Rural Rounds: Rural Substance Use Care and Innovation

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THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
Faculty of Medicine

Land Acknowledgement

I acknowledge that I work on the traditional, ancestral and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Sə̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations, as well at the Kitsumkalum and Kitselas Peoples of the Ts’msyen (Tsimshian) Nation.

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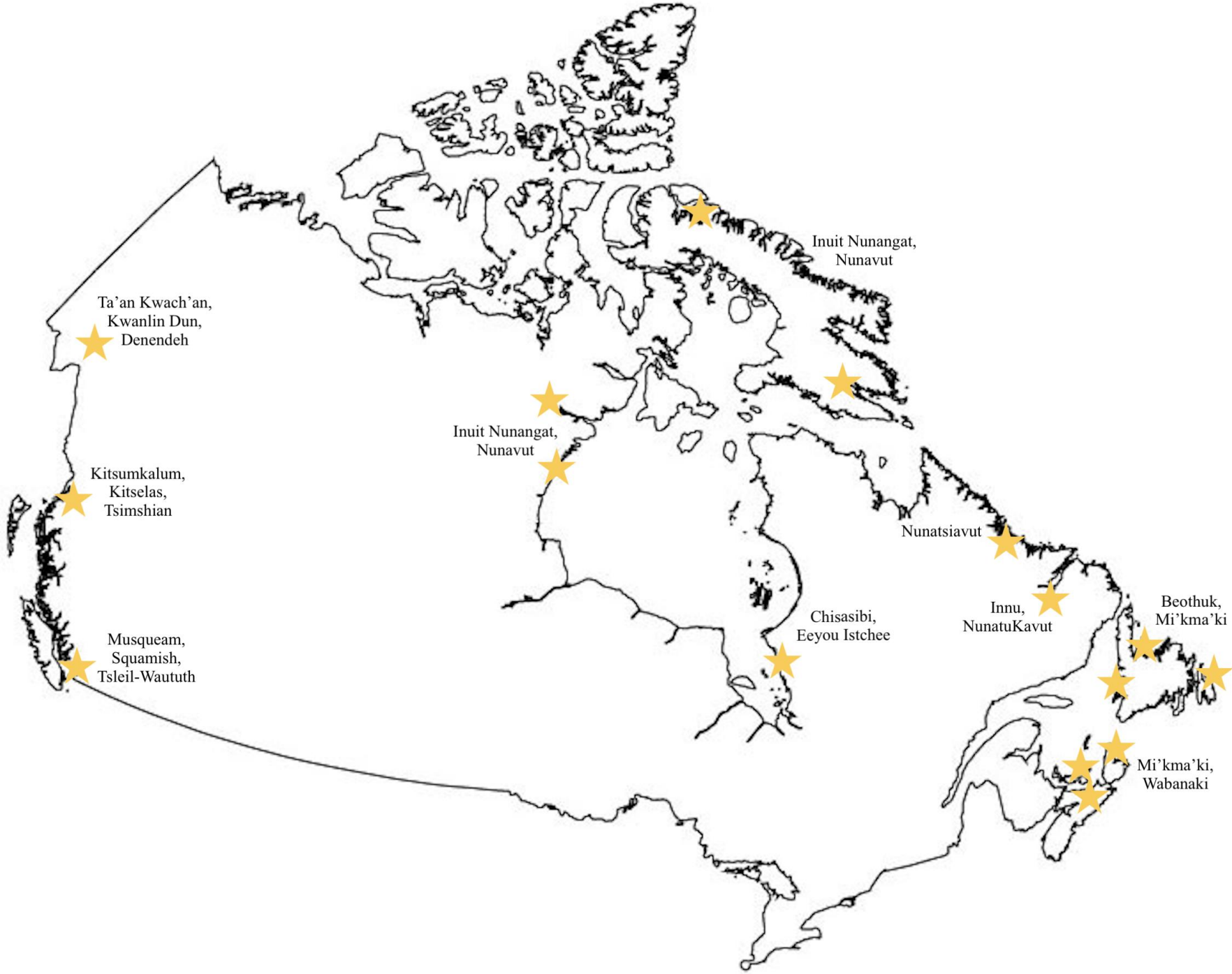

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Land Acknowledgement

I recognize that substance use disorders and discrimination against people who use drugs disproportionately harm Indigenous Peoples, and that continuous efforts are needed to dismantle ongoing colonial systems of oppression.

