Acute Care and Opioid Use Disorder

Note: This document provides information on opioid agonist treatment (OAT) options. Regional health authorities may opt to develop relevant pre-printed orders (PPOs), decision support tools (DSTs), workflows, or other tools to support implementation

Acute Care Resources

There are 4 resources on opioid use disorder for acute care settings in this package.

1. Acute Care and Opioid Use Disorder (this document)
2. Managing Acute Opioid Withdrawal
3. Opioid Agonist Treatment Initiation
4. Opioid Agonist Treatment Maintenance

Preamble

Opioid agonist treatment is the standard of care for opioid use disorder (OUD)

Patients with OUD should be provided with evidence-based treatment while in acute care in order to:

- Prevent self-initiated discharge
- Reduce the risk of unregulated opioid use
- Prioritize patient comfort and safety
- Reduce barriers to meeting other treatment, harm reduction, and self-defined recovery and wellness goals

In addition to clinical care, some patients may benefit from other supports available in hospital:

- Indigenous patient navigators
- Indigenous Elders or Sacred Spaces to participate in culture and ceremony
- Peer navigators
- Translation services as needed
- Social worker

These resources address management of opioid use disorder only. Acute pain will generally not be sufficiently managed by a patient's opioid agonist treatment dose or short-acting opioid withdrawal medications

Follow site-specific protocols for managing acute pain

Guidance contained in these resources supports basic opioid use disorder care. For clinical circumstances that require advanced prescribing knowledge and experience, please consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, or RACEapp, or other local addiction medicine resources

Background

British Columbia has been in a public health emergency due to unregulated toxic drug toxicity since 2016

- Death due to drug poisoning is the current leading cause of unnatural death in BC, superseding homicides, suicides, and motor vehicle collisions combined
- The primary driver of the current crisis is the growing toxicity and unpredictability of the unregulated drug supply, which is dominated by fentanyl and other highly potent synthetic opioids

Individuals with opioid use disorder (OUD) have high rates of emergency department (ED) utilization

- Over half (60.4%) of 10,455 drug poisoning deaths in BC from January 1, 2015 to November 30, 2016 had past-year ED utilization
- Individuals who had drug poisoning-related visits to the ED had significantly higher 1-year mortality rates compared to those who visited the ED for other reasons.

  The risk of mortality due to any cause within 1 year after ED treatment of drug poisoning is 5.5%

Compared to those who do not have a substance use disorder, people with OUD experience:

- Higher rates of hospitalization
- More medical co-morbidities

Appropriate treatment of OUD and co-occurring pain are vital to support individuals with OUD to stay in hospital to meet their acute medical and surgical needs and improving health outcomes by:

- Treating opioid withdrawal
- Initiating or optimizing opioid agonist treatment (OAT)

Opioid Agonist Treatment

Opioid agonist treatment is the standard of care for OUD. There is strong evidence to support OAT's effectiveness in:

- Sustaining treatment retention
- Reducing unregulated opioid use
- Minimizing risk of morbidity and mortality

Acute care settings present an opportunity to initiate OAT for patients not engaged in OUD care. Initiation of OAT in inpatient settings can:

- Improve engagement and retention in OUD treatment following discharge
- Reduce reliance on unregulated opioids
- Lower ED utilization following discharge

Patients in acute care who are currently on OAT should continue receiving OAT to prevent treatment disruption and related risks including:

- Opioid withdrawal
- Self-initiated discharge
- Return to unregulated opioid use
- Opioid overdose

Required Qualifications for Ordering OAT in Acute Care

- **Any MD or NP in BC** can write prescriptions for buprenorphine/naloxone in any setting
- **When providing care** to patients being managed in acute care sites, MDs and NPs are not required to complete the Provincial Opioid Addiction Treatment Support Program (POATSP) prior to ordering
- **Depending** on organizational policy, Registered Nurses/Registered Psychiatric Nurses Opioid Use Disorder Certified Practice can order OAT in acute care
- **Prescribers** do not require a methadone exemption from Health Canada in order to prescribe
- **Prescribers** must follow site-specific protocols when ordering OAT
- **Prescriptions** for methadone and slow-release oral morphine (SROM) that will be filled by a community pharmacy (e.g., discharge prescriptions) must be written by a prescriber who has completed POATSP and a preceptorship

