

# Making the Choice, Making It Work

## Treatment for Opioid Addiction

Second edition—formerly published as  
*Methadone Maintenance Treatment: Client Handbook*

**camh**

Centre for Addiction and Mental Health

A Pan American Health Organization /  
World Health Organization Collaborating Centre

Library and Archives Canada Cataloguing in Publication

Methadone maintenance treatment, client handbook

Making the choice, making it work : treatment for opioid addiction.

-- Second edition.

Includes index.

Previously published under title: Methadone maintenance treatment,  
client handbook.

Issued in print and electronic formats.

ISBN 978-1-77114-357-8 (paperback).--ISBN 978-1-77114-358-5 (pdf).--

ISBN 978-1-77114-359-2 (html).--ISBN 978-1-77114-360-8 (epub).--

ISBN 978-1-77114-361-5 (kindle)

1. Opioid abuse--Treatment--Popular works. 2. Methadone  
maintenance--Popular works. 3. Buprenorphine--Popular works.

I. Centre for Addiction and Mental Health, author II. Title.

III. Title: Methadone maintenance treatment, client handbook.

RC568.O45M3 2016

616.86'32061

C2016-905468-3

C2016-905469-1

Printed in Canada

Copyright © 2016 Centre for Addiction and Mental Health

*No part of this work may be reproduced or transmitted in any form or by any means electronic or mechanical, including photocopying and recording, or by any information storage and retrieval system without written permission from the publisher—except for a brief quotation (not to exceed 200 words) in a review or professional work.*

This publication may be available in other formats. For information about alternative formats or other CAMH publications, or to place an order, please contact CAMH Publications:

Toll-free: 1 800 661-1111

Toronto: 416 595-6059

E-mail: [publications@camh.ca](mailto:publications@camh.ca)

Online store: <http://store.camh.ca>

Website: [www.camh.ca](http://www.camh.ca)

Disponible en français sous le titre :

*Faire son choix, réussir son parcours : Traitement de la dépendance aux opioïdes*

This handbook was produced by CAMH Education.

5319a / 10-2016 / P6501

# Acknowledgments

The Centre for Addiction and Mental Health (CAMH) wishes to acknowledge the enthusiastic and valuable participation of the many clients, family members and health and social service professionals who contributed to the redevelopment of this handbook. Our gratitude also extends to all who contributed to the conception and development of the *Methadone Maintenance Treatment Client Handbook*, first published by CAMH in 2001, which provided a foundation for this new edition.

Creating this handbook has been a collaborative effort with professionals, clients and family members reviewing drafts and providing feedback, which was then carefully overlaid and woven into drafts based on the original handbook. The aim of this process was to create a book that carried forward the success of the original handbook, but that reflects the current realities of opioid addiction and treatment. We hope that this new edition will interest and inform people with addiction to opioids, and empower them to direct their own treatment and recovery. We hope that it will also help families, friends and others with an interest in opioid addiction and treatment to better understand the issue, and the people who struggle with it.

A special heartfelt thanks goes out to the people with experience of opioid agonist therapy (OAT) who provided us with the thoughtful quotations that illustrate the book. Your voices tell us that there is no one kind of person who becomes addicted to opioids, or no one kind of experience with the struggle to live with it. We also deeply appreciate the clients and family members who carefully reviewed a draft of the handbook, and provided their feedback.

Client quotes were provided by Andy, Angie, Ann, Ben, Brett, Chantale, Courtney, Dan, David, Eric, Gemma, Glen, J, Jessica, Jim, Jon, Josée, Joyce, Paul, Randall, Ruth, Sean, Shaun and Zar.

Clients and family members who reviewed the draft are Gemma Bennett, Malcolm Birbeck, Dante T. Colaianni Jr., Tammy Hyde, Jon, Betty-Lou Kristy, Sean LeBlanc, Patrick Loewen, Randy Post, Bill and Sheila Robinson, Charlene Winger, Sean Winger and others who chose to withhold their names.

This project would not have been possible without the contribution of the nurses, doctors, pharmacists, counsellors and other professionals whose work supports people with opioid addiction. These reviewers volunteered their time, thoughts and expertise from CAMH, across Ontario and across Canada.

Professionals from organizations outside CAMH also reviewed the draft: Kim Hennessy, Uptown Methadone Clinic, Saint John; Joni Ingram, Western Health, Cornerbrook; David Marsh, Northern Ontario School of Medicine and Canadian Addiction Treatment Centres; Tim Ominika, Nadmadwin Mental Health Clinic, Wikwemikong; Kendrah Rose, Sunshine Coast Mental Health & Addiction Services, Vancouver Coastal Health; Rhonda Thompson, Positive Living, Niagara; Andrew Tolmie, School of Pharmacy, University of Waterloo.

And the professionals who work at CAMH who gave their comments were Roshina Babaei-Rad, Carol Batstone, Alison Benedict, Jonathan Bertram, Narges Beyraghi, Susan Eckerle Curwood, Stephanie Gloyn, Katia Gouveia, Ahmed Hassan, Galit Kadan, Lisa Lefebvre, Heather Lillico, Tamar Meyer, Niall Tamayo, Kari Van Camp and Maria Zhang.

Thank you to CAMH's Provincial System Support Program (PSSP) central and regional team members for their support in organizing

and conducting the client interviews, and in reviewing and commenting on the drafts. PSSP would especially like to acknowledge those who helped to organize and facilitate the focus groups of people with lived experience of opioid addiction. Thanks to Sean LeBlanc for facilitating the group in Ottawa and to Rob Boyd and Hana Dykstra of the Sandy Hill Community Health Centre for supporting the group; thanks also to Betty-Lou Kristy for facilitating the group in Oakville and Katie Kidd of the Opioid Outreach & Treatment Services of Mississauga/Halton for supporting the group. The feedback collected through these groups helped to shape the final draft, and to ensure that the guide is helpful to the people who can benefit from the information it provides.

Client interviews were conducted by Lia De Pauw, Erika Espinoza, Alexandra Lamoureux, Heather Lillico, Janet McAllister, Barb Steep and Cheryl Vrkljan; thanks also to The Hamilton Clinic; Ontario Addiction Treatment Centres; Street Health Centre, part of Kingston Community Health Centre; and Shannon Greene and the CAMH Addiction Medicine Service.

Other professionals who helped to answer questions and to provide accurate content are Ken English and Fiona Sillars, Ontario Ministry of Health and Long-Term Care; Steve Grootenboer, Ontario Ministry of Transportation; Tracey Marshall, College of Physicians and Surgeons of Ontario; Linda Ogilvie, Ontario Ministry of Community Safety and Correctional Services; and James L. Sorensen, University of California, San Francisco (for permission to adapt and reprint the Tapering Readiness Inventory).

The CAMH Education team for this project was Michelle Maynes, writing and development; Mara Korkola, design; and Jacquelyn Waller-Vintar, editorial.



# Contents

*Acknowledgments*   iii

*How to use this book*   viii

*Opioid agonist therapy FAQs*   ix

1 Opioid agonist therapy and other options   1

2 Learning about opioid agonist therapy   15

3 Starting opioid agonist therapy   25

4 Living with opioid agonist therapy   45

5 Opioid agonist therapy and other drugs   61

6 Counselling and other services   71

7 Birth control, pregnancy, family and opioid agonist therapy   83

8 Looking ahead on opioid agonist therapy   91

*Important contact numbers*   101

*Websites*   103

*Index*   107

## How to use this book

This book should answer many of the questions you may have about opioid agonist therapy (OAT) with methadone or buprenorphine (Suboxone). The book can also help you to know what questions to ask your doctor, pharmacist, counsellor and others. It's put together so that you can either dip into it, or read it all at once, as you wish. There's information here for those who are thinking about OAT, for the new client and the client who is already taking OAT, and for family and friends. You can use this information to help you to understand and make decisions about your treatment. You can use it to educate others. You can use it to help yourself.

## A note to family and friends

If you've been struggling to understand what your friend or family member is experiencing because of opioid addiction, and why that person is considering or taking OAT, this book can answer some of your questions, and help you to support the person you care about. Some client and family reviewers have pointed out that chapter 2, "Learning about opioid agonist therapy," provides information that can help family and friends to start making sense of what is happening. You might want to start reading on page 17.

## A note on the client quotes

The quotes included throughout this book are from people with personal experience with OAT. These are their words and opinions. The quotes are included to help those who are thinking about or starting OAT get a better idea of what to consider and what to expect, and to offer some encouragement.

# Opioid agonist therapy FAQs

Q: What is an opioid agonist?

A: Methadone and buprenorphine (Suboxone) are opioid agonists. Opioid agonist therapy (OAT) replaces the opioids you've been using, and prevents you from getting sick with opioid withdrawal.

Q: Will methadone or buprenorphine get me high?

A: When you start treatment, you may feel lightheaded or sleepy. Once you develop a tolerance to these effects, you can expect to feel "normal."

Q: Can I take opioid agonist therapy for a few weeks, and then stop?

A: Stopping OAT before you are ready carries a high risk of relapse, and of overdose. Continuing OAT over a longer term helps to keep you safe. People who start OAT usually continue with the treatment for at least a year or two. Some continue for many years. How long you stay in treatment depends on what is right for you.

Q: Are people on opioid agonist therapy still addicted to opioids?

A: The answer to this question is a bit complicated. It's true that people on OAT are still physically dependent on opioids, and that physical dependence on a drug is one of the signs of addiction; however, physical dependence on its own does not mean that a person is addicted.

Physical dependence is when a person's body has adjusted to the presence of a drug, and not having the drug causes the person to experience symptoms of withdrawal. Addiction is when a drug becomes central to a person's thoughts, emotions and activities, and the person feels a craving or compulsion to continue using the drug. OAT maintains a person's physical dependence on

opioids, and gives them the opportunity to heal and take control of their life.

Q: Will opioid agonist therapy help to relieve my chronic pain?

A: How well OAT works to control your pain depends on what is causing the pain. If your pain is caused by withdrawal symptoms, there is a good chance that it will go away with OAT. OAT may relieve other types of pain for a few hours after you take your dose. If your dose has been stabilized and pain continues to be an issue, your doctor may suggest other options to improve pain control.

Q: What are the long-term effects of methadone or buprenorphine on my internal organs and memory?

A: Long-term methadone or buprenorphine agonist treatment will not damage your internal organs, and when you are on the correct dose, it will not interfere with your thinking. If you have a medical condition such as hepatitis or cirrhosis of the liver, agonist therapy can improve your access to medical treatment, and help you to manage the illness.

Q: Is it true that methadone or buprenorphine will rot my teeth and bones?

A: This is a common concern, and although it's not true, the reasons behind it deserve some consideration.

One of the side-effects of opioids (including methadone and buprenorphine) and many other medications is dry mouth. This can make your teeth more prone to the production of plaque, which is a major cause of gum disease and tooth decay. Once people are into a routine on OAT, they often discover tooth decay that has been developing for many years. For tips on dealing with dry mouth and avoiding dental problems, see page 55.

If you're on OAT, and you feel like your bones are rotting, it's probably because you're on too low a dose. Bone ache, which may feel like bone "rot," is a symptom of opioid withdrawal. When your dose is adjusted correctly, you should not experience any aching or other symptoms of withdrawal.

Q: Will methadone or buprenorphine make me gain weight?

A: Not everyone gains weight when they go on OAT, but some do. This is usually because OAT improves your health and appetite, and so you eat more. If you've been using drugs for a long time, you may be underweight. See page 56 for tips on preventing weight gain.

Q: Will I be on opioid agonist therapy for the rest of my life?

A: There are two factors that determine how long OAT will be helpful to you. One is how much time you need to be able to deal with the issues that led you to opioid use in the first place. These issues could be emotional, such as having experienced trauma, or physical, such as chronic pain from an injury or illness. The other factor has to do with your biology. Long-term opioid use has been shown to make changes to the brain that can make it very difficult for people to live without opioids. If stopping OAT means a high risk of relapse, it makes more sense to continue. It's safer. For more on length of treatment, see page 93.

Q: Is it hard to stop opioid agonist therapy?

A: When you are ready to end OAT, your dose will be "tapered," or gradually reduced, at a rate that keeps you comfortable. The key to stopping is being sure you want to stop. See page 96 for a list of questions to help you decide whether you are ready to develop a plan with your doctor for stopping agonist treatment.



# 1

## Opioid agonist therapy and other options

Is opioid agonist therapy for you? 3

What is opioid agonist therapy? 5

The benefits of opioid agonist therapy 6

The drawbacks of opioid agonist therapy 8

Other options 10

*Withdrawal and abstinence* 10

Weighing your options 13



# 1

## Opioid agonist therapy and other options

### Is opioid agonist therapy for you?

If you've been using opioid drugs such as heroin, oxycodone, codeine, hydromorphone (Dilaudid), fentanyl, Percocet and others, and you've come to a point where you know you can't go on using, but you can't seem to stop either, opioid agonist therapy (OAT) may be right for you.

If you're pregnant, sudden opioid withdrawal can harm the baby. Seek OAT right away. Methadone is the standard OAT used in pregnancy. It prevents opioid withdrawal, and can save the life of your baby (see page 85).

People who are addicted to opioids and who are HIV or hepatitis C positive are strongly urged to begin OAT immediately. OAT helps to stabilize your health, and it lets you focus on getting the best possible care.

You may be ready for OAT if you've been using opioids for a while, and you've tried to stop. You've been through withdrawal, you've seen a counsellor, perhaps you've gone through a residential

treatment program. If you can't seem to stop using for more than a few hours, days, weeks or months at a time, and you know you want to stop, think about going on OAT.

You're ready for OAT when you're still using and all it's doing is keeping you "normal." If there's any high at all, it isn't worth it anymore. You're scared of being sick and all you want is to feel well and be free of the craving. You want to be more in control of your life, your work, your home. You want to feel better about yourself; you want to be able to offer more to the people you care about.

If you think you're ready for OAT, read through this handbook to find out what it is, how it works, what to expect and where to go. Pass this handbook on to your family and friends to help them understand and be able to offer you the support you need.

Treatment providers vary, so be prepared to ask questions. The more you know, the more you'll be in control of getting where you want to go. *Help is available.*

*I tried four types of treatment before methadone.  
I went to treatment centres. I tried cold turkey.  
Methadone allowed me to separate myself from  
my addictive behaviours pretty much overnight.  
Every step I took from the first dose I drank was in  
the right direction.*

Ben, 27 | Methadone, 8 years

*I didn't see it as addiction, it was daily living for  
me because the pain was so excruciating and I was  
just following directions. When a doctor tells you  
to take this, take that, you just take it. You don't  
think of the repercussions. I was given so much  
pain management that it got to the point where I*

*was not functioning. My doctor suggested methadone and I thought: let's give it a go, better one than 13 a day.*

Ann, 42 | Methadone, 2 years, 5 years

*When you're in a situation where you know a couple hours down the road a sickness is waiting for you if you don't do something about it, you go out and you do pretty much anything you gotta do to get it, and that really brings down people's morals, you know what I'm saying? It's not a good look. When I started methadone, that disappeared.*

J, 35 | Methadone, 6 months

## What is opioid agonist therapy ?

Two kinds of OAT are currently available in Ontario and other parts of Canada. When taken at the correct dose by people who are addicted to opioids, both therapies:

- prevent opioid withdrawal symptoms
- reduce cravings for opioids
- do not cause sedation or euphoria.

Methadone is currently the most commonly used medication for OAT, and is the standard opioid agonist therapy used during pregnancy. Buprenorphine and methadone are equally effective, although one may be more effective than the other for some people.

In Ontario, the current brand name for methadone is Methadose. It comes in a form of drink. The brand name for buprenorphine is Suboxone. Suboxone is a pill that is absorbed under the tongue. Suboxone also includes naloxone, which can cause withdrawal

if it is injected. Naloxone is added to help prevent the abuse of buprenorphine. (Naloxone, on its own, is also used to reduce the effects of an overdose; see page 37 for more on this.)

Treatment involves taking your doses while a pharmacist watches you, urine drug screens, medical care and counselling. When other opioid use stops, and you settle into a routine, take-home doses are gradually introduced.

## The benefits of opioid agonist therapy

For people who are addicted to opioids, OAT has a number of benefits over continuing to take other opioids:

- The effects of methadone and buprenorphine can last 24 to 36 hours. For most people, as long as you take your one dose a day at the same time every day, you won't get sick with opioid withdrawal.
- OAT can help to keep away the physical drug cravings, or the feeling that you need to get high. Some people have no cravings at all once they're on OAT. Others may continue to experience the "conditioned" cravings, or those that are triggered by something or someone you associate with opioid use. Keeping busy with work, school, family and things you enjoy that don't involve drugs can help. Counselling can also make it easier to cope with cravings.
- OAT is prescribed by a doctor and dispensed by a pharmacist. The source is reliable and safe.
- The methadone or buprenorphine that is provided to you through OAT is made using strict manufacturing guidelines. The exact strength is known, and it is never cut with unknown substances found in many street drugs.