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PRESENTER DISCLOSURES

No relationships or commercial interests to disclose

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LEARNING OBJECTIVES

- Apply motivational interviewing techniques to a variety of clinical encounters including substance use counselling
- Identify the broad range of psychosocial treatment modalities for substance use disorders
- Examine conversations around prescribed safer alternatives to unregulated substances

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Case # 1

56yo cis-male patient, history of severe opioid use disorder, admitted to hospital for community-acquired pneumonia.

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Case # 1

56yo cis-male patient, history of severe opioid use disorder, admitted to hospital for community-acquired pneumonia.

Somewhat vague about his substance use, not wanting to discuss in detail as he is not feeling well.

What are some strategies for exploring further?

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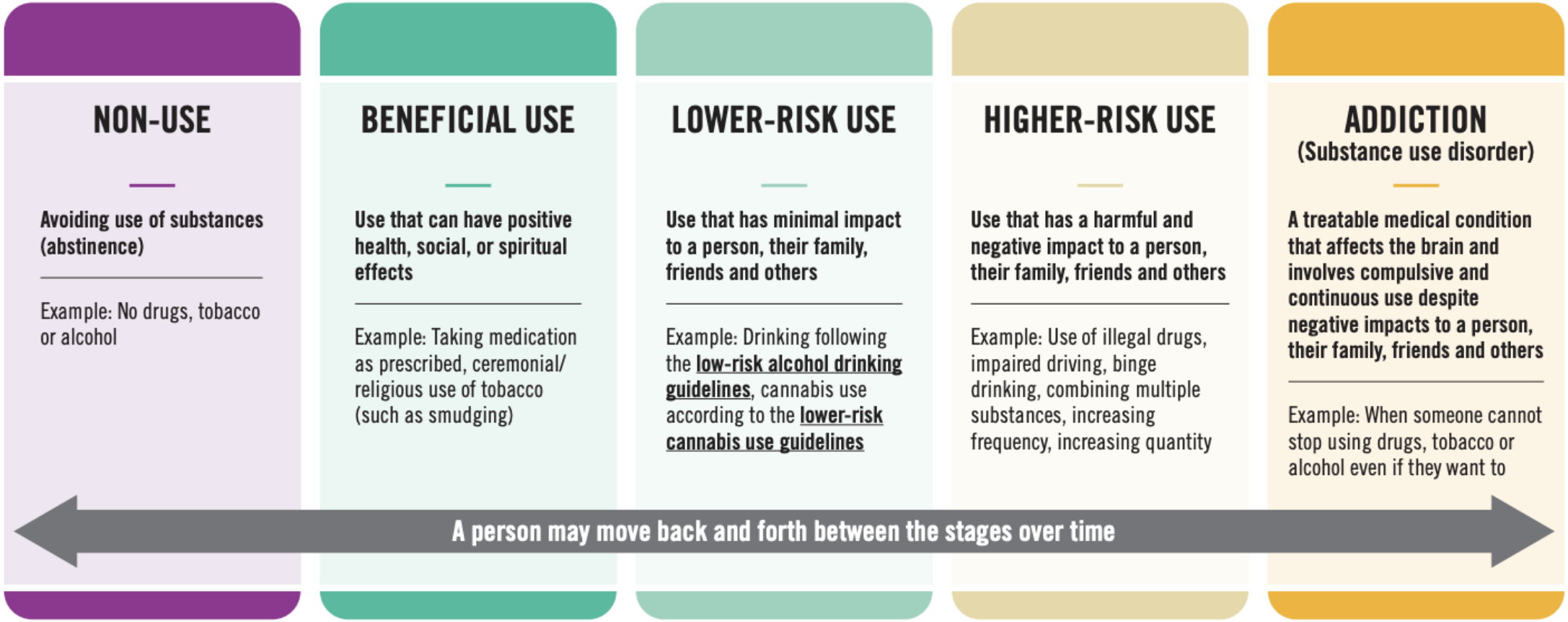
Case # 1 Discussion

- Listening to understand vs listening for info
  - Everyone who's using substances is using for a reason

SUBSTANCE USE SPECTRUM

People use substances, such as **controlled and illegal drugs**, **cannabis**, **tobacco/nicotine** and **alcohol** for different reasons, including medical purposes; religious or ceremonial purposes; personal enjoyment; or to cope with stress, trauma or pain. Substance use is different for everyone and can be viewed on a spectrum with varying stages of benefits and harms.