Eligibility for Opioid Agonist Treatment

1) Opioid use disorder diagnosis

2) Informed consent

Diagnosis

All patients should be screened for substance use using a culturally safe and trauma-informed approach. See *Substance Use: What You Should Know*

Patients who screen positive for opioid use should be assessed further using the DSM-5 TR Clinical Diagnostic Criteria for Opioid Use Disorder to confirm diagnosis and assess the severity of OUD, if possible

- If lieu of a completing a diagnostic interview, a previously established OUD diagnosis and confirmation of near daily or daily opioid use may be sufficient
- See Appendix 2 in the *Guideline for the Clinical Management for Opioid Use Disorder (2023)*

Assessment

Conduct a baseline assessment for all candidates for OAT.

Conduct physical and mental health assessment, including:

- **Medical history** (e.g., prolonged QTc, respiratory disease, other significant chronic diseases, co-occurring substance use disorders)
- **Mental health history**
- **A comprehensive review of substance use**, including:
  - DSM-5 TR confirmed diagnosis of OUD

    Previous confirmed diagnosis and confirmation of current opioid use may be appropriate
  - Route of administration (e.g., inhalation, intravenous)
  - Frequency and amount of use
  - Overdose history and other substance use-related harms
  - Past treatment history
  - How the patient keeps themselves safe while using substances (see Harm Reduction)
  - Exploration of the role of opioids in the patient's life
  - Goals related to opioid use
- **Urine drug test** (UDT) to confirm the presence of substances and to identify other relevant substances such as benzodiazepines
  - Not required for treatment initiation if:
    - The patient is known to clinician or staff
    - There is objective evidence of opioid use (e.g., evidence of withdrawal symptoms)
    - There is sufficient collateral information
  - 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
  - Urine drug tests do not provide information on the timing and frequency of substance use
- **Pregnancy test (if applicable)**
- **Review of co-occurring CNS depressant use**, including alcohol, benzodiazepines, and sedatives (prescribed or unregulated)

  Dosing and titration may be adjusted for patients who are actively using CNS depressants due to increased overdose risk
- **Review PharmaNet**
- **Laboratory tests**: Complete blood count (CBC); renal and liver function panels, HIV and hepatitis A, B, and C serology; syphilis, gonorrhea, chlamydia tests as indicated
  - Not a requirement for treatment initiation
  - An ECG may be indicated for patients starting methadone who have a known cardiac history or at high risk of prolonged QTc

Consult the local inpatient consult team

- 24/7 Addiction Medicine Clinician Support Line, RACEapp or other regional addiction medicine supports as needed

Opioid Agonist Treatment Medications

Oral formulations	Subcutaneous formulation	Injectable OAT (iOAT)
• **Buprenorphine/naloxone (Suboxone)** In these resources, buprenorphine/naloxone will be referred to as buprenorphine • **Methadone** • **Slow-release oral morphine (Kadian)**	• **Extended-release buprenorphine (Sublocade)**	• **Hydromorphone** • **Diacetylmorphine**

Guidance on iOAT is out of the scope of these acute care resources.

Comprehensive guidance of the management of OUD is provided in the BCCSU's *Guideline for the Clinical Management of Opioid Use Disorder (2023)*.

Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp or other regional addiction medicine supports if treating a patient who is currently on iOAT.

Buprenorphine/Naloxone (Suboxone)

Buprenorphine is a partial opioid agonist with a high affinity for the mu opioid receptor

Lower risk of respiratory depression due to ceiling effect

Buprenorphine is commercially available as buprenorphine/naloxone

This document will refer to buprenorphine/naloxone as buprenorphine

The naloxone is added to the buprenorphine to deter injection use or insufflation

Naloxone can precipitate withdrawal when injected or insufflated but is not bioavailable when taken sublingually

Buprenorphine-specific contraindications:

- Allergy to medication component
- Currently taking monoamine oxidase inhibitors (MAOIs) or use within the past 14 days
- Severe acute respiratory or liver dysfunction

Buprenorphine is available in tablets containing 4:1 ratio of buprenorphine and naloxone (available as 8mg and 2mg tablet formulations)