- If you've been buying drugs on the street, you know what it's done to your cash flow. OAT can save you money. If you have an Ontario Drug Benefit card, or are covered by a prescription drug plan, OAT costs you little or nothing. Without coverage, methadone costs about \$10 a day. Buprenorphine costs between \$8 and \$20 a day. (For more information on help with the cost, see page 38.)
- OAT fills up the opioid receptors in your brain. This prevents withdrawal, and it can also prevent you from getting high off other opioid drugs. This is good to know, because taking other opioid drugs on top of methadone or buprenorphine is extremely dangerous. Some people choose to stay on OAT for this reason. Knowing the high risk of overdose, and that they might not even get high, keeps them safe from trying.
- OAT can give you a chance to figure out and address the reasons why you've been using drugs. It can put you in touch with people who understand where you're at, and help you get where you want to go.
- OAT can help to keep you safe. It keeps your head level, making it easier to avoid risky behaviours. For those who inject illegal opioids and share needles, OAT reduces the risk of becoming infected with HIV or hepatitis C. Needle sharing is associated with high rates of HIV and hepatitis C infection.
- People who commit crimes to get money for drugs often stop doing crime when they go on OAT. It helps to keep them out of jail, and to give everyone a safer community. For people who are facing charges, it may be helpful to know that starting OAT is viewed as a positive step by the courts and police.
- OAT can provide relief from mental health symptoms that are related to withdrawal, such as anxiety and depression.

- While OAT is not a treatment for other types of substance addiction, such as alcohol or cocaine, some people who take OAT for opioid addiction find that it can also help to reduce other substance use issues. It is not clear how much of this effect is due to the OAT and how much is due to lifestyle change and counselling.
- OAT can provide an opportunity to get treatment for mental or physical health issues that may be related to opioid use.
- Once you've been on OAT for a while, you should feel more energetic and clear-headed. This lets you focus on things like work, school and family.
- Of all treatments for opioid addiction, OAT has the best record for keeping people off other opioid drugs.

## The drawbacks of opioid agonist therapy

- OAT is not a cure for opioid addiction. What it does do is address the physical aspect of your addiction by replacing the opioids you've been using. It also helps to "break the habit" of finding and using opioids and from seeing people, places or things that can make you want to use. But you may still need to deal with any related emotional or physical issues. Combining OAT with counselling and group support is highly recommended.
- You are still physically dependent on opioids. If you miss more than one dose, you will experience withdrawal sickness.
- OAT clients may be branded as "still addicted" by some members of the community. Some say that people in methadone therapy experience more stigma than those who take buprenorphine. Either way, you may find that many people don't understand OAT, including some people who work in the addiction and

health professions. Some abstinence-based drug treatment programs and mutual-help groups may have trouble accepting OAT clients, though these are fewer now than in the past. Some doctors and pharmacists may be reluctant to work with people who take OAT, perhaps fearing they will be pressured to supply prescription drugs. Some employers may not react kindly if they discover that you're an OAT client. And some communities will protest against having OAT clinics in their neighbourhood. It's probably fair to say that most people regard OAT as a positive step, but there will be exceptions, and you should be prepared for that.

- OAT can be a long-term treatment. Most people stay on it for at least a year or two. Some stay on for as long as 20 years or more. Although it's not known to be a fact, it seems that the longer you've been addicted to opioids, the longer you'll likely stay on OAT.
- There are a limited number of physicians and pharmacies that offer OAT, especially in rural areas. If you have to travel to get your dose, you need to organize a routine to get to the clinic every day.
- OAT involves a lot of visits to the clinic or pharmacy, and to the doctor, especially when you are starting out. These daily visits take up time, which can affect your ability to work, go to school or do other things.
- You'll need to take your dose "under observation" at the clinic or pharmacy every day for at least the first two months of treatment. Even after a year of treatment, you still have to have your dose observed at least once a week.
- You'll be asked to produce samples of your urine frequently. The samples are used to make sure you are taking your OAT and to check for other drug use. You may be asked to produce samples

“under observation,” meaning someone will be watching you, often by camera, to be sure that the urine is yours, and that you haven’t done anything to change it. (For more on the urine sample, see page 39.)

- With any medication, there can be unpleasant side-effects. Side-effects tend to be strongest at the beginning of treatment. The most frequently reported side-effects of methadone and buprenorphine include drowsiness and light-headedness, nausea and vomiting, excessive sweating, constipation and change in sex drive. (See page 54 for tips on dealing with side-effects.)
- Methadone and buprenorphine are strong opioid drugs. The risk of overdose is highest at the beginning of treatment. Taking other opioid drugs, alcohol, benzodiazepines (e.g., Ativan, Valium, Rivotril) or other sedating drugs (e.g., muscle relaxants, Gravol, Sleepeze) while taking OAT can be extremely dangerous. Methadone has a higher risk of overdose than buprenorphine. See page 36 for information on recognizing and responding to the signs of overdose.

## Other options

As you can see, for all its benefits, OAT does have its drawbacks. Before you decide to commit to long-term therapy, consider these other options.

### WITHDRAWAL AND ABSTINENCE

Before opioid agonist therapy became available, the only option for getting off opioids was to go through a period of withdrawal, also known as “detox” or “cold turkey,” followed by abstinence. Withdrawal, in itself, is rarely enough to bring an end to a history of habitual opioid use. When combined with a drug rehabilitation

program, it can be successful, especially if you are highly motivated to get off opioids. However, rates of return to opioid use and overdose risk are high, and because of this, medical experts do not consider withdrawal followed by abstinence to be a treatment for opioid addiction. All the same, many people who are addicted to opioids want to try withdrawal and abstinence before they commit to agonist therapy.

The symptoms of withdrawal can be intense, but are rarely life-threatening. Symptoms can include diarrhea, abdominal cramps, goosebumps and runny nose, accompanied by a craving for the drug. Most symptoms begin to fade within a few days, but some, such as anxiety, insomnia and drug craving, may continue for weeks or months.

Note that withdrawal is not recommended for women who are pregnant, or for people with medical problems.

If you think you would like to try withdrawal, consider the following points when planning ahead:

- Withdrawal can be managed at home, or at a withdrawal management centre. To find a withdrawal management centre in your community, call ConnexOntario's Drug and Alcohol Helpline at 1 800 565-8603, or talk to your doctor.
- It's helpful to work with a doctor or withdrawal management centre if you are going to try withdrawal, as there are non-opioid prescription medications that can help to reduce the symptoms. The one that is most commonly used is clonidine, which lowers your blood pressure. This can also lower your energy level, so if you take it, be prepared to rest. Also ask your doctor about medications that can help to reduce inflammation, diarrhea and nausea.

- Some people find that acupuncture can help to relieve withdrawal symptoms, especially those whose opioid addiction is on the milder end of the scale. The treatment involves the insertion of stainless steel disposable acupuncture needles into the ears. It is believed that the needles can stimulate the release of endorphins, chemicals in the brain that help to relieve withdrawal symptoms.
- For those who are able to stop using opioids, the drug naltrexone may be helpful. Naltrexone blocks the opioid receptors in the brain, which means that even if you take opioids, you won't get high. It is also used in the treatment of alcohol addiction. Naltrexone is available as a pill that can be taken daily. It is non-addictive, and will not cause withdrawal when stopped. It does, however, increase the risk of overdose for those who stop taking naltrexone and then relapse to opioid use. This is because naltrexone reverses your tolerance to opioids.

The most important factor in getting through withdrawal is time. Over time the sickness goes away, and the cravings, which may be strong in the first days or weeks, come less often. However, many people who go through withdrawal continue to feel low, and have trouble sleeping and cravings for some time. Rates of relapse to opioid use are high, and the risk of overdose following withdrawal is greatly increased. Always remember that if you withdraw, and then use again, start low and go slow—the amount of opioids you took before withdrawal could now be enough to kill you.

### **Supports for maintaining abstinence**

Staying off opioids following withdrawal requires a strong support system. Supportive family and friends can be a huge help, but more support is often needed. The following options may help you to reach an abstinence goal.

- Follow up withdrawal with counselling sessions and/or an intensive substance use treatment program. The frequency of sessions can vary, depending on your needs. Intensive treatment programs generally run daily over several weeks, some are in the day or evening (meaning you go home at night), and others are live-in (residential). These programs often have a waiting list, so it may be several months before you can start treatment. To explore the options for support in your community, call Connex-Ontario's Drug and Alcohol Helpline at 1 800 565-8603, or talk to your doctor.
- Many people who are seeking to abstain from substance use participate in mutual help groups, such as Alcoholics Anonymous, Narcotics Anonymous, Smart Recovery or Women for Sobriety. The principle behind mutual help groups is that those who have experienced drug addiction, and have found a way to deal with it, are the most qualified to offer support and advice to others who wish to do the same. Traditionally, mutual help group members gather at informal meetings to share their personal experiences of drug addiction. Many groups now offer online meetings or teleconferences instead of or as well as gatherings. To find a mutual help meeting near you, or online, check the websites listed on page 106.

## Weighing your options

You've read about the benefits and drawbacks of OAT, you've considered and maybe even tried abstinence. If you are still unsure as to whether you are ready to commit to OAT, read on to learn more about opioid addiction, how OAT treatment works and what it involves.



## 2

# Learning about opioid agonist therapy

What's an opiate, what's an opioid? 17

How do opioid drugs work? 17

*Endorphins* 17

*Opioids* 18

Opioid dependence and addiction 19

How opioid agonist therapy works 21

The history of methadone and opioid agonist treatment 21

Opioid agonist therapy in Ontario 23



## 2

# Learning about opioid agonist therapy

## What's an opiate, what's an opioid?

The term “opiate” refers to drugs derived from the opium poppy, such as opium, morphine and codeine, and to drugs that are derived from the opium poppy and then chemically altered, such as heroin. The term “opioid” is like a family name that includes opiates, and also other drugs that have morphine-like effects, but are not made from the opium poppy. These drugs are made by chemists in labs. Pain medications containing hydromorphone, fentanyl or oxycodone (e.g., Duragesic, OxyNeo, Percocet, Dilaudid) are examples of chemically manufactured opioids; methadone and buprenorphine also belong to this group.

## How do opioid drugs work?

### ENDORPHINS

Your body produces its own opioid drugs, called endorphins. Endorphins are your body's natural painkillers.

Inside your brain is a number of what are called “pain receptors.” Their job is to tell you when pain is happening in your body. For example, if someone steps on your toe, your pain receptors light up and you cry “Ow.”

At first the pain is quite intense, but by the time the toe stepper is telling you how sorry he or she is, it doesn’t hurt quite so much. While your pain receptors have told you to feel pain, they are also signaling to your endorphins to come and relieve the pain. The endorphins “fill up” your pain receptors, so in a few minutes the pain in your toe seems trivial.

Endorphins can boost your mood too, and affect how you respond to situations of stress. Exercise is a great way to release endorphins.

## OPIOIDS

What happens if you fall and break your arm? Your body won’t produce enough endorphins to knock out that much pain. Inside your brain many of your pain receptors are still empty, and they’re screaming out to be filled with something to take away the pain.

In situations like this, it’s fortunate that opioid drugs can fill up the pain receptors in the same way as endorphins. What’s more, the strength of the opioid drug and the dose can be adjusted to address the intensity of pain, as needed. You might be moaning when you get to the hospital, but once your doctor gives you a shot of morphine, you can be reasonably comfortable while he or she sets your broken arm and puts it in a cast. Before you go home, you are given a prescription for codeine pills, so you won’t have to suffer while the arm gets better.

For many people, a situation like this would be the only time they take opioid drugs. Once the arm begins to heal and the pain

becomes tolerable, they stop taking the codeine, and don't give it a second thought.

## OPIOID DEPENDENCE AND ADDICTION

But what if the pain doesn't go away? What if the only thing that can bring relief is opioid drugs? You might continue to take them, and if you like the way they make you feel, you get some more.

After a while, your body adapts to the presence of the drug. You find that if you don't take the drug, you feel sick. You may also notice that the good feeling the opioids bring is not coming on as strong as it was. This is what is called physical dependence. Many people who take opioids for pain will develop physical dependence.

Physical dependence in itself is not the same as addiction. You know you are becoming addicted when you take more at a time to get that feeling, or you try a stronger opioid, or you continue to take opioids simply to avoid withdrawal. You think you can stop when you want to, but when you do try to stop, you can't stop thinking about starting up again. Eventually, much of your time, energy and interest are absorbed in getting and taking drugs. You feel like you have to have them.

An opioid addiction can begin in a variety of ways. Some people start out using opioids to manage pain. Some try it out, seeking out a new experience and finding one that is pleasurable and predictable for a while. Some are seeking relief from the daily grind of poverty, from emotional hardship or from depression.

Once people get into it, they may go on using for a long time, even though they know that it's dangerous, and that the pleasures are short-lived and superficial. They know the drugs keep them away from people and things that matter to them.

Some stop using drugs on their own. Some find that counselling and group therapy give them the support they need to stop. Some try to stop again and again and keep on going back. Their health, home, finances and relationships may slip into a state of chaos. They need a chance to put the struggle with the drugs aside and take the time to sort out their lives.

Here's where opioid agonist therapy (OAT) can help.

*Once the snowball starts, you don't really see it until the storm is there, and then the storm is so thick, there's no vision. You don't see anyone, you don't see anything, you don't know where to turn and you kind of fall within yourself and you lose yourself. You don't know who you are anymore. It's important to me to try to explain, because unless you've lived through it, it's very hard to understand.*

Ann, 42 | Methadone, 2 years, 5 years

*Prior to methadone, there was a cycle—find money, find someone to get a pill off of, do the pill, and then three hours later, decide whether to get high again or to feel sick. It's a very time-consuming cycle, there's no time for anything else. Not to mention crime—I ended up breaking the law to find the money. Since I started on methadone, my life has done a total 180-degree turn. I'm employed, I'm clean, I have my daughter back: I have relationships with trust.*

Shaun, 36 | Methadone, 4 years

## How opioid agonist therapy works

Methadone and buprenorphine are used to replace the opioid drugs you've been taking. They fill up the same receptors in your brain as other opioid drugs. This works to prevent withdrawal and reduce craving. While methadone and buprenorphine can be used to relieve pain, they are most noted for their role in stabilizing the lives of people who are addicted to opioid drugs.

Many other opioids, such as morphine, oxycodone and heroin, are “short acting.” This means that people who are opioid dependent will experience withdrawal symptoms only a few hours after using. Because methadone and buprenorphine are “long acting,” they can prevent withdrawal for 24 to 36 hours. Once you're on a stable dose of OAT, you should feel “normal,” and be able to focus your life on things other than drugs.

Another way OAT works is that it can “block the high” of other opioid drugs. If you take other opioids, you can die of an overdose, but you may not get high. Keep this in mind. It may save your life. Taking other opioids on top of methadone or buprenorphine is extremely dangerous.

## The history of methadone and opioid agonist treatment

Methadone was first discovered in Germany before the Second World War. When the Allied forces cut off the supply of morphine to Germany, the Germans manufactured methadone as a painkiller. After the war, the Americans seized the formula.

Methadone's first role as a treatment for opioid addiction was to ease the process of withdrawal.

The potential of methadone as a treatment for people who are addicted to opioids was recognized during a study conducted by Drs. Marie Nyswander and Vincent P. Dole in New York in the 1960s. The study involved two people with a chronic opioid addiction and long criminal records related to their addiction. The doctors hoped to show that when study participants were given enough drugs to satisfy their craving and keep them free of withdrawal, they would no longer commit crimes, and they'd become interested in other things.

Study participants were given frequent doses of morphine to keep them comfortable. Sure enough, they showed no interest in crime or other drugs. However, other than watching a bit of TV, they showed little interest in anything. All they did all day was relax on the couch, either nodding off or asking for their next shot.

Nyswander and Dole were ready to declare their experiment a failure. To prepare their study participants for withdrawal, they put them on methadone, intending to taper down the dose. To everyone's surprise, once on methadone, the participants perked up, showed little desire for drugs and began to talk of other interests. One asked if he might be given some paints so that he could renew his love of painting. The other asked if he might go back to school. The doctors had found what they were looking for! With an adequate dose of methadone, their study participants were comfortable, clear-headed and able to renew their lives.

*. . . you can't ask most drug addicts to stop and consider what vocation they want to go into, or to evaluate anything, so long as their primary preoccupation is to get drugs. When an addict no longer*

*has to worry compulsively about his source of supply, then he can concentrate on other things. At that point, rehabilitation can become a meaningful word.*

— Dr. Marie Nyswander<sup>1</sup>

## Opioid agonist therapy in Ontario

In 1996, there were 650 clients receiving methadone maintenance treatment in Ontario; as of July, 2015, there were more than 42,000. This dramatic increase is partly due to the rise in prescription opioid addiction in Ontario. It also reflects the trend in public health policy to reduce the damage of opioid use. An early sign of this trend, known as “harm reduction,” was the sprouting up of neighbourhood needle exchanges aimed at controlling the spread of HIV and other infections.