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Health Canada Santé Canada

Canada

Case # 1 Discussion

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- Emphasizing shared goals
  - Withdrawal management, pain control
  - Maintaining opioid tolerance while admitted
  - Opportunity for connection to supports, titrating medications

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- Listening to understand vs listening for info
  - Everyone who's using substances is using for a reason
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- Emphasizing shared goals
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- Harm reduction counselling
  - Information exchange: **Elicit – Provide – Elicit**

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Case # 1 Discussion

- Elicit - current knowledge, experience
  - Tell me about your past experience with OAT
  - How do you keep yourself safe when using?

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Case # 1 Discussion

- **Elicit** - current knowledge, experience
  - Tell me about your past experience with OAT
  - How do you keep yourself safe when using?

- **Provide** – education, feedback
  - Seek permission, emphasize personal choice
  - Focused on their expressed goals (ex. safety, stability, reduced use, abstinence)
  - Offering menu of options

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- **Elicit** - current knowledge, experience
  - Tell me about your past experience with OAT
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- **Provide** – education, feedback
  - Seek permission, emphasize personal choice
  - Focused on their expressed goals (ex. safety, stability, reduced use, abstinence)
  - Offering menu of options

- **Elicit** – understanding, interest, questions
  - What are your thoughts on that?
  - Does that sounds like it could be helpful to you?

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Case # 1

56yo cis-male patient, history of severe opioid use disorder, admitted to hospital for community-acquired pneumonia.

Injecting 1g/d fentanyl, no OAT for many years

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Case # 1

56yo cis-male patient, history of severe opioid use disorder, admitted to hospital for community-acquired pneumonia.

Injecting 1g/d fentanyl, no OAT for many years

“I’ve been using for so long, I won’t be able to stop”

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Case # 1 Discussion

- Motivational interviewing (Miller, 1983)[1]
  - Goal of bringing awareness to discrepancies between current behaviours and future goals
  - Helping someone to reflect on their goals, values, priorities

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Case # 1 Discussion

- Motivational interviewing (Miller, 1983)[1]
  - Goal of bringing awareness to discrepancies between current behaviours and future goals
  - Helping someone to reflect on their goals, values, priorities
  - Evoking ‘change talk’ – when people hear themselves talk out loud about change, it makes that behaviour more likely
  - Shift from “why isn’t this person motivated?” to “for what is this person motivated?”

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Case # 1 Discussion

- Motivational interviewing (Miller, 1983)[1]
  - Goal of bringing awareness to discrepancies between current behaviours and future goals
  - Helping someone to reflect on their goals, values, priorities
  - Evoking ‘change talk’ – when people hear themselves talk out loud about change, it makes that behaviour more likely
  - Shift from “why isn’t this person motivated?” to “for what is this person motivated?”
  - Strengths-based: “You have what you need for change, and together we’ll find it”
  - Evidence: reduction in binge drinking, frequency and quantity of alcohol, smoking cessation, increasing physical activity, weight loss

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Case # 1 Discussion

- Fighting the “Righting Reflex”
  - Wanting to fix what seems ‘wrong’, steer someone in the right direction, prevent harm
  - Natural well-intending reflex, present in all of us, will be louder with certain patients
  - Typically ineffective and even counterproductive when the task is helping people change
  - Leads to labels such as ‘not motivated’, ‘non-compliant’, ‘in denial’, etc

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Case # 1

Next day: check-in, withdrawal is well-managed, start catching some change talk…

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Case # 1

Next day: check-in, withdrawal is well-managed, start catching some change talk…

Goal is eventual abstinence, doesn't like needing to use every few hours just to feel normal.