The dose refers to the buprenorphine component only

Tablets are administered sublingually

- Keep the tablet under tongue until it dissolves, which may take 10–15 minutes
- Avoid swallowing, talking, eating, drinking, or smoking during this time to ensure that the full dose is absorbed

→ **The maximum daily dose** of buprenorphine is 32mg

Extended-release Buprenorphine

Extended-release buprenorphine (Sublocade) is a long-acting formula of buprenorphine for the management of moderate to severe opioid use disorder

Given monthly as a subcutaneous injection in the abdomen

Available for those who have been previously stabilized on sublingual buprenorphine

- The product monograph indicates prior stabilization on 8mg–24mg buprenorphine for a minimum of 7 days is required before transition to extended-release buprenorphine

Initial buprenorphine levels peak at 24 hours, then decrease slowly to a plateau

Steady-state is achieved at 2–6 months, depending on the maintenance dose

It is important to ascertain if a patient is currently on extended-release buprenorphine, as it often impacts clinical care

- Check PharmaNet for the at least the previous month, as medication is administered monthly

Methadone

Methadone is a full opioid agonist generally administered as an oral solution

The time to peak plasma concentration and peak clinical effect is 3 hours (range of 2–6 hours)

Methadone takes approximately 5 days of continuous use after a dose increase to reach a steady concentration

Can cause a delayed emergence of serious adverse effects such as respiratory depression or sedation

Exercise caution when prescribing to a patient with contraindications

- Initiating methadone in patients with a contraindication should be avoided in the absence of significant clinical experience of the prescriber and collaborative discussion of risks, benefits, and alternatives with the patient
- It may be appropriate to continue methadone for patients with a contraindication who are already on methadone

Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other regional addiction medicine supports to assess safety of continuing methadone

Methadone-specific contraindications:

- Currently taking MAOIs or use within the past 14 days
- Obstructive disease
- Severe respiratory compromise

Methadone-specific cautions and assessments:

- An ECG is suggested for patients with
  - A pre-existing risk or history suggestive of possible prolonged QT interval (e.g., cardiac hypertrophy, concomitant diuretic use, hypokalemia, hypomagnesaemia, syncope, arrhythmias, history of cardiac disease, or family history of sudden cardiac death)
  - Two or more QT-prolonging medications
- If a baseline electrocardiogram (ECG) indicates a QTc interval 500ms
  - Avoid initiating methadone if patient has prolonged QTc

Consult with the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other regional addiction medicine supports if considering initiating or to discuss alternative OAT medications

Methadone does not have a respiratory ceiling effect; monitoring is required to ensure the safety of the patient receiving care

A stabilized dose can range from 60–150mg or more per day

Slow-Release Oral Morphine (Kadian)

Slow-release oral morphine (SROM) is a long-acting, 24-hour formulation of oral morphine

The time to peak plasma level is 8.5–10 hours

When SROM is taken on a fixed-dose schedule, a steady state is reached within about 2 days

Slow-release oral morphine's peak plasma level is lower and the time to reach peak plasma level is longer than immediate-release formulations of morphine due to the polymer coating on the pellets that slowly release the medication

Exercise caution when prescribing to a patient with contraindications

- Initiating SROM in patients with a contraindication should be avoided in the absence of significant clinical experience of the prescriber and collaborative discussion of risks, benefits, and alternatives with the patient
- It may be appropriate to continue SROM for patients with a contraindication who are already on SROM

  Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other regional addiction medicine supports to assess safety of continuing SROM

Slow-release oral morphine-specific contraindications:

- Hypersensitivity to morphine sulfate or any component of the formulation
- Known or suspected paralytic ileus
- Currently taking MAOIs or use within the past 14 days
- Severe respiratory compromise or obstructive disease
- Moderate to severe chronic kidney disease (eGFR <60mL/min/1.73m^2)

Slow-release oral morphine-specific cautions:

- Adrenal insufficiency
- Gastrointestinal issues (e.g., obstruction, diarrhea, abnormal gut anatomy) that may impact the amount of time this long-acting medication remains in the stomach
  - Gastrointestinal obstruction may increase the amount of time the medication remains in the stomach, which increases the risk of a release of a bolus of morphine when gut motility is restored
  - Gastrointestinal issues that decrease the amount of time the medication remains in the stomach may reduce morphine absorption
- Pregnancy or breastfeeding