Prior to 1996, methadone treatment had been available in Ontario for many years, but there were few doctors authorized to prescribe it, and few specialized clinics to dispense it. Even if you were an ideal candidate for methadone treatment, and you were eager to get started, it might take years before you could begin. Unable to get quick access to effective treatment, people were contracting life-threatening diseases from sharing needles, and dying from overdose at an alarming rate.

In response, new guidelines for the use of methadone as a treatment of patients with opioid addiction were made available to doctors and pharmacists. The number of physicians able to prescribe methadone increased, as did the number of pharmacies ready to dispense methadone.

---

<sup>1</sup> Quoted in *A Doctor among the Addicts*, by Nat Hentoff, Rand McNally, 1968.

In some communities in Ontario, it is now possible to have an opioid addiction assessment and to start OAT on the same day. Most clients take their dose at their local pharmacy and see a doctor at a specialized OAT clinic. In future, it is hoped that more family doctors will provide the therapy, making OAT more accessible to their patients.

Buprenorphine-naloxone (Suboxone) became available for the treatment of opioid addiction in Canada in 2007.

*OAT took me off of the rollercoaster of taking pain medication to numb emotional pain, running out of it, ending up in withdrawal and feeling absolutely horribly ill. It has given me balance in my life and has helped to provide me with the mood stability that I needed in order to engage in counselling to learn to identify and cope with emotions more effectively.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

*I was a mover. I did a lot of pills, for the pain and the work, and I liked it too. I went on methadone 'cause I didn't want to get sick. It got me off my addiction.*

Paul, 57 | Methadone, 4 years

*Methadone will work if you are serious about making changes in your life. While taking methadone, you can go back to work and build healthy relationships and become a productive member of society. When you wake up in the a.m. you will be able to look at yourself in the mirror and know that you are on the right path.*

Shaun, 36 | Methadone, 4 years

# 3

## Starting opioid agonist therapy

Finding opioid agonist therapy 27

Assessment 29

Comparing methadone and buprenorphine 31

Consent and the treatment agreement 32

Your first dose and early treatment 33

Safety and avoiding overdose 34

Recognizing and responding to the signs of overdose 36

*Naloxone* 37

The “stable” dose 37

Cost 38

The urine sample 39

Community pharmacies 40

Switching between methadone and buprenorphine 41

Confidentiality 43



### 3

## Starting opioid agonist therapy

### Finding opioid agonist therapy

*We are interviewed by the clinic and we have to sign an agreement based on the rules and regulations and I think it should be vice versa as well. If I had known better, I would have interviewed all the clinics in my area and made my own choice. Make sure that you end up in the right clinic because it is going to have a major impact on your recovery. Major.*

Ann, 42 | Methadone, 2 years, 5 years

If you have not already made contact with a doctor or clinic and been prescribed opioid agonist therapy (OAT), here are some ways to connect with a treatment provider:

- Start with your family doctor. Many physicians in Ontario have taken the training that authorizes them to prescribe methadone, and all are able to prescribe buprenorphine. Your doctor may be able to treat you directly, or he or she may refer you to another doctor or a clinic that specializes in providing OAT. If you are not

comfortable seeking help for this issue from your family doctor, or you don't have one, go to a walk-in clinic for a referral.

- Contact a referral service. A number of Ontario communities offer drug and alcohol treatment assessment and referral services. To get the number of the referral service closest to you, contact ConnexOntario's 24-hour Drug and Alcohol Helpline at 1 800 565-8603 or online at [www.drugandalcoholhelpline.ca](http://www.drugandalcoholhelpline.ca). If you are in another province, see page 101 for a link to a list of other referral services. When you call your local referral service, you will be able either to get an assessment and referral over the phone or to make an appointment with a counsellor. The counsellor will then be able to direct you to a treatment that is right for you.
- In Ontario, call the Public & Physician Advisory Services at the College of Physicians and Surgeons of Ontario at 416 967-2600. Let them know you are looking for methadone therapy and ask for the number of a clinic that is accepting patients in your area. They keep a list of all doctors who are qualified to prescribe methadone in the province. Many doctors who prescribe methadone also prescribe buprenorphine. In urban areas, you may be able to choose from several methadone providers, but smaller communities or remote areas may have only one provider, or may not offer methadone treatment at all. If you need methadone treatment, you might have to travel or relocate. Some small or remote communities offer buprenorphine treatment.

*My doctor asks me how my month was, a pile of questions, everything, which is nice. She talks to me for 20 minutes, half an hour, how are you doing, have you used? A lot of doctors just give you your prescription; here you go, see you next month.*

Paul, 57 | Methadone, 4 years

*The doctor I deal with is a very caring man. He wants me to succeed.*

Shaun, 36 | Methadone, 4 years

## Assessment

Before you can begin OAT, it must be decided if the treatment is the right one for you. To make this decision, your doctor, and perhaps a nurse, counsellor or intake worker, will need to take some time to get to know you. This process, called “assessment,” gives your treatment providers the information they need to get you started.

The way the assessment process works varies depending on the clinic or doctor, but generally you can expect assessment to look at you as a “whole person.” Assessment always includes a physical examination by a doctor and a urine test to establish that you are opioid dependent. Assessment may also include a chest X-ray to check for tuberculosis and, with your permission, a blood test for HIV and hepatitis. You can expect to be asked questions about your drug use, your physical and mental health, your home and family, your work, and whether you’ve had problems with the law.

Keep in mind that your doctor and any others who interview you are only interested in giving you the treatment that you have come looking for. They are not there to judge you. Try to answer all questions as honestly as you can. Assessment is also your opportunity to get to know the people who are providing the treatment. Don’t be afraid to ask questions. Find out what you’re being tested for. Ask what other services are available along with the medication. Gather the information you need to get ready to make decisions about your treatment.

*It's natural for people in this situation to be a little closed in sharing information, but I chose to be as open as I could and to use the medical people as a resource. They were working for me, instead of just being a supplier of my prescription.*

Glen, 59 | Methadone, 15 years

Methadone is currently the most common agonist therapy; however, more people are choosing buprenorphine. The choice depends on your health and medical history, your age, your location and your own preference. The decision between the two should be based on your assessment, and made jointly by you and your doctor. Table 1 on page 31 lets you see some of the important differences between methadone and buprenorphine.

The assessment serves as a record of where you were when you started on OAT. You will be reassessed at different points in your treatment. Reassessment lets you and your doctor know how you are progressing. Providers differ in the amount of information they gather for assessment. You can expect assessment to take at least an hour, and possibly as much as most of a day.

The time it takes to accept you as a client and begin treatment varies. In some places you may get started the same day as your assessment; in others, especially smaller cities and towns, there may be a waiting list. Ask how long the process will take.

**TABLE 1: COMPARING METHADONE AND BUPRENORPHINE**

|                           | <b>Methadone</b>                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Buprenorphine</b>                                                                                                                                                                                                                          |
|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Effectiveness</b>      | <p>Effective for helping people stop using illicit opioids, and for improving their mood and quality of life</p> <p>Can take weeks to reach a fully effective dose</p>                                                                                                                                                                                                                                                                   | <p>Equally effective, though effectiveness of one or the other can vary, depending on the individual</p> <p>A fully effective dose can be reached in a day or two</p>                                                                         |
| <b>Availability</b>       | <p>Physicians require special training in order to prescribe methadone</p> <p>Most commonly available through specialized opioid addiction treatment clinics</p>                                                                                                                                                                                                                                                                         | <p>Any physician in Ontario can prescribe buprenorphine (though not all do)</p>                                                                                                                                                               |
| <b>Safety</b>             | <p>Methadone is a full opioid agonist, with the ability to suppress the part of the brain that controls breathing (causing breathing to slow or stop); the overdose risk of prescribed methadone is much higher than for prescribed buprenorphine</p> <p>Can cause the heart rhythm to be abnormal (QT prolongation) in some people, especially when taken at high doses or with other drugs</p> <p>Interacts with other medications</p> | <p>Buprenorphine is a partial opioid agonist with limited activity on the part of the brain that controls breathing</p> <p>Lower risk of affecting heart rhythm</p> <p>Fewer and less severe interactions with medications than methadone</p> |
| <b>Starting treatment</b> | <p>Methadone can often be started within 24 hours of last using other opioids</p>                                                                                                                                                                                                                                                                                                                                                        | <p>Must stop using other opioids for 12 hours to three days</p>                                                                                                                                                                               |
| <b>How it is taken</b>    | <p>In a drink that is swallowed</p>                                                                                                                                                                                                                                                                                                                                                                                                      | <p>In a tablet that is absorbed under the tongue</p>                                                                                                                                                                                          |

|              |                                                                                    |                                                                                                                                            |
|--------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Side-effects | Sedation, tooth decay (due to dry mouth), reduced libido, sweating and weight gain | Same as methadone, though these effects are much less pronounced                                                                           |
| Lifestyle    | Requires frequent visits to the pharmacy or clinic, restricts travel               | Same as methadone, but people who do well quickly on buprenorphine may be able to get carries sooner and for longer periods than methadone |

## Consent and the treatment agreement

Once you’re through the tests, you’ve answered all the questions, and it’s been decided that you’re ready for OAT, you may be asked to sign two contracts, often called “treatment agreements”—one with your doctor and one with your pharmacist. These agreements state that you consent to treatment and that you agree to obtain OAT from one physician and pharmacist only. They also set out the rules and expectations of your treatment providers.

The treatment agreements define policies regarding urine samples, drug use, photo ID, carry doses, threats, violent or criminal behaviour and the consequences if you fail to follow rules. The agreements explain that if you appear to be intoxicated when you come to the clinic or pharmacy, you will not receive your dose, and you will be asked to see your doctor before you can receive your next dose. (This is a safety precaution, because methadone or buprenorphine mixed with other drugs can be lethal.) The agreements should also spell out your rights, including your right to confidentiality.

## Your first dose and early treatment

If you start with buprenorphine, you'll be required to have stopped using other opioids for 12 hours to three days, depending on the opioid you've been using. Buprenorphine may feel like a weaker opioid when compared to the one you've been taking, but it has the power to elbow out and replace the stronger opioids attached to the receptors in your brain. If you were to take buprenorphine too soon after taking other opioids, you could experience severe withdrawal. This is why your doctor will ask you to wait for signs that you are beginning to withdraw from the opioid you've been taking before starting you on buprenorphine. When given at the right time, buprenorphine will relieve your withdrawal symptoms.

For safety reasons, your first dose of methadone (5–30 mg) or buprenorphine (1–4 mg) is low or moderate.

The main goal of early therapy is to find the right dose for you. Each person is unique in terms of how their body responds to therapy. Tell your doctor about any symptoms you have, such as craving, aching or drowsiness, because they let him or her know how to adjust your dose. Taking other drugs or alcohol in early therapy will interfere with the dose adjustment process and can be dangerous.

Some clients are reluctant to increase their dose when they start therapy. This can result in continued opioid cravings, and continued opioid use. On the other hand, some clients request increases in their dose in hopes of getting the same pleasurable effects from OAT as they did from their previous opioid. They become disappointed because higher doses of methadone or buprenorphine won't make you high, but they can worsen side-effects, such as drowsiness and constipation. Always remember that it's not the size of the dose that matters—it's the results.

With methadone, adjustments to your dose will be made once every three days. It may take a week or more to experience the full benefits of a dose increase. It can take two to six weeks to get the dose at the right level for you.

With buprenorphine, you will likely receive a few doses on the first day, and need to stay at the clinic so you can be observed between doses. You should have 24-hour relief of withdrawal by the second or third day of buprenorphine treatment.

You may be drowsy at times during the dose adjustment period, so it's important that you avoid driving and any other activities that require alertness.

## Safety and avoiding overdose

Trained health care professionals follow strict guidelines and protocols to deliver methadone and buprenorphine as OAT. Much research has been done on these drugs to establish their safe use. Having said that, all opioids have the potential for overdose, and anyone taking them should be aware of the risks and how to avoid them. You should also be aware of the signs of overdose, and know how to respond.

The risk of overdose is especially high:

- when you start treatment
- if you stop taking opioids for a while, and then start again.

The risk of overdose is highest in the first two weeks of treatment. This is because methadone and buprenorphine have a “slow on-set” and a “long duration of action.” What this means is that the drug builds up slowly in the bloodstream, and is active for a long

time. The same low dose you take on day 1 has a stronger effect on day 3, because that first dose is still working.

The risk of overdose from any opioid is especially high if you use after a period of not using. When you don't use for a while, your tolerance for opioids goes down, and so what used to be your usual dose could now be enough to kill you. Be sure your doctor or pharmacist knows about any missed doses, especially if you miss for several days.

Taking even a small amount more methadone than your body is used to can be dangerous. This is true from the time you begin treatment to when you've been taking methadone for a long time.

Buprenorphine has a lower risk of overdose than methadone because it has a "ceiling effect." This means that at a certain point, a higher dose does not have a stronger effect.

To avoid overdose, follow these precautions:

- Only take your OAT dose in the morning.
- See your doctor twice a week for the first two weeks of therapy.
- Don't take benzodiazepines (e.g., Ativan, Valium, Rivotril), alcohol or other sedating drugs (e.g., muscle relaxants, Gravol, Sleepeze); if you do drink or take other drugs, tell your doctor or pharmacist what, how much and when.
- Only take medications that are prescribed or approved by your OAT doctor; some medications interact with methadone, or add to your drowsiness (e.g., certain antibiotics and antifungals)—be sure your OAT doctor knows about everything you take.
- Discuss your treatment with a close friend or family member; make sure they know the importance of getting immediate medical help if you show the signs of overdose.<sup>2</sup>

---

<sup>2</sup> Adapted from Ontario Harm Reduction Distribution Program: [www.ohrdp.ca/opioid-overdose-prevention/](http://www.ohrdp.ca/opioid-overdose-prevention/)

## Recognizing and responding to the signs of overdose

All opioids are dangerous when taken in amounts that are greater than what the body is used to. Other factors that can affect the risk of overdose include the type of opioid used and the health and age of the person taking the drug. When overdose occurs, the person's thinking and breathing slows down, and blood is deprived of oxygen.

Early signs of overdose include:

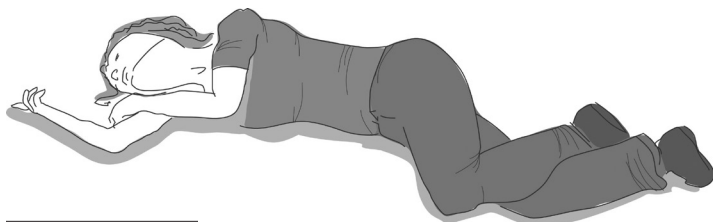
- problems with co-ordination and balance
- trouble speaking, slurring
- feeling sleepy or “nodding off” throughout the day
- becoming overly forgetful, emotional or moody.

If you experience any of these signs, your dose may be too high. See your doctor or go to Emergency right away.

Advanced signs of overdose include:

- bluish colour in the lips and fingers
- eyes have very small pupils
- can't wake the person up
- deep snoring or gurgling sounds
- slow, erratic or stopped breathing.

Any signs of overdose should be treated as a medical emergency. Turn the person on their side in the recovery position (below), and call 911.<sup>3</sup>



---

<sup>3</sup> Adapted from POINT (Preventing Overdose in Toronto) Program materials: [www.cpso.on.ca/uploadedFiles/members/Meth-conf-POINT-PP.pdf](http://www.cpso.on.ca/uploadedFiles/members/Meth-conf-POINT-PP.pdf)

## NALOXONE

Naloxone is a medication that can reduce the effects of overdose temporarily and allow time for medical help to arrive. It is now available in a kit for injection or as a nasal spray. Anyone who takes opioids should have naloxone on hand for friends or family to administer in an emergency. Ask your doctor, pharmacist or public health unit where you can get naloxone.

## The “stable” dose

Your dose is the right dose when you’ve reached a balance where withdrawal symptoms, drug cravings and side-effects are minimal. When your dose has been adjusted correctly, you should feel more energetic, clear-headed, and able to fulfill your responsibilities and pursue your interests.

Never compare the amount of your dose with the amount someone else is getting. The dose that’s right for you might be too much or too little for someone else. Each individual has a unique metabolism and his or her own tolerance level for the drug. Your dose is adjusted according to your individual need.

Take your dose at the same time every day. This helps to maintain a stable level of opioids in your body, keeping you feeling “normal.”

It’s rare, but some people metabolize methadone more quickly, and experience withdrawal well before they are due for their next dose. Usually an increase in the daily dose will fix this problem, but in some cases people require a “split dose”—taking two half-doses 12 hours apart instead of one dose once a day. If you think you are “burning up” your methadone dose too quickly and need a split

dose, ask your doctor to test the levels of methadone in your blood over the course of the day.