Expressing doubt about his ability to do this, already tried treatment years ago…

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Case # 1 Discussion

- Ambivalence
  - Feeling two ways about something, natural part of the change process, we sometimes mistake for resistance
  - Reframing a barrier to an opportunity – one step closer to change
  - **Change talk**: “I don’t like having to use every few hours”
  - **Sustain talk**: “It would be too hard for me to change right now”

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Case # 1 Discussion

- Ambivalence
  - Feeling two ways about something, natural part of the change process, we sometimes mistake for resistance
  - Reframing a barrier to an opportunity – one step closer to change
  - **Change talk**: “I don’t like having to use every few hours”
  - **Sustain talk**: “It would be too hard for me to change right now”
- Recognize and reflect
  - “**On the one hand**, it feels impossible to imagine not using substances – **and on the other hand**, you don’t like feeling physically reliant on them.”

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Case # 1

Review menu of options with Elicit-Provide-Elicit style, he is interested in longer-acting medication for withdrawal symptoms, opts to try SROM

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Case # 1

Review menu of options with Elicit-Provide-Elicit style, he is interested in longer-acting medication for withdrawal symptoms, opts to try SROM

Next day: very happy with SROM, more change talk, interested in detox and discussing psychosocial treatment!

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Psychosocial approaches to substance use care

What are some psychosocial treatment modalities your patients have found helpful?

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Psychosocial approaches to substance use care

- Specialist-led therapies
- Peer-led and mutual support groups
- Intensive outpatient treatment programs
- Inpatient or bed-based treatment programs
- Supportive recovery residences
- Culture-based interventions

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Psychosocial approaches to substance use care

- Specialist-led therapies
  - **Cognitive behavioural therapy**
    - Evidence for mod-severe alcohol use disorder[2], sedative use disorders[3], and cannabis use disorder (combined with contingency management)[4]
  - **Contingency management**
    - First line treatment for stimulant use disorder[5]
    - Resource-intensive, costly
  - **Trauma-focused therapy**
    - Seeking Safety for concurrent PTSD and substance use disorders
  - **Family-based therapy**
  - **Mindfulness-based interventions**

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Psychosocial approaches to substance use care

- Peer-led and mutual support groups
  - Less formal supporting evidence – limited assessment of standard outcomes (reduced quantity/frequency of use, days of abstinence – variable timelines)
  - Plenty of anecdotal evidence, strong social support networks, strong history of advocacy

  12-step programs (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery)
    - Abstinence based, structured counselling approach, widely accessible
    - AA: 'higher-power' focus, frequent meetings, strong established community
    - SMART: newer secular approach, evidence-based tools (MI, CBT, Rational Emotive Behavioural Therapy, mindfulness) and peer support
    - Systematic reviews: as effective as other psychosocial interventions, lacking high-quality evidence[6]

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Psychosocial approaches to substance use care

- Peer-led and mutual support groups

Clinical Tip

"If I have a patient who loves AA, I'm very supportive of them attending and it's great to chat about how their steps are going during their clinic visits. Some patients dislike AA, and I make sure to discuss a variety of options, such as a women's only group or SMART Recovery group. If someone reports that they didn't enjoy AA, or had no benefit, I document this, and don't continue to suggest the intervention."

-Dr. Christy Sutherland

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Psychosocial approaches to substance use care

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Psychosocial approaches to substance use care

- Intensive outpatient treatment programs
  - Several hours of structure programming per day, individual and group therapies
  - Life skills and vocational training, relapse prevention strategies
  - Peer support meetings, recreational activities
  - Systematic review (small studies): similar outcomes to inpatient treatment[7]
  - Intermediate level of support – works well for patients with housing, not able to leave home for extended period of time

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Psychosocial approaches to substance use care

- Inpatient or bed-based treatment programs
  - Abstinence based, intensive supports, individual and group counselling, life skills, peer supports, medical and mental health services
  - 1-3 months generally, some are longer
  - Publically-funded beds generally have wait list, private $$ options
  - Not standardized, some have restrictive policies around OAT
  - Outpatient aftercare programs, supportive transitional housing
  - Evidence: difficult to standardize, suggests similar outcomes to outpatient treatment[8]
  - Aspect of housing and meeting basic needs for a sustained period of time has potential to be very stabilizing for some

