BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

Co-occurring Substance Use Principles of Care

Preamble

Co-occurring substance use

- Also called polysubstance use
- Includes prescription and over-the-counter drugs, regulated (alcohol, commercial tobacco products, and cannabis), and unregulated substances (e.g., fentanyl, cocaine)
- Not a clinical diagnosis and does not necessarily indicate one or more substance use disorders (SUD)
- Common and many people who use drugs use more than one substance at a time

  In BC, the majority of toxic drug deaths include multiple substances (e.g., opioids and benzodiazepines, opioids and stimulants)
- Patients may not be aware they have ingested multiple substances

  Inadvertent consumption of additional substances through the unregulated drug supply is common (e.g., unregulated opioid supply is often contaminated with benzodiazepines)

Offer a urine drug test (UDT)

- To help identify substances—this is not a prerequisite to care and should not be used punitively
- Explain to the patient the purpose of a UDT
- Unanticipated false positives and false negatives can occur with UDTs due to cross-reactivity and the inability to reliably detect semi-synthetic and synthetic opioids and some benzodiazepines

  Unanticipated results may also occur due to the patient unknowingly consuming contaminated substances from the unregulated drug supply
- Urine drug tests do not provide information on the timing, frequency, or quantity of substance use

Consider referrals to available patient supports, if patient is interested.

Depending on availability at your hospital, some supports may include:

- Peer navigators
- Indigenous hospital liaisons
- Translation services as needed
- Social worker

General Considerations When Caring for Patients with Co-occurring Substance Use

1) **Discuss and identify a patient's reasons for using multiple substances** and align their care plan with their goals

2) **Prioritize safety**—consider and discuss possible **drug–drug interactions** and **other safety concerns** with the patient when offering treatments and interventions

3) **Treat co-occurring SUDs concurrently**, when possible

4) If time or resources are limited, **triage the patient** according to which SUD has the highest and **most immediate risk of mortality or other harms** using a shared decision-making approach

Asking About Co-occurring Substance Use

- All patients should be screened for substance use using a non-judgmental, trauma-informed, and culturally humble approach, with the goal of providing culturally safe care.
- Any positive screen should prompt further follow up (e.g., DSM-5-TR diagnostic interview).

Risks of Withdrawal

Symptoms of withdrawal from all substances can be extremely distressing and uncomfortable.

Each substance carries different risks associated with withdrawal:

Opioids

- Acute withdrawal symptoms begin within 12–30 hours since last use, depending on the opioid formulation
- Subacute withdrawal symptoms can last for longer, protracted periods of time (e.g., weeks to months) and lead to return to unregulated opioid use
- Unmanaged withdrawal can trigger high-risk unregulated substance use and behaviours, resulting in harms, overdose, or self-initiated discharge
- See *Managing Acute Opioid Withdrawal*

Alcohol

- Withdrawal symptoms begin within 6–24 hours since last use and may last up to 7 days
- Can be life threatening
- Seizures and delirium tremens may occur; delirium tremens may occur 48 hours after last use

Benzodiazepines

- Withdrawal symptoms begin within 24 hours since last use and symptoms can last weeks to months
- Can be life-threatening
- Symptoms often appear like alcohol withdrawal but may be more unpredictable

Stimulants

- Acute withdrawal symptoms begin within 24 hours since last use, and distressing symptoms can last days to weeks
- Unmanaged withdrawal can trigger high-risk unregulated substance use, resulting in harms, overdose, or self-initiated discharge
- See *Managing Stimulant Intoxication and Withdrawal*

Cannabis

- Withdrawal symptoms begin within 24–48 hours since last use, and may last up to 3 weeks in patients who consume high amounts of cannabis
- Withdrawal may occur in patients who use high amounts of cannabis or THC extracts (e.g., butter, shatter)

Co-occurring Substance Use Withdrawal Considerations

- ☐ If a patient discloses substance use and they are not in withdrawal, **develop a treatment plan** that is aligned with the patient's goals.
  - May include withdrawal management plan in anticipation of withdrawal symptoms, or evidence-based long-term pharmacotherapy
- ☐ **Early intervention** (e.g., OAT initiation and/or PRN opioids) can **decrease** the **likelihood or severity** of withdrawal symptoms.
  - A treatment plan should be collaboratively developed with the patient as soon as possible to minimize discomfort and medical sequelae
- ☐ **Withdrawal requires urgent management**. In many cases, management approach is primarily based on patient self-report of withdrawal symptoms.
- ☐ If withdrawal symptoms continue following appropriate withdrawal management approaches, consider that **withdrawal from another substance** may be part of the clinical picture (e.g., inadvertent exposure to benzodiazepines from the unregulated opioid supply).
  - Consider offering a UDT to help determine which substance(s) the patient may be withdrawing from
- ☐ **Withdrawal syndromes can be challenging to distinguish from one another**, and withdrawal and intoxication from another substance can be difficult to distinguish.
- ☐ Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, or RACEapp if withdrawal from more than one substance is suspected.