*Don't lose hope, and don't give up. Get over that one hurdle and then the second hurdle comes easier, the third hurdle even easier. By the time you get to your fourth hurdle, you're jumping six feet over it. It's not a big deal. It's getting over your first one that's hard.*

Ann, 42 | Methadone, 2 years, 5 years

## Cost

The cost of OAT is around \$8 to \$20 a day, though this varies, depending on your dose and on the clinic or pharmacy. Some or all of the cost may be covered if you qualify for the Ontario Drug Benefit program or if you have a prescription drug benefit plan through your work or through a family member. Students may also have drug benefits through their college or university.

Ontario Drug Benefits are available to people who:

- are on social assistance (Ontario Works)
- are on disability (Ontario Disability Support Program)
- have a low income (Trillium Drug Program)
- are 65 years of age or older.

Buprenorphine is currently listed as a “limited access” drug in Ontario, although efforts are underway to give buprenorphine the same status as methadone. What this means is that buprenorphine is covered under the Ontario Drug Benefit Program only when methadone therapy can't be used for medical reasons, or when it is not available where you live. Ask your doctor if you are eligible for coverage.

When making a claim for drug coverage, rest assured that the insurance company will not tell your employer or anyone else that you are taking OAT. It's your private business. It's confidential.

One other possible cost of OAT you might not consider is transportation. Getting to and from the clinic or pharmacy can add up, depending on where you live. If you are on Ontario Works or Ontario Disability Support (ODSP) ask your social worker about getting support for this cost. It's important to plan ahead for this expense.

Talk to your counsellor if you need more information about financial help for OAT.

## The urine sample

As an OAT client, samples of your urine will regularly be requested and tested for the presence of a variety of drugs, such as opioids, cocaine, marijuana, amphetamines, benzodiazepines and barbiturates. Some clinics require that you be “observed,” often by camera, when you are producing a urine sample. This practice is to ensure that the urine tested is yours.

Your first urine test will be part of the assessment process, when your urine will help to identify you as opioid dependent.

Once you begin OAT, you will probably be asked for urine samples at least once or twice a week for the first six months, or until you have reached the maximum number of take-home doses. After that, if your tests are negative (no evidence of drug use), the frequency of these tests may decrease. After a year or so of negative tests, you may be asked for a sample only once or twice a month. Most of the time, these tests will be done at

random. The frequency of urine testing may vary depending on your provider.

Another reason for the urine tests is to check that there is methadone or buprenorphine in your system. This is done to make sure that it's you, and not someone else, who is taking your dose. Don't ever forget that a maintenance dose for you may be an overdose for someone else. You have a tolerance to the drug because you take it every day.

Treatment providers look to the results of urine tests for signs of a continuing struggle with drug use, or as an indication of progress in treatment. For some clients, testing negative confirms that they can kick drugs and gives them an extra boost of determination. A positive urine test alerts your treatment providers to your drug use, and gives them an opportunity to protect your safety, or to offer additional emotional support. Some providers expect zero drug use, while others are more tolerant. Positive urine samples may delay or interfere with your schedule for take-home or "carry" doses, and will likely mean you'll be asked for urine samples more often.

If you test positive when you know you haven't used, you can request a retest. Sometimes labs make mistakes. It's rare, but it does sometimes happen that you could test positive for opioids after eating a poppy-seed bagel. It's your responsibility to test negative, so stick to the sesame-seed variety.

## Community pharmacies

Pharmacists in many community pharmacies, including some big drugstore chains, have taken the specialized training required to dispense OAT in Ontario.

Some clients may prefer to pick up their dose at a local pharmacy for convenience or to reduce contact with other clients at an OAT clinic. When you go to the local pharmacy to collect your dose, you'll be lining up with everyone else in your neighbourhood. If you're worried about your neighbours seeing you and knowing what you're there for, trust that the pharmacist is a professional, and will be discreet.

If you'd like to pick up your dose at your local pharmacy, call them up or drop by and ask if they stock methadone or buprenorphine, or if they would be willing to order it for you. Community pharmacists who dispense methadone or buprenorphine are providing a much-needed service. Let them know you appreciate it.

If you are having trouble locating a pharmacy that will dispense methadone in your community, speak to the staff at your current pharmacy; they can help.

*I found a fantastic pharmacy with amazing staff who treat me as if I were receiving treatment for any other condition. They are respectful of my privacy and take me into a separate room to give me my OAT if there are lots of other customers around.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

## Switching between methadone and buprenorphine

If you are on a stable dose of either methadone or buprenorphine, and the treatment is going well, you're not likely to feel a need to

switch from one to the other. However, if you find the side-effects of methadone are a problem for you, for example, or that buprenorphine is not working for you, you might consider talking to your doctor about switching medications.

A switch from buprenorphine to methadone can be made 24 hours after your last dose of buprenorphine, without any gap in treatment or experience of withdrawal. Going from methadone to buprenorphine, however, involves tapering down your methadone dose and stopping OAT for a few days to allow methadone to clear from your body. You need to be in withdrawal or clear of other opioids when you start treatment with buprenorphine. This requires some planning and preparation, but depending on your experience with methadone, it could be worth it.

*I had to wait five days for the methadone to come out of my system before I could take the Suboxone [buprenorphine]. I went to detox, and they gave me pills so I wouldn't feel the withdrawal. It was not as bad as I thought it might be, just a little bit of pain in my legs, a little anxious, maybe a couple times I was in a little bit of withdrawal, feeling a little down, but they give you a pill every four hours. After the fifth day they gave me the Suboxone—they gave me 2 mg, and I waited around a half hour and then they gave me another 2, then another half hour wait and then another 2. The way they did it was a good way.*

Andy, 33 | Methadone, 1 year;  
buprenorphine, 1 month

## Confidentiality

Understanding your rights to confidentiality in treatment can make it easier to relax and open up with your doctor or counsellor. It's important that you know that no one will be told you are in treatment, or be told anything you might talk about or reveal in treatment, except in the following circumstances:

- Information about a client is often shared and discussed among members of a treatment team, such as between your doctor and counsellor.
- When you give your consent in writing. For example, if you wish to transfer to another doctor or clinic, and need to forward your records.
- If you say something, or behave in a way that makes your doctor or counsellor think that you might hurt yourself or someone else, the law states that he or she must inform others in order to ensure safety and protect lives. Incidents or suspicion of child neglect or abuse must be reported to the police or child protection agency. Your doctor is also obligated by law to report medical conditions that may impair your ability to drive.
- If a court requires your treatment records as evidence.

If your treatment is a condition imposed by a court, or part of your probation or parole, or is a condition of keeping the custody of your child, you may be asked to sign a form that waives some of your rights to confidentiality.

All testing for HIV and other communicable diseases is confidential. If you test positive, however, this information will be shared with the public health department, and your needle-sharing or sexual partners must be informed that they have been exposed to the disease. You will have a chance to ask any questions you may have about this when you are tested.

Make a point of discussing the limits of confidentiality with your doctor or counsellor early in treatment. This is especially important if you have children. When children are involved, your right to confidentiality may be waived if the children are deemed to be “at risk.” This term is open to some individual interpretation. Some treatment providers may think that any evidence of illicit drug use puts children at risk. You’ll feel a lot more comfortable if you understand your treatment provider’s definition of the term.

# 4

## Living with opioid agonist therapy

Stigma 47

Carry doses 48

*Safety and storage* 49

*Lost or stolen doses* 50

When you can't get to the clinic or pharmacy 50

*Going out of town / out of Canada* 51

*Illness* 52

*Hospital* 52

*Arrest/jail* 53

Dealing with side-effects 54

*Constipation* 54

*Dry mouth* 55

*Excessive sweating* 55

*Weight gain* 56

*Changes in sex drive* 56

Opioid agonist therapy and employment 57

Other health issues and opioid agonist therapy 58

Resolving treatment problems 59

*Changing opioid agonist therapy providers* 60

*Involuntary discharge* 61

# 4

## Living with opioid agonist therapy

### Stigma

Given the increase in the number of people on opioid agonist therapy (OAT), and the recognition of opioid addiction as a medical problem, it's frustrating that there is still so much stigma surrounding the treatment. No one would think of scoffing at a person with diabetes for taking insulin, and yet, there are still many people who regard OAT as a sign of weakness or bad character.

You can't deny that the stigma exists, but you also can't let it get to you. When someone treats you in a way that lets you know they look down on you because of the treatment you are receiving, you can either ignore them, or you can educate them. If it's someone you care about, or who is likely to make others in your situation feel badly about themselves, the best choice is to educate them.

*There is a lot of stigma that goes with methadone.  
Everyone who is on methadone is on it for different*

*reasons. Everybody has to be treated as an individual. Nobody should be banged together in stigma. It's not helping anybody, especially people who are trying so hard. Things can only get better with more knowledge and understanding.*

Ann, 42 | Methadone, 2 years, 5 years

*My parents thought I was replacing heroin with something cheaper and legal; that it was the same thing except you're drinking it instead of sticking it in your arm. Now my parents stand behind me 100 per cent. They got educated and they understand.*

Brett, 50 | Methadone, 1 year

*Succeeding with OAT requires the ability to recognize that you are not your addiction, and to advocate for yourself, challenge and educate anyone who treats you poorly because of your decision to use OAT.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

## Carry doses

Current guidelines require that people starting out on methadone go to the clinic or pharmacy daily to take their dose under observation for at least the first two months of treatment. This is also the case with buprenorphine, although carry doses may be available sooner than with methadone in some situations. The daily contact during this initial period helps the staff to see how the therapy is working for you. They'll be looking to see if your dose is enough or too much, if you are experiencing side-effects, and if you are using other drugs.

After two months, you may be able to begin to take home, or “carry,” doses. At the beginning you will be provided with one carry dose a week. Every four weeks you’ll be given one more carry dose a week, until you reach a maximum of six take-home doses per week. There may be some flexibility around this standard rate, depending on your situation, whether you are taking methadone or buprenorphine, and on your service providers.

Carry doses are available when you have progressed well in therapy, and are prepared to take responsibility for using and storing the doses safely. One requirement for carries is that you produce a certain number of drug-free urines.

You will be asked to sign an agreement stating that you take responsibility for the safe and secure storage of carry doses, and that you understand that the doses are to be taken by you and only you. Your carry privileges may be taken away if you fail to meet the terms of agreement or if your urine tests positive for drug use.

Before you begin to carry doses, you must agree to bring any empty or full dose containers back to the clinic or pharmacy at any time, if requested. Some clinics or pharmacies require that you return all carry dose containers once they are empty. You must also agree to provide a urine sample upon request. Giving away or selling carry doses may result in criminal charges being laid against you and in the suspension of your carry privileges.

You must come to the clinic or pharmacy to collect your carry doses. Home delivery is not available.

## **SAFETY AND STORAGE**

Your maintenance dose of methadone or buprenorphine could seriously harm or kill someone who has no tolerance for the drug.

A small child might mistake your dose of methadone for ordinary juice, drink it, and die. Never transfer your dose to a container that might make it easier to mistake what's inside. You are responsible for the safekeeping of your doses, and you will be held responsible if someone else takes your dose.

Even though carry doses are generally stored in childproof bottles, it is required that you store carry doses in a locked box, such as one sold for fishing tackle or cash. You may be able to buy one of these at your local pharmacy.

It's recommended that you keep your methadone carries in the fridge.

## LOST OR STOLEN DOSES

Carry doses that are lost or stolen may not be replaced, and must be reported to police in order to alert the public and prevent harm. Loss or theft of carry doses may result in having your carry privileges suspended, meaning you will have to come to the clinic or pharmacy every day to take your dose. It is your responsibility to store your carry doses safely.

## When you can't get to the clinic or pharmacy

There will be times when you can't make it to the clinic or pharmacy. It's important that you don't miss your dose in the following situations:

- You wish to travel away from home.
- You are ill.
- You are in an accident.
- You are hospitalized.
- You are arrested.

In general, follow these guidelines to help ensure you don't miss your dose:

- Some clinics will issue you an OAT client photo ID card. If you have one, carry it with you at all times to identify you as a client.
- Keep the phone number of your clinic or pharmacy and doctor in your wallet. If you are hospitalized or arrested, contacting your pharmacy or doctor will help to ensure that you receive the correct dose.
- Consider getting a MedicAlert bracelet stating that you are an OAT client, and wear the bracelet at all times. If you are in an accident, this can help to ensure you get the correct medication.

## GOING OUT OF TOWN / OUT OF CANADA

It takes a little organization and thinking ahead, but if you want to travel, you can go a long way and still get your methadone or buprenorphine. You may be able to “guest dose” at another pharmacy, in another town or city, in another province, or even in another country. When planning a trip, talk to your doctor well in advance. If you are already receiving carries, and you have not had problematic drug use for months, your doctor may give “special carries” for work or vacation travel up to a maximum of two to four weeks at a time. Your doctor may also help to make arrangements for guest dosing.

If you have earned carry privileges, and wish to take your carry doses with you on a trip across the border, follow these guidelines from U.S. customs:

- Declare all medications.
- Be sure the packaging of your doses is marked by the pharmacy with your name and the prescription information.

- Carry only the doses you will need for personal use while you are in the U.S.
- Travel with a letter from your doctor or clinic that describes your therapy and your dose. Be sure the letter includes a telephone number to call to confirm the letter.

Methadone and buprenorphine are available as prescription drugs in many countries around the world. The INDRO website (<http://indro-online.de/travel.htm>) has information on travel regulations for more than 150 countries for patients participating in drug substitution therapy. The site includes, for some countries, names of providers and customs contacts. Follow up to be sure the information is up to date. If you don't have access to the Internet, your pharmacist should be able to find out about the legal status and availability of methadone or buprenorphine in the country that you wish to visit.

## ILLNESS

If you are too ill to get to the pharmacy to collect your dose, contact your pharmacy to let them know. In extreme situations your pharmacist may be willing to deliver your dose and watch you take it.

## HOSPITAL

If you are admitted to hospital, either as a planned visit or in an emergency situation, it's extremely important that the staff there know that you are an OAT client. This is important not only so that you can receive your dose, but also because some other drugs can be dangerous if taken in combination with methadone or buprenorphine. Encourage the hospital staff to speak with your OAT doctor about your medication, and your care. If you can, it's a good idea to take someone with you who can help with this communication. Not everyone who works in health care understands OAT, and the extra support can be helpful.

*I had a stroke, and my counsellor came to the hospital and organized my methadone right away, and she came three or four times when I was in rehab. After, when I had appointments to test my abilities, she went with me. It was good.*

Ruth, 64 | Methadone, 22 years

*When I went to Emergency with a migraine and disclosed that I was on OAT, it was assumed that I was drug seeking. I was treated very poorly. The majority of stigma that I faced as a result of using OAT was from health care providers.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

## ARREST/JAIL

If you have to spend time in a provincial or federal jail in Ontario, you should be able to continue your treatment while in jail, provided it is still the right treatment for you. Both the provincial and federal governments are striving to provide OAT to anyone who was receiving treatment before the beginning of a sentence. Methadone clients who have been to jail report that it can take a few days to get your first dose. If you have any problems with continuing treatment, contact your OAT doctor or clinic for help in advocating for you. Doctors serving jail populations in Ontario are either authorized to prescribe methadone or able to arrange that it be made available.

*When I went to jail, it took four days to finally get my methadone. I told them when I got there that I needed it, but I guess the way the system's running right now in jails, they're all behind in everything, so that's why it took them*

*so long to come. After that they gave it to me every day.*

Andy, 33 | Methadone, 1 year;  
buprenorphine, 1 month

## Dealing with side-effects

Some people are troubled by the side-effects of OAT, and others barely notice them at all. That said, side-effects tend to be more of an issue early in treatment, and when you are on a higher dose. Side-effects also tend to be stronger with methadone than buprenorphine. Be sure to talk with your doctor about anything you are experiencing that might be a side-effect, and try some of the tips for each of the common side-effects listed below.

*There are things to help with all side-effects: don't give up. It may be time to look at where your dose is at, you may be plateaued too long, you may be up too high, you may need to go down—something needs to be played with.*

Ann, 42 | Methadone, 2 years, 5 years

### CONSTIPATION

Like other opioids, methadone and buprenorphine can cause constipation. Try to keep things moving by keeping active with any kind of exercise and by eating plenty of fruits, vegetables and other high-fibre foods. Prunes and prune juice are a good old-fashioned tried-and-true remedy. Beware of foods that are high in fat like cheese and pastries. These are harder to digest and tend to make your system sluggish.

If you're not used to a high-fibre diet, go easy at first. Wash it all through with plenty of water. These foods can cause bloating and gas. Gradually your body will be able to process this diet without too much embarrassment.

If problems with constipation persist, talk to your doctor or pharmacist. The constipating effects of opioids are not something that people get used to with time. Use of regular laxatives is safe and may be needed. Fibre-based laxatives, (e.g., psyllium) are not recommended because they can increase constipation if not taken with enough water.

*I wish I'd know that it binds you up, that you can't  
go to the bathroom for days, sometimes a week,  
you get pains, sweating. It really hurts.*

Paul, 57 | Methadone, 4 years

## DRY MOUTH

Dry mouth is a common side-effect of many medications. To protect your teeth, follow the dental routine recommended for everyone: brush and floss every day, go to the dentist at least twice a year and cut sugar from your diet. Drinking plenty of water and chewing sugarless gum can also help to relieve dry mouth. If the problem persists, your pharmacist may be able to suggest products that can help.