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Psychosocial approaches to substance use care

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Psychosocial approaches to substance use care

- Supportive recovery residences
  - Abstinence based, safe substance-free accommodations
  - Less structured, often used as step-down from bed-based treatment
  - Limited evidence, lots of variability

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Psychosocial approaches to substance use care

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Psychosocial approaches to substance use care

- Culture-based interventions
  - Land-based programs, sweat lodges, ceremonial practices, storytelling, access to Elders and Knowledge Keepers
  - Addressing the overlapping and intertwined harms of colonialism and discrimination against people who use drugs
  - Lots of room for further inclusion of traditional knowledge and practices from many cultures, limited non-English treatment options

Psychosocial approaches to substance use care

- Mixed evidence, difficult to standardize
- Limited resources for publicly-funded services, generally concentrated in urban areas
- Importance of patient-centred approach
    - Past experiences
    - Goals for substance use
    - Housing, income, transport, childcare
    - Capacity for travel

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Case # 2

37yo cis-female patient, unhoused, complex medical history including chronic pain from prev injuries. History of severe opioid use disorder, currently using a few points of fentanyl daily to manage her pain.

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Case # 2

Her goal is abstinence, her main priority is chronic pain management. She has previously tried methadone and buprenorphine and did not find either helpful. She has an anaphylactic morphine allergy.

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Case # 2

She describes a past 5-yr period of abstinence while she was on a regimen of both controlled-release and short-acting hydromorphone, she is interested in restarting this.

How would you approach managing her OUD?

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Prescribed/safer alternatives (SA)

- March 2020: ”Risk Mitigation in the Context of Dual Public Health Emergencies” as harm reduction strategy for pandemic-related disruption to unregulated drug supply

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- July 2021: “Access to Prescribed Safer Supply in British Columbia: Policy Direction” to address the overdose crisis by helping to separate people from increasingly contaminated unregulated supply

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Prescribed/safer alternatives (SA)

- March 2020: ”Risk Mitigation in the Context of Dual Public Health Emergencies” as harm reduction strategy for pandemic-related disruption to unregulated drug supply
- July 2021: “Access to Prescribed Safer Supply in British Columbia: Policy Direction” to address the overdose crisis by helping to separate people from increasingly contaminated unregulated supply
- Anecdotal benefits, but also pattern of impeding OAT titrations, reports of diversion, ++ politically-charged discourse

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Prescribed/safer alternatives (SA)

- February 19th, 2025 – policy change requiring SA doses be witnessed (few exceptions for extenuating circumstances)

Witnessed Dosing Requirements

Are all doses required to be witnessed under this policy for individuals who do not meet exemption criteria?

Under this policy, the full dose must be witnessed, unless the individual meets the exemption criteria outlined in the policy. A partial dose cannot be carried following the witnessing of a partial dose.

Do doses have to be witnessed in a pharmacy?

Doses of PA must be witnessed in person by a health professional. They may be witnessed in a variety of care settings, including PA programs, clinics, and community pharmacies.

Are there specific care considerations for people living in rural and remote settings who do not meet the exemption criteria outlined in the policy?

- For those who do not meet exemption criteria, consider the following:
  - Transitioning to a care plan that requires less frequent dosing (see "What care options are available for individuals currently receiving unwitnessed PA doses who do not meet eligibility criteria?," below)
  - Utilizing flexible approaches to accommodate witnessed consumption for individuals who do not have or cannot access a pharmacy in their community (for example, if they have been banned), such as working with local community-based services to support witnessed dosing

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Prescribed/safer alternatives (SA)

