiate Withdrawal Scale [COWS] score greater than 12 or Subjective Opiate Withdrawal Scale [SOWS] score greater or equal to 17).

Identifying Precipitated Withdrawal

Precipitated withdrawal may be evident within 30–60 minutes after the first buprenorphine/naloxone dose. Individuals will feel markedly worse after their first dose.

Signs and symptoms of precipitated withdrawal include:

- Muscle aches and pains
- Fever
- Cramping
- Sweating
- Dilated pupils
- Insomnia
- Diarrhea
- Rapid heart rate
- High blood pressure

Starting Buprenorphine/naloxone Dose to Avoid Precipitated Withdrawal

During a traditional buprenorphine/naloxone induction, the starting dose of buprenorphine/naloxone may be increased if there is a lower risk of precipitated withdrawal.

Table 1. Recommended starting buprenorphine/naloxone dose based on risk of precipitated withdrawal

Indication	Starting dose	Total Starting Dose
Concern about precipitated withdrawal	One 2mg/0.5mg buprenorphine/naloxone tablet	2mg/0.5mg buprenorphine/naloxone
Low risk of precipitated withdrawal	Two 2mg/0.5mg buprenorphine/naloxone tablet	4mg/1mg buprenorphine/naloxone

Managing Precipitated Withdrawal

Time Since Last Opioid Use to Avoid Precipitated Withdrawal

During a traditional buprenorphine/naloxone induction, individuals should:

- Abstain from opioid use for a minimum amount of time, based on the opioid's duration of action
- Reach moderate withdrawal prior to induction

Key Changes:

- Increased duration of time since last opioid use for intermediate- and long-acting opioids

Table 2. Recommended duration of time since last opioid use to prevent precipitated withdrawal

Short-acting opioids	≥12 hours since last dose	***Examples:*** *heroin, oxycodone, hydromorphone*
Intermediate-acting opioids	≥ 24 hours since last dose	***Examples****: slow-release oral morphine, fentanyl (confirmed or suspected)*
Long-acting opioids	48–72 hours or more since last dose	***Example****: methadone*

Managing Precipitated Withdrawal

Explain to the client what has occurred and offer reassurance that symptoms will resolve

> *"Suboxone is really "sticky" but has less of an opioid effect than fentanyl. This means that Suboxone kicks the fentanyl off of your receptors and replaces it with a much less potent opioid, which can make you feel uncomfortable and very sick. We have some options to help you feel better. Shall we talk about them?"*

·Discuss the options presented below and engage in shared decision-making in developing a plan for management

> *"What are your goals for today? If you want to be on buprenorphine/naloxone by the end of the day, we can give you additional doses but this may make you feel worse before you feel better. We can also give you some medications that can help you feel better during this time.*
>
> *If you feel like it is too uncomfortable, we can try again in the future or explore other options of OAT. We'll work together to find the best approach to help you achieve your goals."*

Managing Precipitated Withdrawal

Options for Managing Precipitated Withdrawal

Key changes

- Describes options for managing precipitated withdrawal: continue, delay, or stop the induction, or provide a high dose of buprenorphine/naloxone

Option 1: Continue induction

1. Give additional doses of 2mg/0.5mg buprenorphine/naloxone every 1–2 hours until withdrawal symptoms are resolved.
2. Inform the person that additional doses of buprenorphine/naloxone can initially worsen withdrawal symptoms before improvement.
3. Offer non-opioid adjuncts for symptom management.

Option 2: Delay induction

1. Wait a few hours to allow the full agonist to clear opioid receptors before administering the next buprenorphine/naloxone dose.
2. Offer non-opioid adjuncts to treat withdrawal symptoms as needed.
3. Continue giving doses until withdrawal symptoms are resolved or Day 1 maximum dose is reached.

Option 3: Stop induction

1. Provide reassurance that symptoms will resolve as the buprenorphine detaches from the opioid receptors and the full agonist can resume its activity.
2. Offer non-opioid adjuncts and/or short-acting full opioid receptor agonists to treat withdrawal symptoms as needed.
3. Offer to discuss a plan for a future induction attempt or an alternate form of OAT.

Option 4: High dose of buprenorphine/naloxone

1. Provide additional doses of buprenorphine/naloxone, typically from 8mg/2mg to 24mg/6mg. Several high doses of buprenorphine/ naloxone may be necessary.
2. Inform the person that they can expect to feel better within a few hours of receiving a high dose of buprenorphine/naloxone.