## EXCESSIVE SWEATING

This persistent symptom can be difficult to control. Sometimes, if you are on a high dose, lowering the dose may stop the sweating, although some people continue to experience this side-effect even on a low dose. There is a medication that can help to reduce sweating, although it may worsen constipation; ask your doctor if he

or she would recommend it. Lighter, natural-fibre clothes, strong antiperspirant and baby powder help some to feel less humid.

*I never sweated until I started methadone—not a drop! I was prescribed something for the sweating, and I just had to take it for a bit, until I was at the right dose of methadone, and then I was fine.*

Ann, 42 | Methadone, 2 years, 5 years

## WEIGHT GAIN

Not everyone gains weight when they go on OAT, but some people find that they eat more and are less active, and that the pounds pile on. Methadone and buprenorphine can slow your metabolism and cause water retention, which can also lead to weight gain.

The best thing you can do is to get up, get out, walk, jog, take a class, join a team, do whatever it takes to get you moving—it will help you to feel better in your mind and body. If you don't cook for yourself already, now could be a good time to learn how to make the fresh, healthy food your body needs to maintain a good weight and to feel great. Choose healthy foods that are high in fibre such as whole grains and fruits and vegetables.

*I wish I would have known that it was going to make me gain 70 pounds; warn people that they may gain weight.*

David, 56 | Methadone, 3 years

## CHANGES IN SEX DRIVE

Some people on methadone or buprenorphine say they have little sex drive and are unable to experience an orgasm. Others say that since they are off other opioids and feeling better, their sex life has improved. It's an individual experience.

All opioids, including methadone and buprenorphine, can lower testosterone levels in men, which can reduce sex drive and lower mood and energy. If you are a man and you are feeling these effects, ask your doctor to test your testosterone levels. Depending on the levels and where you are at in treatment, your doctor may suggest you take testosterone replacement medication. There can be some risks with this treatment, so be sure to go over these with your doctor.

Another possible reason for a change in your sex drive could be another medication you are taking. Mental health problems, such as depression, can also affect your sex drive. If you are having problems of a sexual nature, work with your doctor to see if there might be a medical reason.

## Opioid agonist therapy and employment

Once you're on a stable dose, the fact that you take methadone or buprenorphine shouldn't affect your job. The only issues that might limit your choice of work would be travel or working in a remote area, which can make it hard to get to your pharmacy every day, and whether your pharmacy is open outside of your work hours.

For most jobs, there's no reason to mention that you take OAT, and your employer has no right to know. If you wish to do a job that involves operating a vehicle, however, your doctor must be willing to "recommend" you for a licence. OAT clients applying for a commercial licence are considered on a case-by-case basis, and must prove that they are stable and show no other drug use on their urine test.

*In the beginning you may need to take some time off work/school/life to fully commit to the program.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

*Methadone has helped me be more active with my children and more productive at work.*

Dan, 37 | Methadone, 2 years

*I find it hard to maintain employment on this treatment because the clinic is only open so many hours a day, so if you are working you might have an issue getting there.*

Josée, 34 | Methadone

*If you are unable to take time off work, Suboxone (buprenorphine) is much easier to work on and stay active.*

Gemma, 34 | Methadone and  
buprenorphine, 4 years

## Other health issues and opioid agonist therapy

OAT can be a great benefit to opioid users who have other physical and mental health issues. Because OAT allows you to lead a “normal” life, it’s easier to take care of yourself, to eat better, to get the medical care you need and to take your medications at the right times. OAT helps you to feel well and to be able to do the things you want to do with your life.

Be sure to discuss any prescription drugs you are taking with your OAT doctor. Some of these drugs may interfere with methadone or buprenorphine, and your dose may need to be adjusted.

## Resolving treatment problems

If you are unhappy with your treatment, your first approach should be to talk it over with your doctor. If, for example, you feel your dose has not been adjusted correctly, explain what you feel. That might be all it takes to fix the problem.

If you feel there's a problem with your treatment that hasn't been fixed by talking to your doctor or counsellor, you may consider changing your provider. If you live in an urban area, there may be a number of doctors and clinics to choose from. You should be able to find one whose approach to treatment meets your needs. If you live in a small community, you might have to work it out or be willing to travel.

As a last resort, and if you feel the problems with your treatment provider are severe and remain unresolved, you can complain to the College of Physicians and Surgeons of Ontario at 416 967-2600.

Most of the professionals you'll meet through OAT will treat you with respect and offer support and encouragement. But there may be exceptions.

*The clinic I started with was extremely inflexible, treating everyone with the same cookie-cutter model. It felt impossible to gain their trust. I could not live with the stigma and poor treatment. I eventually switched treatment providers. Because my new doctor trusted me, I worked so much harder to make the treatment work.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

## CHANGING OPIOID AGONIST THERAPY PROVIDERS

If you move to a different neighbourhood or town, or if you do decide you want to try another doctor or clinic, you can change your provider. All that it takes, once you identify where you want to go and they've agreed to take you, is for you to give permission to have your records transferred. There will be a form to sign. Ask how long the process will take.

## INVOLUNTARY DISCHARGE

Clients who break the rules outlined in the treatment agreement may be discharged from treatment. Reasons for discharge include:

- behaving in a threatening, violent or disruptive manner toward staff, other clients or other people
- selling or giving away methadone or buprenorphine
- not showing up to pick up your dose more than three days in a row, or missing picking up your dose often (without good reason)
- committing an illegal act on the premises, such as shoplifting or selling drugs
- continuing to use other drugs.

If you are to be discharged, your physician or pharmacist will clearly let you know that your treatment will no longer be available through them (usually in writing) and the process for ending treatment. Your current provider will either try to transfer you to another physician or pharmacist or give you a reasonable amount of time to find treatment services elsewhere.

# 5

## Opioid agonist therapy and other drugs

Opioid agonist therapy and pain relief 63

*Narcotics Monitoring System* 65

Mixing opioid agonist therapy and other drugs 65

*Alcohol and benzodiazepines* 65

*Is there a safe level of drinking?* 66

*Other opioids* 67

*Drugs that will cause withdrawal* 67

*Cocaine and crack* 68

*Marijuana* 69

*Other drugs / vitamins / herbal remedies* 69

*Opioid agonist therapy, antidepressants  
and other psychiatric medications* 69

Safe injection 70



## 5

# Opioid agonist therapy and other drugs

## Opioid agonist therapy and pain relief

Thirty to 40 per cent of opioid agonist therapy (OAT) clients suffer from chronic pain. Unrelieved pain can lead to illicit drug use or to misuse of prescription pain medication. Unrelieved pain can also affect your quality of life.

Methadone and buprenorphine can provide effective pain relief, but when they are used for pain, the dosage is different from the dosage used to treat opioid addiction. Also, the pain-relieving effects of methadone and buprenorphine last for a shorter time than the maintenance effects. If pain relief is an issue, and you are able to take home carries, your doctor may prescribe that your dose be divided and taken throughout the day. You may also wish to seek out an assessment by a pain and addiction specialist, who may offer recommendations to your OAT provider to treat your pain more effectively.

Acute pain in OAT clients is sometimes under-medicated because medical staff may assume that the methadone or buprenorphine you take provides pain relief. The truth is, once you are on a stable dose of OAT, you may be tolerant to its pain-relieving effects. This means that if you are in pain, you need pain medication just as much as anyone else in a similar situation.

For example, if you have a headache, menstrual cramps or any other low-level pain, you should get relief with a normal dose of Aspirin or Tylenol without codeine. If you require surgery or are in an accident, you should continue to take your normal dose of methadone or buprenorphine, and receive pain medication for the same length of time as anyone else in a similar condition. In some cases, if you are tolerant to the pain-relieving effects of methadone or buprenorphine, you may also be tolerant to the pain-relieving effects of other opioids. Some clients run into trouble with this because the medical staff who are treating them may suspect they are complaining of pain in order to get more drugs to get high.

If you are booked for surgery or dental work, ask your OAT doctor to provide you with a letter that says you are on OAT and how that affects your needs for pain relief. An even better option is to ask the doctor or dentist who is treating you to talk to your OAT doctor.

When you are struggling to overcome opioid addiction, you may question whether or not you want or need to take medication for pain relief. Some people may fear that even taking an Aspirin might lead them back into taking other drugs. Others may feel that their history of opioid use makes it even more difficult for them to cope with pain. If pain is a problem for you, talk to your doctor.

## **NARCOTICS MONITORING SYSTEM**

Ontario launched a central system to monitor prescriptions for opioids and certain other drugs in 2012. When filling a prescription for opioid drugs, you may now be asked to show ID. This allows the pharmacist to be aware of other prescriptions for opioids that have been filled for you at other pharmacies. The system is aimed at making the prescribing and dispensing of opioids safer and more secure.

## **Mixing opioid agonist therapy and other drugs**

Methadone and buprenorphine are potent drugs, and can interact with other drugs to have undesirable or dangerous effects or that can affect the effectiveness of OAT. Your doctor knows not to prescribe drugs that will interact or interfere with OAT, but it's up to you to know the potential impact of any recreational drugs you might take.

Dangerous combinations are described in the sections below.

## **ALCOHOL AND BENZODIAZEPINES**

Mixing methadone or buprenorphine with alcohol or benzodiazepines (e.g., Ativan, Xanax, Restoril, Valium, clonazepam) can kill you. The danger is particularly high when you first start treatment. Most OAT-related deaths involve alcohol and other drugs, and occur early in treatment.

Alcohol, benzodiazepines, methadone and buprenorphine are all central nervous system (CNS) depressants. If you take too much of any CNS depressant, it slows down your breathing, which can lead to heart failure and even death.

When you mix CNS depressants together, they intensify each other's effects. This means they can make you feel more drunk or stoned than you might expect. It also means that the effect on your breathing is intensified. Combining these drugs is extremely dangerous.

If you show up at your clinic or pharmacy, and it's clear that you've been drinking or using other drugs, you won't be given your methadone or buprenorphine dose until your doctor has determined that it is safe. Some pharmacists might ask you to do a breathalyzer test if they suspect you've been drinking. It's their job to medicate you safely. They're on your side.

Alcohol or benzodiazepines can impair your judgment. When your judgment is impaired, it's easier to get into a situation where you might think you can use your drug of choice "just one more time," or, just as serious, you might think the person who's offering it to you is a friend who's doing you a favour. If you want to keep control of your actions, and protect yourself from people you can't trust, make it easier for yourself: Stay sober.

Alcohol can also speed up the metabolism of opioids in your body. This means that the methadone or buprenorphine will wear off quicker, and you might end up feeling sick before it's time to get your next dose.

## **IS THERE A SAFE LEVEL OF DRINKING?**

If you want to drink, this is a question you should ask your doctor. Whether or not it's safe for you to have a drink or two now and then depends on a number of factors. For example, anyone who is hepatitis C positive should avoid drinking altogether because of the stress alcohol puts on the liver. Another consideration is how alcohol might interact with any other medications you might be taking besides methadone or buprenorphine.

Even though alcohol is everywhere and it's cheap and it's legal, when you're on OAT, drinking can cause more problems than it's worth.

## OTHER OPIOIDS

As we've mentioned earlier, methadone and buprenorphine can block the high of other opioid drugs. That means that if you're on OAT and, for example, you take some heroin, codeine, fentanyl, Dilaudid or Percocet, you may not get the desired effect. What you could get is an overdose, especially if you are taking methadone.

*The one thing that surprises me you don't hear: If you're on a stable dose of methadone, you cannot get high off opiates. You can die; you just can't get stoned. I have friends who stay on methadone for just that reason, even when they are secure in their sobriety, just in the off chance they have one of those days, they know they can't use.*

Glen, 59 | Methadone, 15 years

## DRUGS THAT WILL CAUSE WITHDRAWAL

Certain drugs can reverse the effects of opioids and cause withdrawal. Naloxone is an example of one that could save your life if you were to overdose. Another one is naltrexone. It can be used by people who have stopped using opioids to prevent them from getting high if they use again. Naltrexone can also be used by people with alcohol addiction to help reduce the urge or desire to drink.

If you are taking buprenorphine, you are likely taking Suboxone, which is a combination of buprenorphine and naloxone. When Suboxone is placed under the tongue, the body does not absorb the naloxone. However, if you were to inject Suboxone, the naloxone would take effect, and you could experience withdrawal.

Buprenorphine itself can cause withdrawal if used by someone who uses opioids regularly, including methadone.

Some medications can cause the body to break down methadone more quickly and can cause withdrawal if the dose is not adjusted.

## COCAINE AND CRACK

Too many people who get on OAT start using cocaine or crack. Cocaine is highly addictive and has the potential to make people anxious and paranoid, even violent and deluded. Taking it will give you a whole new set of problems, and there are no drug therapies like OAT to help you to deal with a cocaine addiction.

*When I first began methadone, in some ways I felt the same opioid effect as when I was using—I did not have cravings. Over time the satisfaction diminished and I was vulnerable to seeking a replacement drug. Methadone is not a cure for drug cravings other than for opioid cravings. I was not prepared for this return desire to get high and I thought I would be fine to take cocaine and crack, etc. People should be prepared for this change in desire that may occur over time and take steps to protect their environment so they are not too vulnerable to being with people who use other drugs.*

Sean W., 36 | Methadone, 15 years

*Once I went on methadone, I found cocaine and I fell in love with that. I haven't stuck a needle in my arm in years, but I just can't get rid of the pipe.*

Brett, 50 | Methadone, 1 year

## **MARIJUANA**

People often focus on the benefits of marijuana, saying it helps them to relax, improves their appetite or reduces their pain, and dismiss the risks. While marijuana can have positive effects for some people, it's important to recognize that it can also distort your senses and thinking. In some people, marijuana can reduce motivation or trigger anxiety, paranoia and depression. If you use marijuana, talk to your doctor or counsellor about whether it might cause problems for you.

## **OTHER DRUGS / VITAMINS / HERBAL REMEDIES**

Some other drugs can be dangerous if taken in combination with methadone or buprenorphine. Others may alter or interfere with the effectiveness of OAT. This includes drugs that are prescribed or that you get from a pharmacy or health food store. To be safe, and to be sure you're comfortable, let your pharmacist and physician know about all of the other drugs, vitamins and herbal remedies you take.

## **OPIOID AGONIST THERAPY, ANTIDEPRESSANTS AND OTHER PSYCHIATRIC MEDICATIONS**

Mental health issues, such as depression, anxiety or posttraumatic stress, may make people more vulnerable to developing an addiction to opioids. If you were taking antidepressants or other psychiatric drugs to treat your mental health symptoms before starting OAT, your doctor will check for potential interactions and change your medication if needed. It's important to take any prescribed medications as directed, and to tell your doctor about any symptoms you experience or any unwanted effects that might be caused by the medications. Some people find that OAT helps to relieve mental health symptoms.

## Safe injection

If you have a history of injection drug use, everybody's hoping that once you're on OAT, you'll never touch another needle in your life. Sometimes, though, it takes longer to get clear of drugs than it does to begin agonist therapy. Always avoid injecting, but if you do, please follow this advice:

Always use a new needle. Even cleaning with bleach may not protect you from becoming infected with hepatitis C (HCV). Many people who inject drugs are infected with HCV. Sharing needles, spoons and filters, and anything else used around injection can pass on blood containing the HCV or HIV virus and put you at risk of becoming infected or of passing an infection on to someone else. Needles are only meant to be used once. After that they are dull and could damage your veins. Dispose of used needles safely so no one gets sick or hurt. Needles are available through needle exchanges, pharmacies, some clinics and public health departments.

# 6

## Counselling and other supports

|                                   |    |
|-----------------------------------|----|
| Counselling services              | 73 |
| The benefits of counselling       | 75 |
| <i>Talking to your counsellor</i> | 76 |
| <i>Group therapy</i>              | 77 |
| <i>Family therapy and support</i> | 78 |
| Mutual help and peer support      | 78 |
| Learning a new way of living      | 80 |
| What'll I do if I don't do drugs? | 80 |



## 6

# Counselling and other supports

## Counselling services

Combining counselling with opioid agonist therapy (OAT) is highly recommended for all OAT clients. Addiction is often a consequence of unresolved emotional issues that cannot be addressed by OAT. It is generally accepted that OAT with counselling is far more effective than OAT alone.

The level of counselling services that are available through OAT providers varies widely. Some doctors provide counselling along with medical care, some clinics have counsellors on staff who offer individual and/or group counselling, and some OAT providers offer no counselling support at all, leaving it up to the client to seek out counselling services elsewhere.

If the level of counselling support offered by your OAT provider does not meet your needs, consider seeking out a psychological assessment to help identify and address issues that may be affecting your emotional health. A history of neglect, abuse and other kinds of trauma is common among people with addiction. Dealing with an addiction often requires dealing with these issues as well.