Key Messages | Background | For Prescribers | For Pharmacists | Resources

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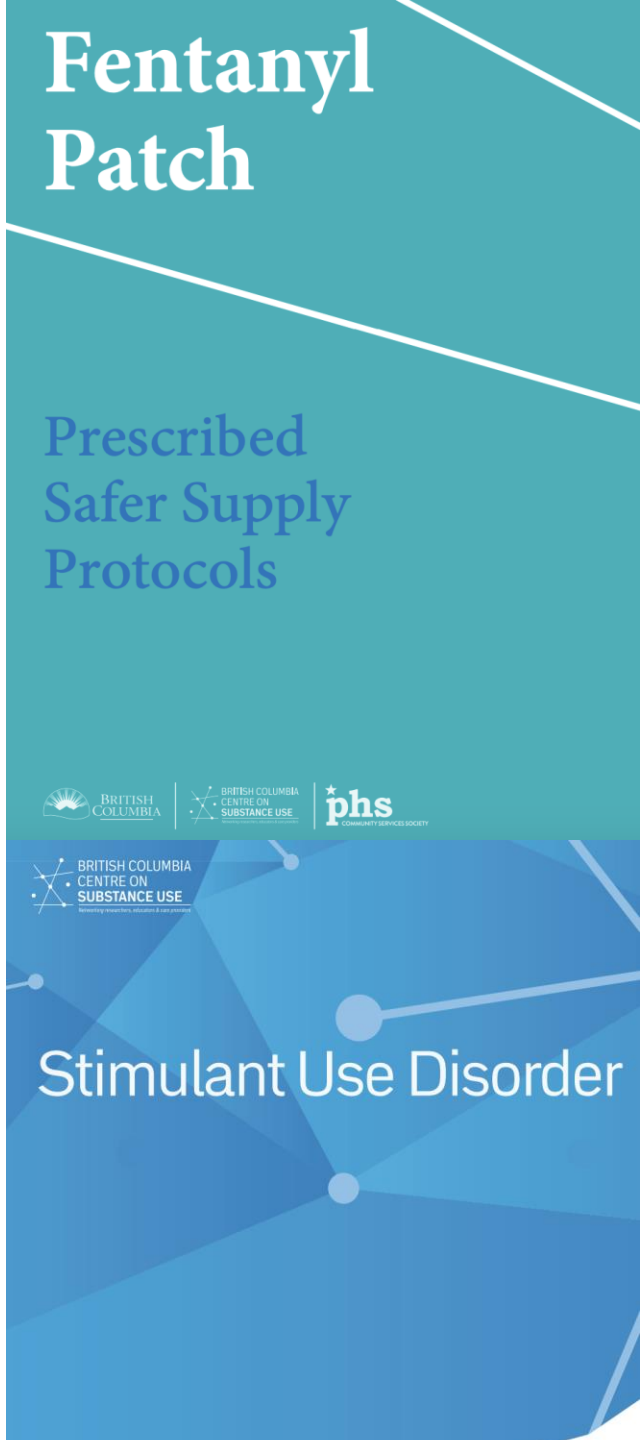
Interim Clinical Resource: Transition to Witnessed Dosing for Prescribed Alternatives

Prescribed/safer alternatives (SA)

- Many provider groups have since moved away from short-acting opioid prescribing and towards longer-acting safer alternative options such as fentanyl patch
- Developing protocols for more rapid OAT titrations (inpatient + outpatient)
- Pilot programs - SAFER Fentanyl Powder Program, Fentanyl capsule program (largely Vancouver-based)
- Stimulant prescribed alternatives – ongoing research

> *"Food, stability, safety, housing, offering CBT, counselling, support. All of these need to be part of the plan. It can't just be the stimulant prescription.*
>
> *Stimulant prescribing should be looked at as a harm reduction piece—giving those options to someone, especially with the toxicity in the drug supply, is huge. But it's not the end-all, be-all."*
>
> *— Katt Cadieux*



Prescribed/safer alternatives (SA)

- Consistent clinic policies enable clear expectations of patient and provider(s), often include UDS monitoring
- Single longitudinal provider is ideal
- Review first-line OAT options as gold standard treatment
    - Reduction in all-cause mortality and overdose deaths
    - Increase in abstinence
    - Decrease in incidence of HIV and Hepatitis C infections

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Prescribed/safer alternatives (SA)

- SA can facilitate connection to and further engagement in care, creating opportunities to later transition to first-line OAT
- However taper may also interfere with OAT titration
- Limitation of witnessed dosing, particularly in rural communities – consider longer-acting options
- Frequent reassessments are key to ensuring SA remains stabilizing