> ☞ For information on managing opioid withdrawal, see *Managing Acute Opioid Withdrawal* or follow site-specific protocols.
>
> ☞ For information on managing stimulant withdrawal, see *Managing Acute Stimulant Intoxication and Withdrawal* or follow site-specific protocols.
>
> ☞ For information on managing alcohol withdrawal, see site-specific protocols.

Evidence-based Treatment for Substance Use Disorders

Withdrawal management is important to keep the patient safe (e.g., avoid medical sequelae or complications) and comfortable (e.g., withdrawal symptoms are sufficiently managed).

An acute care visit is an opportunity to offer the patient in evidence-based care for co-occurring SUDs, when appropriate. Patients may not be able to consider treatment options until withdrawal and pain are sufficiently managed.

Opioid use disorder (OUD)

Standard of care: **opioid agonist treatment** (buprenorphine/naloxone, extended-release buprenorphine, methadone, slow-release oral morphine).

See *OAT Initiation* or follow site-specific protocols.

Alcohol use disorder (AUD)

First-line pharmacotherapy: **acamprosate, naltrexone**.

See the BCCSU's *Help with Drinking website* and the *AUD Continuing Care Treatment Pathway*.

Benzodiazepine use disorder

Best practice: **tapering** following guidance in the College of Family Physicians of Canada's *Deprescribing Benzodiazepine Receptor Agonists: Evidence-based Clinical Practice Guideline*.

Stimulant use disorder

Refer to **psychosocial treatment** resources in your region (e.g., cognitive behavioral therapy, contingency management, Matrix Model).

See the BCCSU's *Stimulant Use Disorder Practice Update (Part 1)*.

Tobacco use disorder

First-line pharmacotherapy: **nicotine replacement therapy, varenicline, bupropion**.

See the Guidelines and Protocols Advisory Committee's (GPAC) *Tobacco Use Disorder*.

See the Centre for Addiction and Mental Health's *Smoking Cessation*.

Considerations for Pharmacotherapy for Co-occurring Substance Use Disorders

Safety should be prioritized; pharmacotherapies should be selected with consideration of drug–drug interactions (e.g., naltrexone is contraindicated for patients using opioids) and other safety risks (e.g., pre-existing risk of prolonged QT interval).

Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other regional addiction supports as needed

How to Help – Practical Strategies to Keep You and Your Patients Safe

- ☐ It is important to create a space for discussion about substance use that aims to be culturally safe, free of stigma, and anti-racist so that patients feel safe enough that they do not leave before their care is completed

- ☐ Signal safety to people who use substances by using person-centred and trauma-informed principles of care, which:
  - Reduce stigma
  - Increase access to care
  - Reduce conflict

- ☐ Ask how the patient keeps themself safe when they use substances and discuss an overdose prevention plan

- ☐ Clinicians are responsible for making decisions based on the patient's presentation and with the consent of the patient
  - Decisions to provide or administer medications should be based on whether the patient meets the clinical indication for that medication at the time of assessment

- ☐ Develop a plan to reduce harm if the patient continues to use substances or returns to use

- ☐ Offer education on overdose prevention, recognition, and response

  Discuss strategies to prevent overdose:

  - Using with others when possible
  - The Brave app or Lifeguard app
  - National Overdose Response Service
  - Starting with a small amount of substance, especially after a period of abstinence or decreased use (i.e., a "test dose")
  - Share safety concerns and harms (e.g., sedation, overdose) related to co-occurring substance use
    - Increased risk of overdose when using more than one CNS depressant (e.g., benzodiazepines, alcohol, opioids)

- ☐ Encourage the use of harm reduction services in the local area, such as:

  Drug checking services

  - Drug Checking BC provides a list of local drug checking services
  - Get Your Drugs Tested offers testing by mail and is available to all Canadians
  - Substance Drug Checking offers testing by mail for people on Vancouver Island, by drop in in Victoria, and at a number of sites across Vancouver Island

  Supervised consumption sites or overdose prevention services

  - Patients may access support related to safer use strategies and linkages to addiction care
  - Some existing overdose prevention services and supervised consumption sites do not allow substances to be smoked due to ventilation restrictions
  - Discuss potential alternate routes of administration and safety with the patient
  - Offer harm reduction supplies

- ☐ Review signs and symptoms of an overdose to ensure the patient can recognize an overdose

- ☐ Discuss how to respond to an opioid overdose
  - Take-home Naloxone
    - Provide kits early in admission in case the patient self-initiates discharge
    - Review how to use naloxone with the patient, if the patient is interested
  - Nasal Naloxone
    - First Nations patients may access nasal naloxone without a prescription through FNHA at pharmacies across the province
  - Seek medical assistance for overdoses and after naloxone administration

Discharge Planning

Discuss discharge plans as soon as possible and again before anticipated discharge (e.g., determine the patient's pharmacy in case of abrupt discharge), including the continuation or discontinuation of any medications ordered in the hospital.