Counselling services can be provided by a drug treatment counsellor or a social worker, or by your doctor. The level of training and experience of counsellors can vary widely, from those who can tell you where to find food banks and hostels, to those who are able to treat complex psychological problems. Be aware also that counsellors vary in their approach to substance use issues. Some are abstinence based, and may require that you stop all drug use before accepting you as a client. Others are more interested in harm reduction, and are willing to work with you “where you are at.” Make sure you are comfortable with the counsellor’s approach, and that you feel respected, understood and supported. It can be a challenge to find a counsellor who is a good match for you, but it can be well worth the effort.

If you are considering an intensive “rehab” experience, note that many residential treatment centres and therapeutic communities are abstinence based. Some accept residents in OAT, but some don’t because they don’t have a pharmacy on-site or the staff to monitor trips to the pharmacy.

Get started by discussing your counselling needs with your treatment provider to see if you need a referral to outside services. You can also call the ConnexOntario Mental Health (1 866 531-2600) or Drug and Alcohol (1 800 565-8603) helplines to connect you with the counselling services you need. Be prepared that it could take a while to get an appointment with a counsellor; waiting lists are common.

*Prior to counselling I didn't realize why I got into this mess. There are diverse reasons why people do drugs. I took drugs as a way of getting away from things, but it made it much worse. Counselling helps you to deal with the issues and to move in a positive direction.*

Shaun, 36 | Methadone, 4 years

## THE BENEFITS OF COUNSELLING

It's accepted wisdom that talking out your problems with someone you trust can help to make things clearer, simpler and easier to solve.

Most often the person you trust is a friend or family member. This is the person you call when you want help or advice. This is the person who listens. If you have someone like this in your life, someone who can offer you support, you may be more fortunate than you know. Strong personal relationships give emotional strength, and you need that strength to learn to live without drugs.

Even if you have a good friend, it is still a good idea to seek out the services of a qualified counsellor. Your friend may be wise in many ways, but he or she may not know how to help you in your struggle with drugs. Sometimes your friend may be too close and too involved to be able to provide the support you need. Find a counsellor with experience in helping people in your situation.

Having the services of a good counsellor can also help to ensure that you keep your good friend. If you're trying to get through a difficult time in your life, you may be looking to your friend for help a little too often. You may not be able to offer much in return. You can avoid stressing your relationship by laying the heavy stuff on your counsellor. Your counsellor's job is to listen, to understand and to help you solve your problems for yourself.

*You have to work at your recovery; it's more than just going and getting methadone everyday.*

Gemma, 31 | Methadone and  
buprenorphine, 4 years

## TALKING TO YOUR COUNSELLOR

You may find it difficult to open up and trust your counsellor at first. He or she understands that and is willing to help you at whatever level you need. People starting OAT may need help to find a better place to live, to get a job or get into school, to heal relationships, to get through court or to get their kids back. When you're ready, you'll be encouraged to talk about your drug use.

As you progress in counselling, you should find it easier to relax and open up. Your counsellor is not going to judge you for what you have or haven't done. Your counsellor's job is to understand and, more importantly, to help you understand why you use drugs. You'll talk about the people, places and things that make you vulnerable to using, your past attempts to change your use, and the challenges you are currently experiencing with changing your use. You'll talk about what will happen if you continue to use, and what will happen if you stop. Your counsellor will work with you to set goals, and then provide the support you need to work toward those goals.

Counselling may be optional, but the success of your treatment may depend on it.

*Counselling has been very important. I may not be ready to discuss something, but my counsellor brings it up and we talk about it a little bit, and the next time a little more, so you get into it, and she doesn't force it.*

Ruth, 64 | Methadone, 22 years

*Counselling has been an integral part of my learning to understand the process of addiction, the situation and feelings that created a desire for escape.*

*It has provided me with validation for my feelings  
and put issues into proper perspective.*

Courtney, 39 | Buprenorphine, 1 year

*Engaging in trauma therapy has been absolutely  
critical to my recovery. I was not aware of how  
desperate I was to numb my feelings.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

*To succeed you can't just take it and not follow  
up with counselling. Anyone on methadone  
needs to sit down with a counsellor minimum  
once a month.*

Chantale, 35 | Methadone, 6 years

## GROUP THERAPY

In addition to individual counselling, you may be encouraged to participate in group therapy. Group therapy can provide an opportunity to connect with others who have had experiences that are similar to yours. It can be helpful to realize that you are not alone, and the exchange of strategies and feedback with others can be therapeutic and rewarding. Consider seeking out group therapy through your OAT provider.

*My last big rehab was group therapy based and it  
was crucial for me—I called it my lottery win. My  
take on addiction—you're doing that to yourself for  
some reason—and to stop it, you need to find out  
what the issues are, and to deal with those issues.  
I did that through a combination of group therapy  
and one-on-one with professional people.*

Glen, 59 | Methadone, 15 years

## **FAMILY THERAPY AND SUPPORT**

Family therapy provides a safe space for family members to communicate openly and effectively. People often hide their drug use from their family. Families may be unaware of what is happening until the situation becomes a crisis. Families need to understand why their family member uses drugs and what they can do to help. Family therapy also helps the person who uses drugs to understand how it affects other members of the family and what support their family members can offer.

Family members and friends may also wish to seek out the support of other families who are experiencing similar challenges. To find family support in your community, contact ConnexOntario's Drug and Alcohol Helpline at 1 800 565-8603.

## **Mutual help and peer support**

When people think of support for people with addictions, they often think of 12-step mutual support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). These groups can be helpful, but they don't suit everyone. One issue is that AA and NA discourage all substance use and may consider OAT to be a form of substance use. This can vary though, depending on the group. Another issue is that NA groups may introduce you to people who are losing the struggle to stay away from drugs and who may not be the best company for you at a vulnerable time.

On the other hand, some people say these groups provide exactly the support they need. It's a personal choice. If you think you'd like to try an AA or NA group in your community, you may want to check first to see if they welcome OAT clients.

*I have participated in these groups and have mixed feelings. The groups can be catty but the principles are something to ponder. They can be helpful. Take from it what you want.*

Randall, 29 | Methadone, 7 months

*My exposure to NA has been mostly negative. I don't see the merit in constantly reinforcing your addiction by using the mantra "I'm Ben and I'm an addict."*

Ben, 27 | Methadone, 8 years

*NA is good support. You get people's numbers. If you get that urge you can call someone. You can go to meetings 24/7. Groups are very helpful.*

Brett, 50 | Methadone, 1 year

Some communities also offer groups that are not based on the 12-steps. SMART Recovery groups are becoming more available in Canada. These groups focus on increasing motivation to quit, handling urges, developing new ways of coping and creating a healthy, positive lifestyle. Another option is Women for Sobriety, which has an aim to empower women to handle life situations without resorting to alcohol or drugs. Both offer online support as well as meetings. To find out more about mutual help groups, see page 106 for a list of websites.

Another form of help that may be available in your community is peer support. Peer supporters are generally well educated and trained in supporting people with addiction. Check with your local community health agency (see page 101 for a link to a list of agencies in Ontario), or ask your OAT provider about peer support.

If you cannot find the right support for you in your community, or you are at a point in your recovery where you feel you can offer support to others who might benefit from your experience, consider forming a group or becoming a peer support worker yourself.

## Learning a new way of living

Few people can stop using drugs overnight just because they decide they want to quit. You may have to learn a whole new way of living. For most, it is an ongoing process that takes time, patience and determination. Make your decision and follow through. Don't be afraid to ask for help when you need it. You may even be able to offer help to others. It will get easier.

*I changed my whole life. I knew too many people.  
People don't care if you're trying to get help,  
they're still going to offer you to get high; it's just  
the way it is. You gotta find other things to do.*

Paul, 57 | Methadone, 4 years

## What'll I do if I don't do drugs?

Doing drugs can fill up your day. It's a busy life: getting the cash, finding your dealer and getting high. Drugs can be a reason to get up and go out. They can offer an identity, a lifestyle, a career. Drugs can block out the past and stand in the way of planning for what's ahead. When you go on OAT and you stop using drugs, the days will open up. You'll be able to choose from a variety of possibilities of what you might do with your time. Drugs won't decide it for you.

The surprising thing is, this newfound freedom can be hard to adjust to. For some, the time is easily filled and welcome. This may be the chance to get back to school or to get ahead in your work. If you have small children, your days can fly by taking care of them. Others may need to search harder to fill the gap that drugs have left. If boredom sets in, it can make you vulnerable to relapse. You need to find new ways to spend your day.

Having things you want to do with your time, that you enjoy, that you take pride in and that make you feel good about yourself can be a great motivator to staying off drugs. Getting out to get your dose takes up a chunk of the day, but it still gives you plenty of time to do other things. If it seems like everyone else is busy and you're left with nothing to do, take that time to work out what you want to do. Talk it over with your family, your friends, your counselor. Think about what you used to do before drugs took away your time. Renew those interests and activities, or find new interests. Use the time to make your life your own.

*. . . learning to manage, or control, or simply live with an opioid addiction is not really about stopping the use of narcotic drugs. It's more about learning how to find satisfaction and meaning through your interactions with the world and the people around you.*

Sean W., 36 | Methadone, 15 years



# 7

## Birth control, pregnancy, family and opioid agonist therapy

Birth control 85

Pregnancy 85

Infant withdrawal 87

Breastfeeding 87

Child protection services 88



## 7

# Birth control, pregnancy, family and opioid agonist therapy

## Birth control

Long-term use of heroin, oxycodone or other opioids can result in reduced sexual desire for both sexes, and for women, it can cause them to stop having a period. Getting stabilized on opioid agonist therapy (OAT) may help to increase interest in sex. For women, the improvements in health can include a return of the menstrual cycle. It's important to note that you can become pregnant even when you have not had a period for some time. To avoid an unwanted pregnancy, use birth control.

## Pregnancy

Women who are pregnant and who continue to use opioids are advised to start OAT, usually methadone, as soon as possible. Opioids such as heroin and oxycodone are short acting, which means that withdrawal comes on quickly. Sudden withdrawal from opioids

can cause the uterus to contract, which can bring on miscarriage or premature birth. OAT prevents withdrawal for 24 to 36 hours. It is safe for the baby, and gives the woman who is pregnant a chance to take care of herself.

Pregnant women are encouraged to stay in hospital while beginning OAT. This usually takes a few days.

Buprenorphine in the form of Suboxone is not often used during pregnancy. This is because Suboxone includes naloxone, which has not been officially approved for use in pregnancy. If you already take Suboxone when you become pregnant, your doctor may recommend you switch to a buprenorphine without naloxone (Subutex), available in special situations, or to methadone.

Women who are pregnant and have a history of addiction may be asked to reassure child protection services that they have stopped using drugs and are preparing to be a mother. Look to your doctor and counsellor for help in dealing with this issue.

If you are taking OAT and thinking about becoming pregnant, talk with your doctor about how it will affect your treatment. Methadone is safe to take throughout pregnancy. If the treatment is helping you to live a full and healthy life, taking it when you are pregnant is also good for your baby.

*I used OAT through a pregnancy and through nursing a baby. I had fantastic support throughout the process and have a beautiful and healthy baby.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

## Infant withdrawal

Some babies born to mothers on OAT will go through withdrawal after birth. This usually begins a few days after birth, but symptoms could arise two to four weeks after birth and may last several weeks or months. Infants in withdrawal may be cranky, not eat or sleep well, or have a fever, vomiting, trembling and occasionally seizures. Infants going through withdrawal must be closely watched in hospital, depending on how well the baby is doing. If the symptoms are severe, your baby may be medicated to ease the withdrawal. Never give methadone or buprenorphine to your baby. Even a small amount can be enough to kill a baby. Let your doctor manage the baby's withdrawal.

While it is not known for certain what long-term effects the exposure to OAT may have on your baby, babies born to mothers on OAT usually do as well as other babies, and have a much greater chance at doing well than babies born to mothers on other opioids. Taking OAT while pregnant will not result in any deformities or disease in the baby.

## Breastfeeding

Women on low doses of OAT who are not HIV positive are encouraged to breastfeed. Women who are hepatitis C positive are usually able to breastfeed, but should check with their doctor.

The benefits of breastfeeding outweigh the effect of the tiny amount of OAT that enters the breast milk. If you have questions about the risks and benefits of breastfeeding while taking OAT, be sure to discuss them with your doctor.

## Child protection services

Taking care of kids can be a tough job even when everything is going well, and when things are rough, it can be overwhelming. Every parent needs support, but not every parent gets as much support as he or she needs. Ideally, the role of child protection services is to give you a hand when you need help caring for your child, and to provide access to training in parenting skills. If you are having trouble coping with parenthood on top of other struggles, talk to your counsellor about it. You may need the support of child protection services.

Most child protection services caseworkers are more interested in seeing your child enjoy and benefit from your care than in taking him or her away from you. They want to see you provide a healthy, loving and secure home for your child. Unfortunately, not all caseworkers are well informed about OAT. They may make assumptions about you based on your history of drug use. Dealing with child protection services can be confusing. Again, look to your doctor or counsellor for help.

In some communities there are special programs offering services for parents in recovery. The support and practical help they provide can make a difference in day-to-day life for you and your children. Ask your local child protection agency if such a program is available in your area.

If you continue to use drugs, your child protection services caseworker will question your ability to care for your child. Taking good care of a child demands your alertness, attention, patience and good judgment. Drugs can affect all these qualities. Using drugs doesn't necessarily make you a bad parent, but it can make it harder to be a good parent.

*I participated in a program for mothers who are struggling with addictions. The experience was great because I got to meet other moms with the same issues as myself. The group was a good support and I would definitely recommend it.*

Josée, 34 | Methadone

*Now that I'm on methadone, I have a wonderful relationship with my two daughters. I wasn't calling, just ignoring them, cause I was embarrassed or so high I didn't care.*

Joyce, 58 | Methadone, 3 years



# 8

## Looking ahead on opioid agonist therapy

How long will I be on opioid agonist therapy? 93

Tapering readiness 96

Methadone or buprenorphine tapering 97

Changing your mind 99

After treatment ends 99



## 8

# Looking ahead on opioid agonist therapy

## How long will I be on opioid agonist therapy?

This is one of the most frequently asked questions, and one of the most difficult questions to answer.

There are two different schools of thought concerning length of treatment. One approach looks at agonist therapy as long term, and possibly indefinite—like insulin treatment for the person with diabetes. Opioid addiction is explained as a biological disorder, and opioid agonist therapy (OAT) is the medicine used to treat the condition.

The other approach looks at maintenance as a shorter-term treatment. This approach sees opioid addiction as the result of the person's attempts to solve emotional problems with drugs. When the person who uses opioids learns to deal with problems in other ways, and their life becomes stable and happier, there is less reason to look to drugs for help.

OAT is seen as allowing the person the chance to get well and get their life in order. Once this is accomplished, the person can then

taper off methadone or buprenorphine. Short-term agonist therapy is usually one to two years.

There is truth in the ideas underlying both long- and short-term treatment approaches. Opioid addiction does change the way the brain works in that it suppresses the brain's ability to produce the body's natural opioids, endorphins. People who withdraw from opioids, including methadone or buprenorphine, may feel emotionally low and have trouble sleeping long after withdrawal. It's also true that having a supportive home life, a good counsellor, meaningful employment or other activities, and a strong desire to be drug free can help make the period after withdrawal easier to get through, and less likely to result in a return to opioid use.

You should know that those who withdraw from OAT after short-term treatment are more likely to return to opioid use than those who stay in treatment. This is why many doctors and counsellors encourage clients to stay in treatment for at least 12 months, and possibly long-term.

Keep in mind that the consequences of long-term agonist therapy are minimal compared to the dangers of using street opioids. Long-term use of methadone or buprenorphine has no effect on the internal organs, or on thinking. If it helps you to lead an active and happy life, then it is well worth the inconvenience, the side-effects, and any possible stigma you may encounter from people who do not understand the nature of your treatment.