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Indications That The Patient is Benefitting

Clinical

- Reduced (or cessation of) illicit substance use
- Reduced risk and incidence of overdose due to reduction or cessation of illicit opioid use
- Reduced cravings
- Reduced potential communicable disease exposure and infection
- Reduced emergency department or acute care usage
- Increased engagement in primary care and other health services
- Management of withdrawal symptoms
- Patient report of improved overall wellbeing
- Urine drug tests consistently positive for prescribed medications[r]

Psychosocial[s]

- Reduced need to engage in high-risk and criminalized activities (e.g., sex work) to support substance use
- Maintaining, seeking, or gaining employment or volunteer activities
- Improved attitude toward self
- Ability to set and meet goals in major areas (e.g., personal health, career)
- Enrolled in education or training programs
- Integrating new activities
- Reconnecting with family and friends (e.g., improved social functioning)
- Attaining safe housing and accessing other social services

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Indications That The Patient is Not Benefitting

Clinical

- No change or increased intensity of illicit substance use
- No change or increased overdose risk
- Ongoing cravings and withdrawal symptoms
- Urine drug tests consistently negative for prescribed substance
- No change in wellbeing or social functioning
- Consistently missed doses
- Development or worsening of mental or physical health conditions associated with prescribed medications

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[r] Note that UDTs consistently negative for illicit substances are not required in order to continue this intervention. Given the extremely high potency opioids in the illicit drug supply, many individuals may continue to use a combination of prescribed hydromorphone and illicit opioids. In the case of UDTs negative for the prescribed substance (e.g., hydromorphone), prescribers should use clinical judgement to determine if it is appropriate to continue prescribing based on an assessment of the risks and benefits and discussion with the patient. It is recognized that each dose of prescribed, regulated opioids reduces risk of overdose.

[s] Structural barriers such as lack of affordable and accessible housing or suitable employment may make these difficult to achieve for individuals who are otherwise benefitting from the intervention. Improvements in these domains are not required, but—where possible—may be additional indications that the patient is benefitting and should continue to receive this intervention.

Case # 2

Given her past hx of stabilizing on prescribed hydromorphone, you agree to trial restarting a form of SA. She will not be able to attend the pharmacy multiple times per day, therefore opts to trial a fentanyl patch titration with witnessed patch changes three times weekly.

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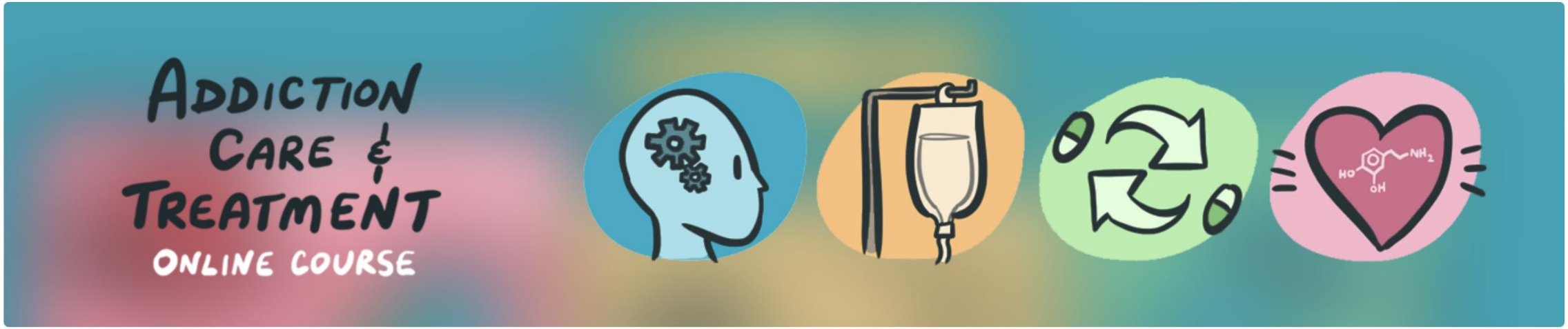

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Provincial Opioid Addiction Treatment Support Program

Online Course

Perinatal Substance Use

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Q&A

POST YOUR QUESTIONS IN THE CHATBOX

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