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Key Updates to A Guideline for the Clinical Management of Opioid Use Disorder

Topic	2017 OUD Guideline	2023 OUD Guideline Update
1. Principles of Care	No principles of care included	Principles of care include: • Patient-centred care • Social determinants of health • Indigenous cultural safety and humility • Anti-racist practices • Trauma- and violence-informed practice • Recovery and self-defined wellness • Harm reduction • Integrated continuum of care • Comprehensive health management • Family and social circle involvement
2. Selecting OAT	• Buprenorphine/naloxone presented as first-line OAT • Methadone presented as option if buprenorphine/naloxone is not preferable • Slow-release oral morphine (SROM) presented as a specialist-led option	• Language around first-line treatment removed • Prescribers should work with each individual to determine which of the following OAT medications is most appropriate, based on individual circumstances, goals, and previous treatment experience ◦ Buprenorphine/naloxone ◦ Methadone ◦ Slow-release oral morphine
3. Extended-release Buprenorphine	No recommendation included	Individuals who have been stabilized on buprenorphine/naloxone may be offered extended-release buprenorphine
4. Injectable OAT	No recommendation included	Injectable OAT with diacetylmorphine or hydromorphone should be considered for adults with severe opioid use disorder and ongoing unregulated injection opioid use who have not benefitted from, or have declined, oral options for opioid agonist treatment (aligned with CRISM iOAT Guideline)

KEY UPDATES

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5. Dosing and Titration	**Buprenorphine/naloxone**	
	• Guidance for traditional inductions • More restrictive considerations for home inductions • Maximum dose: 24mg	• Guidance for low-dose inductions • Relaxed considerations for home inductions • Maximum dose: 32mg
	Methadone	
	• Starting dose: 5–30mg • Dose increases: 5–10mg every 5 days • Optimal therapeutic dose: 60–120mg	• Starting dose: 5–40mg • Dose increases: 5–15mg every 3–5 days • Optimal therapeutic dose: 150mg or higher may be required
	Slow-release oral morphine	
	• Starting dose: not included • Increases: not included • Maximum dose: not included	• Starting dose: 50–300mg • Increase up to 100mg every 24–48 hours • No defined maximum dose
6. Missed Doses	**Buprenorphine/naloxone**	
	• Dose adjustment after 6 or more consecutive missed doses, based on total daily dose • Restart required for missed doses with return to full agonist use	• Re-titration after 6 or more consecutive missed doses without return to full agonist use • Restart or resume after 4 consecutive missed doses with return to full agonist use • Pharmacy to cancel prescription after 6 consecutive missed doses (without return to full agonist use) OR 4 consecutive missed doses (with return to fulll agonist use)
	Methadone	
	• Dose adjustment after 3 or more consecutive missed doses, based on total daily dose	• Dose adjustment after 4 or more consecutive missed doses • Pharmacy to cancel prescription after 4 or more consecutive missed days
	Slow-release oral morphine	
	• Dose adjustment after 2 or more consecutive missed doses, reduction a percentage of daily dose	• Dose adjustment after 4 or more consecutive missed doses • Pharmacy to cancel prescription after 4 or more consecutive missed days

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KEY UPDATES

<table>
<tr><th>Topic</th><th>2017 OUD Guideline</th><th colspan="2">2023 OUD Guideline Update</th></tr>
<tr><td rowspan="5">7. Take-home Dosing</td><td colspan="3">Buprenorphine/naloxone</td></tr>
<tr><td>• Considered at any time once the patient is clinically stable and able to safely store medication at home
• Generally provided as 1–2 weeks' worth of medication at a time
• Experiencing homelessness or ongoing substance use are considerations to restrict daily witnessed ingestion</td><td colspan="2">• Considered immediately for all patients who meet the following criteria:
  ◦ Clinical and psychosocial stability
  ◦ Ability to safely store medication (access to a secure lockbox or cabinet)
• People experiencing homelessness can be considered for take-home dosing
• People who continue to use substances can be considered for take-home dosing</td></tr>
<tr><td>Methadone</td><td>Methadone</td><td>Slow-release oral morphine</td></tr>
<tr><td>The following criteria must be met:
• Appropriate UDTs for a minimum of 12 weeks and established on a stable methadone dose for a minimum of 4 weeks
• Social, cognitive, and emotional stability
• Ability to safely store methadone at home (i.e., secure, locked containers or cabinets)
• No signs of injection drug use during the 12-week monitoring phase and in follow-up</td><td colspan="2">• Criteria aligned for methadone and SROM
• Potential ability to receive take-home doses earlier, based on clinical and psychosocial stability, UDT results, and ability to safely store medication</td></tr>
<tr><td>Slow-release oral morphine
• ·Offered in exceptional circumstances or when daily witnessed ingestion is a significant barrier to treatment
• Distinct and more restrictive criteria compared to methadone</td><td colspan="2"></td></tr>
</table>

# 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 (e.g., causing frequent overdoses, blackouts, or hospitalizations)
1–3 (non-consecutive take-home doses)	4 weeks	**All** of: • Ability to safely store medication • Evidence of medication adherence (e.g., UDT positive for methadone) • Clinical and psychosocial stability (i.e., ability to keep appointments and manage medication, no acute behavioural or psychiatric issues at point of assessment, no high-risk or uncontrolled substance use patterns that cause frequent overdoses, 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. (i.e., rare missed appointments, minimal unprescribed substance use, in alignment with treatment plan and goals, with no recent overdoses or blackouts)

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8. Continuing Care Appendix	Not included	Contains information on: • Concurrent mental health concerns • Ongoing substance use • Acute care and inpatient considerations • Chronic pain • Long-term effects of OAT • Tapering OAT medications • Opioid agonist treatment and driving
9. Emergency Department Bup/nal Induction	Not included	Contains guidance on buprenorphine/naloxone initiation in emergency departments.
10. Urine Drug Testing	Contains limited guidance and information about UDT	Contains updated guidance based on the BCCSU's 2021 *Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment Breakout Resource*, including: • Purposes of UDT • Frequency of UDT • Immunoassay-based UDT • Confirmatory testing • Guidance for UDT for SROM Allows for more clinical discretion regarding frequency. Urine drug testing should be performed when the results may impact treatment plan.

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