*I thought maybe two, three years. It's restrictive, it's a time commitment. Travel is hard. I'm tied to it.*

Ruth, 64 | Methadone, 22 years

*I remember saying to a friend, I will probably be on methadone for the rest of my life. It's not an issue. You drink your juice every day. However, you do get married to the doctors, the clinics, the drug-store—it is a downside, but it's a small downside compared to my previous existence.*

Glen, 59 | Methadone, 15 years

*OAT is not a cure. After you are off it, you have to figure out the root cause of your addiction or there is a good chance you will be back on it, or develop another addiction. You need counselling or support groups to make it. It gets rid of the physical sickness, but not the disease.*

Jon, 41 | Methadone, 5 years and  
buprenorphine, 1.5 years

*I have thought about tapering off, but I know that it improves my mood (more than any antidepressant I have ever taken) so for right now I am content to use it.*

Jessica, 36 | Methadone and  
buprenorphine, 3 years

*I think it is going to be life-long. With my Crohn's disease, I'm going to require some kind of maintenance. It's either methadone or flare up. I've come to terms with it. This is the life I was dealt and I do the best with what I got.*

Ann, 42 | Methadone, 2 years, 5 years

## Tapering readiness

If you think you might be ready to end treatment, ask these questions to help you decide whether to begin the tapering process:\*

|                                                                                                   |                                                          |
|---------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Have you been abstaining from other opioids and from illegal drugs, such as cocaine and speed? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Do you think you are able to cope with difficult situations without using drugs?               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Are you employed or in school?                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Are you staying away from people who use drugs or who are involved in illegal activities?      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Have you gotten rid of any equipment you used to take drugs?                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Are you living in an area that doesn't have a lot of drug use, and are you comfortable there?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Are you living in a stable family relationship?                                                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Do you have friends who don't use drugs that you spend time with?                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Do you have friends or family who would be helpful during a taper?                             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10. Have you been participating in counselling that has been helpful?                             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11. Does your counsellor think you are ready to taper?                                            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 12. Do you think you would ask for help when you were feeling bad during a taper?                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Have you stabilized on a relatively low dose of methadone or buprenorphine?                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 14. Have you been on OAT for a long time?                                                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 15. Are you in good mental and physical health?                                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 16. Do you want to stop taking OAT?                                                               | Yes <input type="checkbox"/> No <input type="checkbox"/> |

The more “yes” answers you can honestly provide, the greater the likelihood that you are ready to make a tapering plan from methadone or buprenorphine

---

\*Adapted from Tapering Readiness Inventory in *Treatment of Opiate Addiction with Methadone: A Counselor Manual*, U.S. Department of Health and Human Services. In S. Brummett, R. Dumontet, L. Wermuth, M. Gold, J.L. Sorensen, S. Batki, R. Dennis & R. Heaphy (1986),

with your doctor. Each “no” response represents an area you probably need to work on to increase the odds of a successful taper and recovery.

*I feel I am ready to begin to taper. I am hopeful and excited to become opiate free. I also feel scared and worried that withdrawal may be uncomfortable and that I may be at increased risk of relapse.*

Courtney, 39 | Buprenorphine, 1 year

*I am tapering off slowly, about 1–2 mg every couple of months, this way I don't feel withdrawals. I feel positive.*

Josée, 34 | Methadone

## Methadone or buprenorphine tapering

The decision to taper off OAT should be made with the support of your doctor and counsellor, friends and family. If you've been on OAT for a long time, you may have stopped seeing your counsellor. Now is a good time to seek out the services of a counsellor once again. Feelings of fear and anxiety are common as you get close to the end of treatment. The risk of relapse is increased. It's important that you prepare for the challenge by setting up a safety net of support.

Learning about what to expect throughout the tapering process can also be helpful in reducing anxiety. The more you know the less there is to be afraid of.

Tapering works best when done as a slow and gradual reduction in dose. A good rule of thumb in tapering is to decrease no more than 5–10 per cent per month.

Once the dose is lowered to around 20 mg methadone or 8 mg buprenorphine, the tapering may be slowed down to an even more gradual reduction to reduce or eliminate any symptoms. Your taper is more likely to be successful if you adjust the rate according to how you are feeling, rather than to set a fixed schedule. Nowadays, most providers will allow you to choose the rate at which your dose is reduced. This gives you more control of the process, and lets you keep withdrawal symptoms to a minimum. The entire process should be given plenty of time.

Regardless of whether you have been in agonist therapy for a short or long time, on a high or low dose, the process is the same, and the degree of difficulty in withdrawing is the same. All clients withdrawing from OAT find that the most difficult stage is at the end of the taper. This is when you are most likely to have to tolerate some symptoms of withdrawal.

Withdrawal from methadone or buprenorphine comes on more slowly and may last longer than withdrawal from opioids such as heroin or oxycodone. With tapering, the withdrawal symptoms should be minimal, but you can expect aching, insomnia and lack of appetite. These symptoms should go away within 10 to 14 days, but beyond that, you may still feel a sense of loss, sadness and sleeplessness that may go on for several months.

Relapse, or return to opioid use, is all too common at this time. It's important to recognize the things that might trigger you to use again before it happens. You may find it helpful to identify ways of thinking that can lead you back to opioid use, and also thoughts that can help to ground you and stay on course. Some people find it helpful to stay away from old hangouts and old friends from their using days. Call on your non-using friends, family or counsellor if you're feeling low or frustrated or stressed. Keep in mind that after you've been off opioids for a while, your

tolerance to their effects is lowered, meaning that what used to be a normal dose is now an overdose.

## Changing your mind

Keep in mind that you don't have to go off OAT. You can change your mind and return to treatment at any point in the tapering process. Maybe you're not ready yet, maybe you'll be ready at a later time, maybe you'll never be ready. Staying on methadone or buprenorphine can be the right choice for some. It's up to you. A return to treatment is not a failure. If the choice is between being on OAT or risking a return to dangerous opioid use, stick to OAT.

## After treatment ends

If you decide to go through with the taper, and you stop taking methadone or buprenorphine, it may still take a while for your body to adjust from long-term opioid use. Some people have trouble sleeping and may feel low. This can go on long after the end of the taper. During this period it is important to maintain and extend your support. Some people find that support groups can help provide the extra strength to stay firm in their decision to be drug free. Individual counselling can also help.

Recovery from addiction is not an instant fix. It takes time; it's a process. What works for you may not work for someone else. The important thing is to find your own way, and get headed in the right direction.



# Important contacts

## **Addictions Treatment Helplines in Canada**

[www.ccsa.ca/Eng/Pages/Addictions-Treatment-Helplines-Canada.aspx](http://www.ccsa.ca/Eng/Pages/Addictions-Treatment-Helplines-Canada.aspx)

This page on the Canadian Centre on Substance Abuse website provides phone numbers of addiction treatment helplines across Canada.

## **Community Health Centres in Ontario**

[www.health.gov.on.ca/en/common/system/services/chc/locations.aspx](http://www.health.gov.on.ca/en/common/system/services/chc/locations.aspx)

This page lists locations of community health centres in Ontario. These centres offer various programs, often including support groups for people with addiction. These centres can also provide information about where to get a naloxone kit in your community.

## **ConnexOntario**

[www.drugandalcoholhelpline.ca](http://www.drugandalcoholhelpline.ca)

1 800 565-8603

ConnexOntario's Drug and Alcohol Helpline provides information about treatment for drug and alcohol problems. Call their 24-hour toll-free number to find the number of the assessment referral centre in your community.

## **Public & Physician Advisory Services**

College of Physicians and Surgeons of Ontario

416 967-2600

[methadoneinfo@cpsy.on.ca](mailto:methadoneinfo@cpsy.on.ca)

Public & Physician Advisory Services keeps a list of all doctors authorized to prescribe methadone in Ontario. Call to find a clinic offering treatment in your area.



# Websites

## Information about opioid addiction and treatment

### **Addiction Treatment Forum**

[www.atforum.com](http://www.atforum.com)

This U.S. site reports on new developments in the understanding of medication-assisted opioid addiction treatment. The site is designed for both medical professionals and clients. It is funded by an unrestricted educational grant from a pharmaceutical company.

### **Canadian Centre on Substance Abuse**

[www.ccsa.ca](http://www.ccsa.ca)

This organization seeks to promote awareness of drug and alcohol use problems and to advance research-based solutions to drug-related harm.

### **Centre for Addiction and Mental Health**

[www.camh.ca](http://www.camh.ca)

CAMH is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health.

### **National Alliance of Advocates for Buprenorphine Treatment**

[www.naabt.org](http://www.naabt.org)

This U.S. organization aims to educate the public and reduce the stigma affecting people with opioid use disorders.

## **Opioid Resource Hub**

[www.porticonetwork.ca/web/opioid-resource-hub](http://www.porticonetwork.ca/web/opioid-resource-hub)

This site focuses on opioid awareness, treatment solutions and education for many different groups, including people with lived experience, individuals supporting loved ones, and health, social service and justice professionals. It is hosted by the Centre for Addiction and Mental Health.

## **SAMHSA** (Substance Abuse and Mental Health Services Administration)

[www.samhsa.gov/topics](http://www.samhsa.gov/topics)

This U.S. agency aims to reduce the impact of substance abuse and mental illness; its publications section features a variety of publications on medication-assisted treatment for opioid addiction for clients, families and professionals.

## **Opioid agonist therapy clinical guidelines**

### *Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline*

[www.cpsso.on.ca/uploadedFiles/policies/guidelines/office/buprenorphine\\_naloxone\\_gdlns2011.pdf](http://www.cpsso.on.ca/uploadedFiles/policies/guidelines/office/buprenorphine_naloxone_gdlns2011.pdf)

### *Methadone Agonist Treatment Program Standards and Guidelines*

[www.cpsso.on.ca/policies-publications/cpgs-other-guidelines/methadone-program/mmt-program-standards-and-clinical-guidelines](http://www.cpsso.on.ca/policies-publications/cpgs-other-guidelines/methadone-program/mmt-program-standards-and-clinical-guidelines)

## Opioid agonist therapy and travel

### **INDRO**

<http://indro-online.de/travel.htm>

This site provides information on travel regulations for patients participating in drug substitution treatment for more than 150 countries.

## Harm reduction

### **CATIE**

[www.catie.ca](http://www.catie.ca)

CATIE is Canada's source for up-to-date, unbiased information about HIV and hepatitis C. It connects people living with HIV or hepatitis C, at-risk communities, health care providers and community organizations with the knowledge, resources and expertise to reduce transmission and improve quality of life.

### **Drug Cocktails**

[www.drugcocktails.ca](http://www.drugcocktails.ca)

"Facts about mixing medicine, booze and drugs." This site was created by a pharmacist and a nurse at Children's & Women's Health Centre of British Columbia. It lets the user search by substance, and rates risk as "Serious Risk," "Think First" or "Unknown."

## Mutual help groups

### **Alcoholics Anonymous**

[www.aa.org](http://www.aa.org)

### **Narcotics Anonymous**

[www.canaacna.org](http://www.canaacna.org)

### **Smart Recovery**

[www.smartrecovery.org](http://www.smartrecovery.org)

### **Women for Sobriety**

[www.womenforsobriety.org](http://www.womenforsobriety.org)

# Index

## A

abstinence. *See* withdrawal and abstinence (detox or cold turkey)  
aches in bones x–xi  
acupuncture 12  
addiction. *See also* OAT (opioid agonist therapy); *See also* withdrawal and abstinence (detox or cold turkey)  
    comparison of addiction and dependence ix–x, 19–20  
    helplines 101  
    variety of treatments 20  
agreements for OAT 32, 60  
alcohol  
    about 65–67  
    assessment before dosing 66  
    and benzodiazepines 65–66  
    overdose risks for OAT clients 10, 35, 65–66  
    safe levels 66–67  
    website (Drug Cocktails) 105  
alcohol addiction  
    helplines 101  
    mutual help groups 13, 78–80, 106  
    naltrexone treatment for 12, 67  
    treatments 8  
Alcoholics Anonymous 13, 78–80, 106  
antidepressants 69  
arrests. *See* criminal actions  
Aspirin 64  
assessment for OAT  
    about 29–30  
    helplines 101  
    how long it takes 24, 30  
    urine samples 29, 39–40  
Ativan, overdose risks 10, 35, 65–66

## B

babies in withdrawal 87  
balance problems, overdose signs 36

benzodiazepines (Ativan, clonazepam, Restoril, Rivotril, Valium, Xanax)  
    overdose risks 10, 35, 65–66  
birth control 85. *See also* pregnancy  
bone aches x–xi  
brain chemistry  
    acupuncture 12  
    changes in opioid addiction 19, 94  
    endorphins (natural painkillers) 12, 17–18, 94  
    how OAT works 21  
    naltrexone effects 12  
    pain receptors 18  
breathalyzer tests 66  
breathing difficulties, overdose signs 36  
buprenorphine with naloxone (Suboxone). *See also* side-effects; *See also* OAT (opioid agonist therapy)  
    about ix  
    availability of 28, 31  
    ceiling effect 35  
    comparison with methadone 5, 10, 31–32, 54  
    costs 7, 38–39  
    effectiveness 5, 31  
    “high” effects prevented by ix, 7, 21, 33, 67  
    injection risks 5–6, 67  
    long-acting effects 21, 34–35  
    long-term effects on your body x, 94  
    naloxone effects 6  
    overdose risks 10, 31, 34–35  
    safety 31  
    starting after last opioid use 31  
    switching between methadone and buprenorphine 41–42  
    withdrawal prevention 21  
buprenorphine without naloxone (Subutex) 86

## C

### carry doses

- about 48–50
- child overdoses and deaths 50
- divided doses 63
- locked box for 50
- lost or stolen doses 50
- for pain relief 63
- safety 49–50
- split doses 37
- storage 49–50
- travel out of town 51–52
- treatment agreements 32, 49
- urine samples 40, 49

### chemically manufactured opioids 17.

*See also* opioids

### childproof bottles 50

### child protection services

- about 88–89
- confidentiality 43
- reports by doctors and counsellors to 43
- support for OAT clients 88–89

### children. *See also* parenthood; *See also* pregnancy

- about 88–89
- overdoses and deaths 50

### chronic pain x, 63. *See also* pain relief

### clinics. *See also* counselling services and supports; *See also* doctors

- about 27–29
- assessment process 29–30
- changing doctors and clinics 59–60
- client photo ID cards 51
- confidentiality 43–44
- involuntary treatment discharge by 60
- referrals to 28
- treatment agreements 32

### clonazepam, overdose risks 65–66

### clonidine 11

### cocaine and crack 68

### codeine. *See also* opioids

- overdose risks 67
- pain relief drugs without codeine 64

### cold turkey. *See* withdrawal and abstinence (detox or cold turkey)

### College of Physicians and Surgeons of Ontario

#### list of doctors 28

#### phone numbers 101

### Community Health Centres 101

### comparison of buprenorphine and methadone 5, 10, 31–32, 54

### confidentiality. *See also* consent

- about 41–42
- child protection services 43
- drug benefit plans 39
- employment 57–58
- exceptions and limits 43–44
- pharmacists 40–41
- treatment agreements 32

### ConnexOntario Drug and Alcohol Helpline 101

### consent. *See also* confidentiality

- for assessment 29, 32
- to release confidential records 43, 60
- treatment agreements 32

### constipation 54–55

### costs

- costs per day 7, 38
- drug benefit plans 7, 38–39
- transportation to clinics or pharmacies 39

### counselling services and supports. *See also* clinics; *See also* doctors

- about 73–75
- after ending OAT 98
- benefits of 8, 75–77
- confidentiality 43–44
- family therapy 78
- group therapy 77
- helplines 101
- lifestyle changes 80–81
- mutual help groups 78–80, 106
- parents in recovery 88–89
- peer support 79–80
- referrals 74
- tapering off period 97–98
- treatment problems 59–60
- what you talk about 77–78
- withdrawal (detox) 13

### courts. *See also* criminal actions

- confidentiality exceptions 43–44
- positive views of OAT 7

crack and cocaine 68  
 cravings ix, 6, 11, 12, 68. *See also*  
 withdrawal  
 criminal actions  
   causes for involuntary discharge  
     from OAT 60  
   OAT treatment in jail 53–54  
   selling carry doses 49  
   treatment agreements on  
     consequences of 32, 60

## D

dental care  
   dry mouth x, 55  
   OAT effects on teeth x  
   pain relief for dental work 64  
 dependence and addiction compared  
   ix–x, 19–20  
 depressants, overdose risks 65–66  
 detox. *See* withdrawal and abstinence  
   (detox or cold turkey)  
 diet and exercise xi, 54–55, 56  
 Dilaudid. *See* hydromorphone  
   (Dilaudid)  
 disability  
   drug benefit plans 38–39  
 diseases, communicable. *See also*  
   hepatitis C; HIV  
   assessment process 29  
   confidentiality 43  
 divided and split doses 37–38, 63  
 doctors. *See also* clinics; *See also*  
   counselling services and  
   supports  
   about 27–29  
   assessment process 29–30  
   changing doctors 59–60  
   complaints about doctors 59  
   confidentiality 43–44  
   counselling services 74  
   guidelines for OAT 23, 104  
   helplines to find doctors 101  
   involuntary treatment discharge  
     by 60  
   referrals to 28  
   treatment agreements with 32  
   treatment problems 59–60

doses  
   assessment for other drugs or  
     alcohol 66  
   divided doses 63  
   first dose and early treatment 33–34  
   guest doses at other pharmacies  
     51–52  
   observed at clinics or pharmacies 9  
   same time every day 37  
   split doses 37–38  
   stable dose 37–38  
   switching between methadone and  
     buprenorphine 41–42  
   tapering of doses 97–98  
   tolerance to pain-relieving effects  
     64  
 doses, missed  
   causes for involuntary discharge  
     from OAT 60  
   how to avoid 50–51  
   overdose risks 35  
   withdrawal sickness 8  
 drinking. *See* alcohol  
 driver's licence  
   for employment 57  
   reports on impairment of driving  
     ability 43  
 drowsiness 34, 35  
 Drug and Alcohol Helpline,  
   ConnexOntario 11  
 drug benefit coverage 38–39  
 drug interactions. *See also* OAT and  
   other drugs  
   comparison of buprenorphine and  
     methadone 31  
   drowsiness from 35  
   Drug Cocktails website 105  
   hospitalized OAT clients 52–53  
   over-the-counter drugs 69  
   prescription drugs 35, 52–53  
   psychiatric medications 69  
   vitamins and herbal remedies 69  
 drugs, recreational. *See* OAT and other  
   drugs  
 dry mouth x, 55  
 Duragesic. *See* fentanyl (Duragesic)

