START
SUBSTANCE TREATMENT AND REHABILITATION TEAM

5 THINGS TO KNOW ABOUT

OPIOID USE DISORDER IN HOSPITAL

1. Discharge from hospital is a high-risk time for overdose death.
Opioid tolerance (i.e. how sensitive your body is to a substance) can change within days. When an individual who uses opioids daily is forced to abstain while admitted to hospital, their tolerance may decrease. When they return to using opioids on discharge at their pre-admission dose, they are at high risk of drug-related death - up to 15X higher (!) in the 28 days post-discharge, according to one study.[i]

2. Patients with OUD (especially those who inject or smoke Fentanyl) often need very high doses of opioids to treat their pain and withdrawal, *even if they are on methadone or Suboxone*. One "point" (0.1g) of street Fentanyl IV is roughly equivalent to 300-500 mg of oral morphine or 64-96 mg of oral hydromorphone, and individuals with OUD may use up to 10+ points per day! While sensitivity to opioids may be affected by acute illness, do not be surprised if patients require much higher doses than you are used to. For patients normally on methadone and Suboxone, do not expect their usual dose to treat acute pain – they will likely need high dose opioids *in addition* to their usual dose of methadone / Suboxone.

3. Giving opioids for pain and withdrawal to patients with active OUD won't make their use disorder worse.[ii] If anything, it might make it better, as untreated pain and withdrawal can be a trigger to use street-sourced opioids.[iii] At the very least, by maintaining their opioid tolerance in hospital, you may decrease their risk of overdose on discharge (see above). You may also decrease their risk of leaving against medical advice and increase their chance of completing treatment.

4. Opioid agonist therapy (OAT) such as methadone, buprenorphine/ naloxone (Suboxone), long-acting injectable buprenorphine (Sublocade), or slow-release oral morphine (Kadian) - <u>can be life changing</u> for individuals with OUD. These long-acting medications act on opioid receptors to alleviate withdrawal and reduce cravings. Without OAT, patients with active OUD are at high risk of relapse upon discharge from hospital. OAT has been shown to...

- Reduce all-cause and opioid-related mortality
- Reduce illicit opioid use
- Reduce the risk of HIV and hepatitis C
- Improve treatment retention

START can help initiate OAT in hospital for patients with OUD, and help arrange follow up for them on discharge. They can also help adjust doses and advise what to do if a patient on OAT misses doses.

5. All patients using opioids (or other street substances) should have take-home naloxone. Take-home naloxone (Narcan) saves lives by reversing sedation and respiratory depression in opioid overdose. Anyone can get a naloxone kit for free from any Ontario pharmacy. To make sure your patient picks up a naloxone kit, you can include it in their discharge scripts.

START is a group of MDs who provide Addictions consults for inpatients with substance use disorders Monday-Friday from 9am-4pm. To consult START, page/call the START MD on call (via switchboard). To learn more about START or Addiction Medicine, call or email us at MHACSTARTeam@kingstonhsc.ca.

If your patient is being discharged and needs outpatient care for a substance use disorder, they can be seen at the **Street Health Rapid Access Addiction Medicine** Clinic at 115 Barrack Street Monday-Friday from 9am-12pm and 1pm-4pm. Appointments can be booked by phone (613-549-1440) but walk-ins are welcome. Referrals are not required.

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[i] White, Simon R., Sheila M. Bird, Elizabeth L.C. Merrall, and Sharon J. Hutchinson. 2015. "Drugs-Related Death Soon after Hospital- Discharge among Drug Treatment Clients in Scotland: Record Linkage, Validation, and Investigation of Risk-Factors." *PLoS ONE* 10 (11): 1–11. https://doi.org/10.1371/journal.pone.0141073

[ii] Kantor, T.G., Cantor, R. and Tom, E., 1980. A study of hospitalized surgical patients on methadone maintenance. *Drug and alcohol dependence*, *6*(3), pp.163-173

[iii] Merrill, Joseph O., Lorna A. Rhodes, Richard A. Deyo, G. Alan Marlatt, and Katharine A. Bradley. 2002. "Mutual Mistrust in the Medical Care of Drug Users. The Keys to the 'Narc' Cabinet." *Journal of General Internal Medicine* 17 (5): 327–33. https://doi.org/10.1046/j.1525-1497.2002.10625.x.