Slow-release oral morphine is generally dispensed as a once-daily dose with witnessed ingestion

Provide SROM capsules to be swallowed whole

- The pellets in the capsule can be sprinkled in a cup for immediate ingestion if preferred by patient

  Pellets must be swallowed whole as crushing, chewing, or dissolving capsules or pellets can cause a rapid release and absorption of a potentially fatal dose of morphine sulfate

→ A stabilized dose may exceed 1200mg per day

Medication Selection

Use shared decision-making with the patient to select the best medication option, prioritizing patient preference and goals

Consult patients on the risks and benefits of all OAT medications prior to medication selection

Individual factors to consider for treatment selection may include:

- Initial presentation
- Comorbidities
- Drug–drug interactions
- Treatment preferences and goals
- Lifestyle requirements (e.g., rural/remote location, limited pharmacy hours)
- Previous experiences with OAT

Buprenorphine may be considered the favourable option due to its superior safety profile in the absence of patient preference or other patient-specific factors

See the decision support tool below for further considerations in medication selection

Table 1. Decision Support Tool for Selecting OAT Medications

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine	Extended-release buprenorphine		
Retention in treatment	May be slightly lower than methadone; retention improves at higher doses (above 16mg)	Substantially higher than placebo, but no direct comparisons with oral OAT have been studied	Potentially slightly better treatment retention than buprenorphine	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	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 (following stabilization on SL buprenorphine)	(May take weeks) Longer time to achieve therapeutic dose	1–2 weeks

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine	Extended-release buprenorphine		
Requires stabilization on oral OAT prior to initiation	N/A	Requires stabilization on sublingual buprenorphine prior to initiation	N/A	N/A
Safety				
Risk of overdose	Low. Due to ceiling effect for respiratory depression in the absence of co-occurring use of central nervous system (CNS) depressants	Low. Due to ceiling effect for respiratory depression in the absence of co-occurring 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
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated
Risk of precipitated withdrawal during initiation	Yes	No, due to need for stabilization on SL dosing first	No	No
Side effects				
Side effects	Milder side effect profile	Medication adverse effects are similar to buprenorphine 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
Dosing				
Dosing	Health Canada-approved maximum dose of 24mg, but higher doses (up to 32mg) may be necessary for some patients 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

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine	Extended-release buprenorphine		
Take-home doses	Suitable for immediate take-home doses, including take-home initiation when indicated, which may contribute to increased patient 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
Rotation				
Rotation	Easier to rotate from buprenorphine to methadone or SROM	Rotation to other OAT medications is challenging. Avoid transitioning to a full agonist, if possible Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other regional addiction medicine supports	Risk of precipitated withdrawal when rotating to buprenorphine May be rotated directly to SROM	Risk of precipitated withdrawal when rotating to buprenorphine May be rotated directly to methadone
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

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

- ☐ 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
- ☐ Be aware 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
- ☐ 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

- ☐ 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)

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

Discuss how to respond to an 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 on an ongoing basis 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

Buprenorphine can be given or prescribed as take-home doses

- If the patient had a current buprenorphine prescription, write a prescription with the same number of take-home doses, unless clinically indicated otherwise
- If the patient did not have a current buprenorphine prescription, write a prescription for a minimum of 7 days of 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
- If the patient had an existing methadone or SROM prescription, write a prescription with the same number of take-home doses, unless clinically indicated otherwise
- If the patient did not have an existing methadone or SROM prescription, follow take-home dosing protocols (see p.152 in the BCCSU's *Guideline for the Clinical Management of Opioid Use Disorder [2023]*)

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 the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other local addiction medicine resources to discuss discharge PRN medications

- ☐ Offer non-opioid adjunct medications if needed

Discharge Planning (Continued)

☐ Provide continuity of care

Offer the patient resources to support continuity of care

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

- If patient does not have a community pharmacy, help locate an accessible pharmacy
  - Send relevant information to the community prescriber, including a discharge summary and pertinent investigations, procedures, 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

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), in alignment with patient goals

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: The Provincial Opioid Addiction Treatment Support Program

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)