Managing Precipitated Withdrawal

Options for Managing Precipitated Withdrawal

Note: Providing a high dose of buprenorphine/naloxone is an emerging practice based on accumulating clinical experience and available case studies.[1-3]

Once you have decided on the best option for an individual, you may need to prescribe or provide adjunct medications to help treat withdrawal symptoms.

- Offer non-opioid adjuncts to treat withdrawal symptoms
  - Clonidine: 0.1–0.2mg PO PRN every 4 hours for <12 hours
  - Acetaminophen: 325–1000mg PO PRN every 4 to 6 hours (maximum 4000mg/day; 2000mg for older adults or those with liver impairment)
  - Dimenhydrinate: 50–100mg PO PRN every 6 hours
  - Ibuprofen: 400mg PO PRN every 4 hours
  - Loperamide: 2–4mg PO PRN every 6 hours (maximum 16mg/day)
- Specialty consultation (e.g., the RACEapp or 24/7 Addiction Medicine Clinician Support Line) may be contacted for support

References:

1. Quattlebaum THN, Kiyokawa M, Murata KA. A case of buprenorphine-precipitated withdrawal managed with high-dose buprenorphine. Fam Pract. Mar 24 2022;39(2):292-294. doi:10.1093/fampra/cmab073
2. Oakley B, Wilson H, Hayes V, Lintzeris N. Managing opioid withdrawal precipitated by buprenorphine with buprenorphine. Drug and alcohol review. May 2021;40(4):567-571. doi:10.1111/dar.13228
3. Hailozian C, Luftig J, Liang A, et al. Synergistic Effect of Ketamine and Buprenorphine Observed in the Treatment of Buprenorphine Precipitated Opioid Withdrawal in a Patient With Fentanyl Use. Journal of Addiction Medicine. 2022;16(4)

Missed Doses Protocols

Missed doses protocols have been simplified based on clinical experience and alignment with other North American guidelines.

Buprenorphine/naloxone

Key changes:

- Separate protocols based on if the person has returned to full opioid agonist use
- The dispensing pharmacy is required to cancel the prescription and notify the prescribing clinician if the individual misses:
  - 6 consecutive days, without return to full opioid agonist use
  - 4 consecutive days, with return to full opioid agonist use

Table 1. Protocol for missed buprenorphine/naloxone doses without return to full opioid agonist use

Consecutive missed once-daily doses	Suggested protocols
≤5 without return to full agonist use	Resume without dose reduction
≥6 without return to full agonist use	Re-titration is required. The re-titration process should be individually tailored with the goal to re-titrate to previous stable doses within a few days.

Table 2. Protocol for missed buprenorphine/naloxone doses with return to full opioid agonist use

Consecutive missed once-daily doses	Suggested protocols
≤3 days with return to full agonist use	Safe to continue buprenorphine/naloxone without re-induction
4 days with return to full agonist use	Discuss the risk of precipitated withdrawal and weigh them against the benefits of continuing buprenorphine/naloxone
≥5 days with return to full agonist use	New induction may be required

Missed Doses Protocols

Missed doses protocols have been simplified based on clinical experience and alignment with other North American guidelines.

Methadone and Slow-release Oral Morphine

Key change:

- Simplified missed doses protocols
- The dispensing pharmacy is required to cancel the prescription if the individual misses 4 consecutive doses, and notify the prescribing clinician
- Conduct an assessment for a dose reduction after 4 consecutive missed doses

Table 3. Suggested protocol for managing missed methadone doses

Consecutive missed once-daily doses	Suggested dose adjustment
1–3	Same dose (no change)
4	Cancel prescription. Assess. Resume at 50% of previous dose or at 30–40mg (whichever is higher)
5 or more	Cancel prescription. Assess. Restart at 30–40mg (depending on tolerance)

Table 4. Suggested protocol for managing missed SROM doses

Consecutive missed once-daily doses	Suggested dose adjustment
1–3	Same dose (no change)
4	Cancel prescription. Assess. Resume at 50% of previous dose or initiation dose (whichever is higher)
5 or more	Cancel prescription. Assess. Restart at initiation dose

Take-home Dosing

Take-home dosing considerations for oral OAT medications are less restrictive, balancing person-centered care through increased flexibility, reduced treatment burden, and collaborative decision making between clinicians and individuals, with individual and community safety.