- Connect with a local OAT clinic and community pharmacy of the patient's preference before the patient is discharged for a seamless transition of care

If initiating BUP-to-go in an ED, provide and review BUP-to-go home induction handouts with the patient.

Provide discharge prescriptions or medications

SL **Buprenorphine/naloxone** can be given or prescribed as take-home doses

Methadone and **SROM** prescriptions to be filled by a community pharmacy must be written by a prescriber who has completed POATSP and a preceptorship

- Liaise with the local inpatient consult team, virtual addiction clinic, or community OAT clinic to ensure a discharge prescription is faxed to a community pharmacy
- Follow organizational protocols on how to discharge a patient when a prescriber is not immediately available

Extended-release buprenorphine may be prescribed upon discharge for community administration by a healthcare professional in a clinical setting (e.g., pharmacy, clinic)

PRN medications

Some patients may need PRN medications (e.g., for acute pain) following discharge

- Generally, discharge prescriptions for PRN medications should be short-term with a plan for outpatient follow-up arranged prior to discharge
- Consider consulting with the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other local addiction medicine resources to discuss discharge PRN medications

Alcohol use disorder pharmacotherapy can be prescribed

Tobacco use disorder pharmacotherapy can be prescribed

Offer non-opioid adjunct medications, if needed

Continuity of care

Offer the patient resources to support continuity of care.

Contact the community pharmacist and/or prescriber directly, when possible, before the patient is discharged.

- Send relevant information to the community prescriber, including a discharge summary and pertinent investigations, procedures, and consultations
  - If the patient requires a community-based OAT prescriber, refer to a local Rapid Access to Addiction Care Clinic (if available in your region) or community addiction clinic
    - OAT Clinics Accepting New Patients
    - Note: Some community OAT providers charge additional clinic fees. Contact clinics before referral to determine if clinic fees are required and discuss with the patient
    - In collaboration with the patient, book an appointment before discharge

Provide linkages or referrals to psychosocial interventions such as counselling, cognitive behavioural therapy, or contingency management, and inform patients about what to expect if waitlisted.

- Be familiar with which services are available locally or virtually

Consider referral to an outreach team, if available in the region.

Provide information on community supports such as harm reduction services (e.g., overdose prevention sites), community-based health care clinics, psychosocial supports, Indigenous cultural supports and services, and educational materials (e.g., Opioids: A Survivor's Guide).

Discuss with the patient if any support people should be alerted of the treatment plan (e.g., family members, friends, staff at supportive housing, etc.).

- Offer to give a copy of important paperwork to a friend of family member, if helpful

Consultation

Consult with an addiction specialist, such as the local inpatient addiction medicine consult team (available at some acute care sites), for any questions or concerns.

24/7 Addiction Medicine Clinician Support Line

- Consult with an addictions medicine specialist 24 hours a day, 7 days a week
- Available to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment in BC
- 778-945-7619

Rapid Access to Consultative Expertise (RACE)

- Online application where primary care providers (physicians and nurse practitioners) can receive specialist advice

Resources

BCCSU: *A Guideline for the Clinical Management of Opioid Use Disorder (2023)*

BCCSU: *Stimulant Use Disorder Practice Update*

BCCSU: *Guideline for the Clinical Management of High-risk Drinking and Alcohol Use Disorder*

GPAC: *Tobacco Use Disorder*

MetaPhi: *Management of Cannabis Use*

Patient Resources

Rapid Access to Addiction Care (RAAC) Clinics

Providence Health Care, St. Paul's Hospital, Vancouver

Fraser Health Authority

- Fraser East RAAC
  - Abbotsford, Abbotsford ACT Building
  - Chilliwack, Chilliwack General Hospital
  - Mission, Mission MHSU Centre
- Fraser North RAAC
  - New Westminster, MHSU Centre, RCH
- Fraser South RAAC
  - Surrey, Creekside Withdrawal Management Centre

Island Health, Pembroke St, Victoria

Virtual Addictions Medicine Services

Vancouver Coastal Health Lighthouse Virtual Substance Use Care Clinic

- Free virtual clinic that uses telephone appointments to provide medical treatments and short-term stabilization for people who use substances
- Available 7 days per week including statutory holidays (604-806-8223 or toll-free 1-877-842-8884)

Interior Health Virtual Addiction Medicine (VAM)

- Provides urgent care and medical support for those with substance use disorder

Northern Health Virtual Substance Use Clinic

- Offers substance use support to residents of Northern Health 1-844-645-781

Opioid Treatment Access Line

- 1-833-804-8111
- People with opioid use disorder can access care from clinicians, including physicians and nurses
- Prescriptions for opioid agonist treatment medications
- Covered by PharmaCare

First Nations Virtual Doctor of the Day

- Virtual appointments available to all First Nations people and their families living in BC (1-855-344-3800)