## E

emergencies  
  naloxone kits 37  
  signs of overdose 36  
employment 57–58  
ending OAT, readiness xi, 96–97. *See also* OAT treatment, tapering off (ending)  
endorphins (brain chemicals). *See also* brain chemistry  
  acupuncture treatments 12  
  as natural painkillers 17–18  
  suppression in opioid addiction 94  
exercise and diet xi, 54–55, 56  
eyes, overdose signs 36

## F

family and friends  
  knowledge of overdose signs 35  
  lifestyle changes 80–81, 98  
  naloxone for emergencies 37  
  support for tapering decision 97  
  support from counsellors 75  
  support from friends 12, 75  
  use of this book viii  
family therapy 78. *See also* counselling services and supports  
fentanyl (Duragesic). *See also* opioids  
  manufactured opioid 17  
  OAT treatment 3–5  
  overdose risks 67  
fingers and lips, overdose signs 36  
friends. *See* family and friends

## G

Gravol, overdose risks 10, 35  
group therapy 77. *See also* counselling services and supports  
guest doses at other pharmacies 51–52  
gurgling or snoring, overdose signs 36

## H

harm reduction  
  counselling approach 74  
  needle exchanges 23  
  websites 105

harm to self or others  
  confidentiality exceptions 43–44  
health, mental. *See* counselling services and supports; *See* mental health  
heart rhythms, abnormal 31  
helplines 101  
hepatitis C  
  alcohol use 66–67  
  breastfeeding 87  
  CATIE website 105  
  OAT treatment 3–5, 29  
  risks from needle sharing 7, 70  
herbal remedies 69  
heroin. *See also* opioids  
  OAT treatment 3–5  
  overdose risks 67  
  pregnancy 85–86  
  short-acting effects 21, 85–86  
“high” effects prevented by OAT ix, 7, 21, 33  
history of OAT 21–24  
HIV  
  breastfeeding 87  
  CATIE website 105  
  confidentiality 43–44  
  harm reduction 23, 105  
  needle exchanges 23  
  OAT treatment 3–5, 29  
  risks from needles 7, 70  
hospitalization  
  OAT clients 52–53  
  pregnant women starting OAT 86  
hydromorphone (Dilaudid). *See also* opioids  
  OAT treatment 3–5  
  overdose risks 67

## I

identification, personal  
  for filling prescriptions 65  
  MediAlert bracelets 51  
  OAT client photo ID cards 51  
  policies in treatment agreements 32  
illegal acts. *See* criminal actions  
illness 52–53. *See also* diseases, communicable  
infant withdrawal 87

injections and safe needles. *See* needles  
 injections of Suboxone, risks 5–6  
 involuntary discharge from OAT 60

## J

jail. *See* criminal actions  
 jobs 57–58

## L

lifestyle. *See also* counselling services  
     and supports  
     about 32, 80–81  
     adjusting to changes 80–81  
     benefits of OAT 6–8  
     employment 57  
     sexuality 56–57  
     travel planning 51–52  
 lips and fingers, overdose signs 36  
 long-term or short-term treatment ix,  
     xi, 93–95. *See also* OAT treat-  
     ment, tapering off (ending)  
 low incomes and drug benefit plans  
     38–39

## M

maintenance of OAT. *See* OAT  
     treatment, middle stages  
 marijuana 69  
 MedicAlert bracelets 51  
 medications with OAT. *See* drug  
     interactions  
 menstrual cycles 85. *See also* women  
 mental health. *See also* counselling  
     services and supports  
     assessment process 29  
     endorphins 18  
     helplines 101  
     OAT benefits 7, 58  
     psychiatric medications 69  
     sex drive 56–57, 85  
 methadone (Methadose). *See also*  
     side-effects; *See also* OAT  
     (opioid agonist therapy)  
     about ix  
     availability of 28, 31  
     comparison with buprenorphine  
     5, 10, 31–32, 54

methadone (*continued*)  
     costs 7, 38–39  
     effectiveness 5, 31  
     “high” effects prevented by OAT ix,  
     7, 21, 33, 67  
     long-acting effects 21, 34–35  
     long-term effects on your body x, 94  
     overdose risks 10, 31, 34–35  
     pregnancy 5, 85–86  
     safety 31  
     starting after last opioid use 31  
     switching between methadone and  
     buprenorphine 41–42  
     websites 103–104  
     withdrawal prevention 21  
 Methadose (methadone) 5. *See*  
     *also* methadone (Methadose)  
 miscarriage 85–86. *See also* pregnancy  
 missed doses. *See* doses, missed  
 moodiness, overdose signs 36  
 morphine, short-acting effects 21. *See*  
     *also* opioids  
 motherhood. *See also* pregnancy  
     birth control 85  
     breastfeeding 87  
     child overdoses and deaths 50  
     child protection services 43–44,  
     88–89  
     infant withdrawal 87  
     services for parents in recovery  
     88–89  
 mouth, care of  
     dry mouth x, 55  
     pain relief for dental work 64  
 moving to another area 59–60  
 muscle relaxants, overdose risks 10  
 mutual help groups (AA, NA, SMART  
     Recovery, Women for Sobriety)  
     about 13, 78–80  
     after ending OAT 99  
     peer support 79–80

## N

naloxone  
     availability of kits 101  
     buprenorphine without naloxone  
     (Subutex) 86  
     reversal of overdose effects 37, 67

naloxone (*continued*)

- risks of injecting Suboxone 5–6, 67
- naltrexone
  - “high” effects prevented by 12, 67
- Narcotics Anonymous 13, 78–80, 106
- Narcotics Monitoring System 65
- needles
  - availability of safe needles 23, 70
  - communicable diseases 7, 43
- nodding off, overdose signs 36

**O**

OAT (opioid agonist therapy). *See*  
*also* side-effects

- about ix–xi
  - assessment for 29–30
  - availability of 28, 31
  - benefits 6–8, 58, 94
  - brain chemistry changes 21
  - costs 7, 38–39
  - drawbacks 8–10
  - drug plans 38–39
  - helplines 101
  - involuntary discharge from 60
  - long-term effects on your body x, 94
  - long-term or short-term treatment
    - ix, xi, 93–95
  - problems 59–60
  - questions about (FAQs) ix–xi
  - readiness for 3–5
  - statistics on 23
  - stigma 8–9
  - urine samples 39–40
  - websites 103–104
- OAT agreements 32
- OAT alternatives. *See* withdrawal and abstinence (detox or cold turkey)
- OAT and other drugs. *See also* drug interactions
- about 65–67
  - antidepressants 69
  - assessment before OAT dosing 66
  - benzodiazepines and alcohol 65–67
  - CNS depressants 65–66
  - cocaine and crack 68
  - injection of drugs 70
  - marijuana 69

OAT and other drugs (*continued*)

- psychiatric medications 69
  - treatment agreements 32
  - use and involuntary discharge from OAT 60
  - vitamins and herbal remedies 69
  - website (Drug Cocktails) 105
  - withdrawal 67–68
- OAT medications. *See* buprenorphine with naloxone (Suboxone); methadone (Methadose)
- OAT providers and supports. *See also* clinics; *See also* counselling services and supports; *See also* doctors
- clinics and doctors 27–28
  - counselling services 73–75
  - phone numbers to find providers 101
  - referral services 28, 101
  - websites 103–104
  - where to go 27–28
- OAT treatment, early stages
- about 33–34
  - assessment 29–30
  - first doses 33–34
  - overdose risks 10, 34–35, 65–67
  - pregnancy 86
  - readiness to start 3–5
  - side-effects 54
  - starting after last opioid use 31, 33
  - urine samples 39
  - use of other drugs or alcohol 33, 65–67
- OAT treatment, middle stages. *See also* carry doses
- reassessment 30
  - stable dose 37–38
  - urine samples 39
- OAT treatment, tapering off (ending)
- about 97–99
  - changing your mind 99
  - counselling support 97–98
  - long-term or short-term treatment
    - ix, xi, 93–95
  - overdose risks 99
  - readiness (checklist) 96–97
  - reassessment 30
  - withdrawal symptoms 98

Ontario Disability Support Program (ODSP) 38–39

Ontario Drug Benefit (ODB) program 7, 38–39

Ontario Works 38–39

opiates 17

opioids. *See also* OAT (opioid agonist therapy)

- about ix, 17
- comparison of buprenorphine and methadone 5, 10, 31–32, 54
- comparison of opiates and opioids 17
- long-acting and short-acting effects 21, 34–35
- opioid agonists ix
- tolerance to opioids 64
- websites 103–104

opioids, naturally occurring. *See* endorphins (brain chemicals)

opioid addiction and dependence 19–20. *See also* OAT (opioid agonist therapy)

- about ix–x
- comparison of addiction and dependence ix–x, 19
- helplines 101
- mutual help groups 13, 78–80, 106
- OAT dependence ix–x, 8
- websites 103–106

opium 17

overdose

- about 34–37
- emergencies 36
- how to avoid 35
- long-acting and short-acting effects of opioids 34–35
- naloxone to reduce effects 37, 67
- recovery position (turned on side) 36
- signs of an overdose 36

overdose risks

- about 34–35
- alcohol 10, 35, 65–66
- CNS (central nervous system) depressants 65–66
- comparison of buprenorphine and methadone 10, 31, 35
- during early treatment period ix, 10, 34–35, 65–67

overdose risks (*continued*)

- during OAT treatment 7
- during tapering period 99
- missed doses 35
- naloxone 37
- naltrexone 12
- use of other drugs 32
- website (Drug Cocktails) 105
- withdrawal and abstinence (detox) 12

oxycodone (OxyNeo, Percocet). *See also* opioids

- OAT treatment 3–5
- overdose risks 67
- pregnancy 85–86
- short-acting effects 21, 85–86

## P

pain relief

- about x, 63–65
- endorphins (natural painkillers) 17–18
- methadone and buprenorphine as painkillers 21
- tolerance to opioids 64

parenthood. *See also* motherhood; *See also* pregnancy

- child overdoses and deaths 50
- child protection services 43–44, 86, 88–89
- infant withdrawal 87
- safety of carry doses 50
- services for parents in recovery 88–89

parole or probation 43–44

peer support 79–80

Percocet. *See* oxycodone (OxyNeo, Percocet)

periods, women's 85

perspiration, excessive 55–56

pharmacists

- about 40–41
- carry dose agreements with 32, 49
- guest doses for travelling clients 51–52
- involuntary treatment discharge by 60
- Narcotics Monitoring System 65

pharmacists (*continued*)

- OAT doses from 40–41
- treatment agreements with 32
- phone numbers of helplines 101
- photo ID cards, OAT 51, 65
- physical dependence and addiction
  - comparison ix–x, 19–20
- physicians. *See* doctors
- Physicians and Surgeons of Ontario, College of
  - complaints about doctors 59
  - contact information 28, 101
- police. *See also* criminal actions
  - confidentiality exceptions 43–44
  - positive views of OAT 7
  - reports of child neglect or abuse 43
  - reports of harm to self or others 43
  - reports of lost or stolen doses 50
  - selling carry doses 49
- pot (marijuana) 69
- pregnancy
  - about 85–86
  - breastfeeding 87
  - hospitalization when starting OAT 86
  - infant withdrawal 87
  - menstrual cycles 85
  - methadone OAT during 5, 85–86
  - miscarriage 85–86
  - risks from sudden withdrawal 3, 85–86
  - Subutex (buprenorphine without naloxone) 86
- prescriptions for opioids. *See also* clinics; *See also* doctors
  - provincial monitoring system 65
- privacy. *See* confidentiality
- psychiatric medications 69
- Public & Physician Advisory Services 101
- pupils, overdose signs 36

**R**

- recreational drugs. *See* OAT and other drugs
- referral services for OAT 28
- rehab centres 74. *See also* counselling services and supports

- relapse. *See also* overdose; *See also* withdrawal
  - after short-term treatment ix, 94
  - after withdrawal and abstinence (detox) 11, 12
  - counselling support xi, 98–99
  - during tapering period 97–98
- Restoril, overdose risks 65–66
- right to privacy. *See* confidentiality
- Rivotril, overdose risks 10, 35

**S**

- safety
  - alcohol use 65–67
  - carry doses 49–50
  - child overdoses and deaths 50
  - comparison of methadone and buprenorphine 31
  - injections 70
  - street drugs compared to OAT 6
- seniors, drug benefit plans 38–39
- sexuality
  - communicable diseases 43
  - sex drive 56–57, 85
- short-term or long-term treatment ix, xi, 93–95. *See also* OAT treatment, tapering off (ending)
- side-effects
  - about 10, 54–57
  - bone aches x–xi
  - comparison of buprenorphine and methadone 32, 54
  - constipation 54–55
  - drowsiness and sedation 10
  - drug interactions 31
  - dry mouth x, 55
  - heart rhythm abnormalities 31
  - light-headedness 10
  - nausea and vomiting 10
  - sex drive 56–57, 85
  - sweating 55–56
  - switching between methadone and buprenorphine 41–42
  - weight gain xi, 56
- Sleepeze, overdose risks 10, 35
- sleepiness, overdose signs 36
- sleeping pills, overdose risks 65–66
- slurred speech, overdose signs 36

Smart Recovery 13, 79, 106  
 snoring or gurgling, overdose  
   signs 36  
 social workers 74. *See also* counselling  
   services and supports  
 split and divided doses 37–38, 63  
 starting treatment. *See* OAT treatment,  
   early stages  
 stigma  
   OAT clients 8–9, 47–48  
   websites 103–104  
 stopping OAT. *See* OAT treatment,  
   tapering off (ending)  
 students, drug benefit plans 38–39  
 Suboxone (buprenorphine with  
   naloxone) 5–6. *See also*  
   buprenorphine with naloxone  
   (Suboxone)  
 Subutex (buprenorphine without  
   naloxone) 86  
 support groups. *See* mutual help  
   groups (AA, NA, SMART  
   Recovery, Women for  
   Sobriety); *See also* counselling  
   services and supports  
 sweating, excessive 55–56  
 switching between methadone and  
   buprenorphine 41–42

## T

take-home doses. *See* carry doses  
 tapering OAT. *See* OAT treatment,  
   tapering off (ending)  
 teeth  
   dry mouth x, 55  
   OAT effects on x  
   pain relief for dental work 64  
 testosterone levels 57  
 therapy. *See* counselling services and  
   supports; *See also* OAT (opioid  
   agonist therapy)  
 tolerance to opioids 64  
 tranquilizers, overdose risks 65–66  
 travel planning  
   guest doses at other pharmacies  
   51–52  
   website on international  
   requirements 52, 105

travel to clinics and doctors  
   frequency 9  
   transportation costs 39  
 treatment agreements 32  
 treatment providers. *See* OAT providers  
   and supports  
 treatment stages. *See* OAT treatment  
 Trillium Drug Program (TDP) 38  
 12-step groups. *See* mutual help groups  
   (AA, NA, SMART Recovery,  
   Women for Sobriety)  
 treatment. *See* OAT (opioid agonist  
   treatment)  
 Tylenol 64

## U

urine samples  
   about 39–40  
   eligibility for carry doses 40, 49  
   for employment 57  
   observation of clients 9–10, 39  
   retests 40  
   treatment agreements 32

## V

Valium, overdose risks 10, 35, 65–66  
 vehicles, operating 57  
 violent behaviour  
   discharge from treatment 60  
   threat of harm to self or others 43  
   treatment agreements on conse-  
     quences of 32  
 vitamins 69

## W

water retention 56  
 websites  
   for addiction and treatment  
     103–104  
   for clinical guidelines for doctors  
     104  
   for harm reduction 105  
   for mutual help groups 106  
   for travel information 105  
 weight gain xi, 56  
 withdrawal  
   caused by other drugs 67–68  
   cravings and OAT 6

withdrawal (*continued*)

infant withdrawal 87

miscarriage 3, 85–86

naloxone injections 5–6, 67

naltrexone to prevent highs 12, 67

OAT tapering period 98

withdrawal and abstinence (detox or cold turkey)

about 10–12

how to find withdrawal centres 11

medications to help with 11

overdose risk 12

relapse risk 11, 12

supports for maintenance 12–13

symptoms 11

treatment programs 13

women. *See also* motherhood

birth control 85

menstrual cycles 85

mutual help groups 13, 78–80, 106

Women for Sobriety 13, 79, 106

work 57–58

## X

Xanax, overdose risks 65–66