Buprenorphine/naloxone

Key change:

- Consider take-home dosing of buprenorphine/naloxone immediately, including during induction, where clinically indicated
- Ongoing substance use is not an absolute contraindication to take-home dosing
- People experiencing homelessness can be considered for take-home dosing

Table 1. Take-home dosing considerations for buprenorphine/naloxone

Considerations

Take-home dosing should be considered immediately, including during induction, if the following criteria are met:
• Clinical and psychosocial stability
  ◦ Generally, the indications of clinical and psychosocial stability include:
  • Ability to attend appointments
  • Absence of unstable psychiatric comorbidities (e.g., psychosis, suicidality)
  • Absence of severe behavioural issues at the clinic
  • Absence of severe sedation
  • Absence of high-risk or uncontrolled substance use patterns that cause frequent overdoses or blackouts
  ◦ Point-of-care assessment of stability is patient-specific, depending on each person's circumstances and needs and how they change over time.
• Ability to safely store medication (access to a secure lockbox or cabinet)

Take-home Dosing

Methadone and Slow-release Oral Morphine

Key change:

- Alignment in take-home dosing criteria for methadone and SROM
- Ongoing substance use is not an absolute contraindication to take-home dosing
- Take-home methadone and SROM doses should start as individual non-consecutive doses for individuals who meet the take-home dosing criteria
- Additional take-home doses can be offered gradually (e.g., every 2 weeks) to individuals who:
  - Consistently manage previous take-home doses
  - Sustain medication adherence
  - Experience improving clinical and psychosocial stability

Table 2. Take-home dosing considerations for methadone and SROM

Number of take-home doses per week	Minimum time on methadone/SROM	Conditions/criteria
0 (not a candidate for take-home doses)	-	Any of: • Inability to safely store medication • Unstable psychiatric illness or other acute mental health crisis • Frequent missed doses and appointments • Ongoing high-risk or uncontrolled substance use patterns

1–3 (non-consecutive take-home doses)	4 weeks	All of:
		• Ability to safely store medication
		• Evidence of medication adherence
		• Clinical and psychosocial stability, including:
		  ◦ Ability to keep appointments and manage medication
		  ◦ No acute behavioral or psychiatric issues at point of assessment
		  ◦ No high-risk or uncontrolled substance use patterns that cause frequent drug poisoning, blackouts, or other severe safety risks

4–6 (consecutive take-home doses)	12 weeks	All of:
		• Consistent medication adherence with rare missed doses and appropriate management of non-consecutive take-home doses
		• Improved clinical and psychosocial stability, including:
		  ◦ Rare missed appointments
		  ◦ Minimal unprescribed substance use, in alignment with treatment plan and individual goals, with no recent drug poisonings, or blackouts

Urine Drug Testing

Urine drug testing guidance has been aligned with the BCCSU's Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment and emphasizes person-centered and collaborative care.

Key changes

- No minimum required number of UDT for individuals on OAT
- Urine drug testing should be performed when the results may impact the treatment plan
  - Should not be used punitively or when results will not impact treatment
- Confirmatory testing should only be ordered when results would change clinical management
- Urine drug tests should be scheduled instead of random
- Urine samples should be collected using supervised UDT procedures in clinical settings
  - Witnessed UDT may contribute to stigma, be experienced as a privacy violation, and should be avoided
- A negative UDT for other opioids or substances is not required to be considered for take-home dosing
- A positive UDT for other opioids or substances alone is not grounds for discontinuation of take-home dosing, switching back to daily witnessed ingestion, or discontinuing treatment

Urine Drug Testing

Table 1. Suggested UDT Frequency

Treatment stage	UDT schedule
Initial confirmatory testing	Performed to confirm unregulated opioid use prior to initiating OAT (e)
Buprenorphine/naloxone	
Induction and stabilization	**Monthly** or more or less frequently as required and when clinically indicated
Maintenance	When clinically indicated
Take-home doses	**2–4 tests per year** or when there are any safety concerns Frequency of UDT is as required when clinically indicated
Methadone and slow-release oral morphine	
Initiation, titration, and stabilization	**Monthly** or more or less frequently as required and when clinically indicated. In circumstances where UDT is occurring less than monthly, individual safety can be increased with daily witnessed ingestion.
Maintenance	When clinically indicated
Take-home doses	**6–8 tests per year** or when there are any safety concerns Frequency of UDT is as required when clinically indicated

(e) Although best practice, there may be situations in which it is reasonable to forgo prior to initiating OAT (e.g., telehealth in a remote setting with significant collateral information, where requiring UDT would constitute an unreasonable barrier; emergency department induction with significant collateral information; a person who has been abstinent but is at risk of return to use).