BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

Networking researchers, educators & care providers

Buprenorphine maintenance treatment for opioid use disorder

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Therapeutics Initiative Seminar
October 28th, 2026

BRITISH COLUMBIA CENTRE for EXCELLENCE on HIV/AIDS
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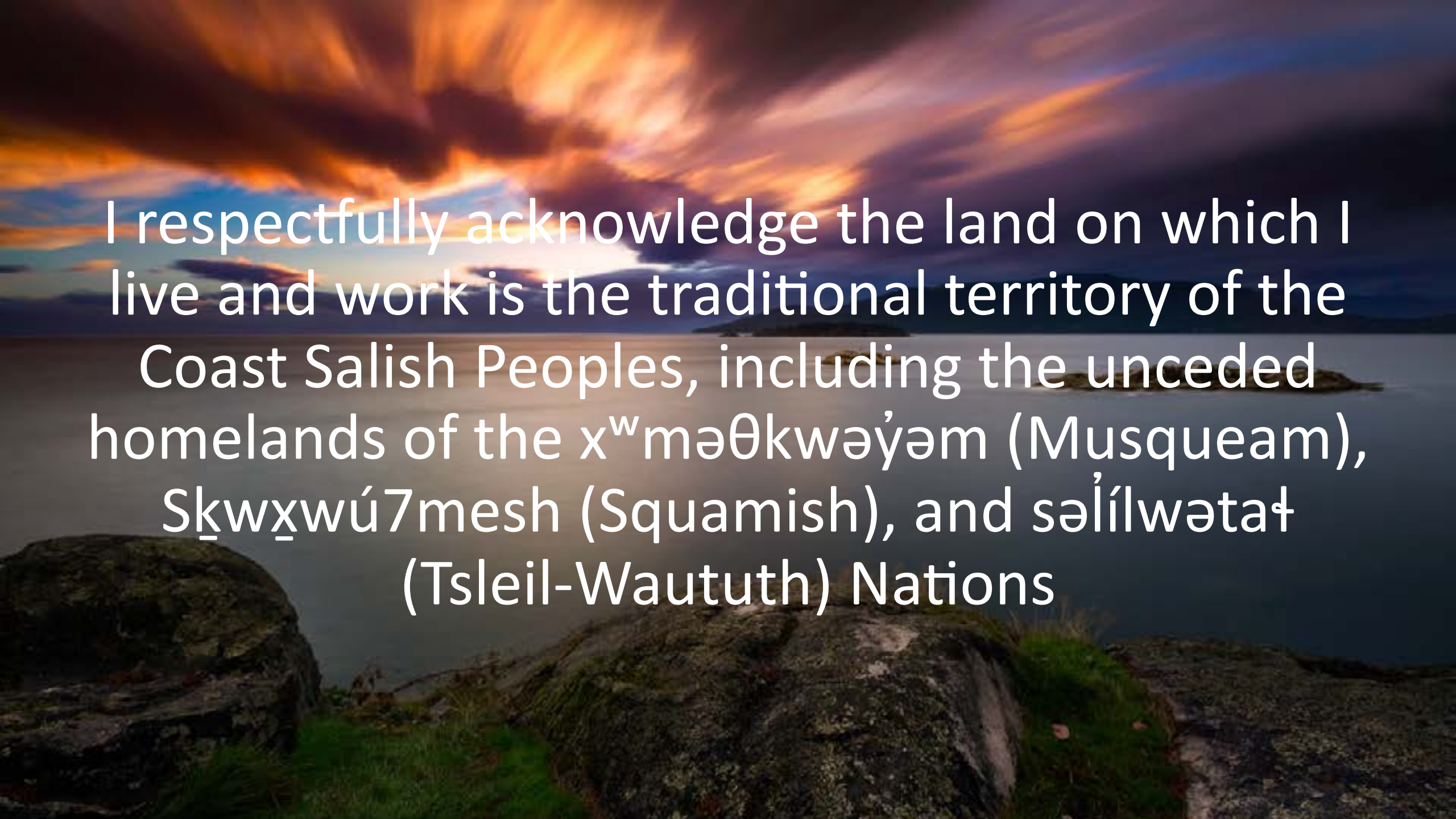

I respectfully acknowledge the land on which I live and work is the traditional territory of the Coast Salish Peoples, including the unceded homelands of the xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səl̓ílwətaɬ (Tsleil-Waututh) Nations

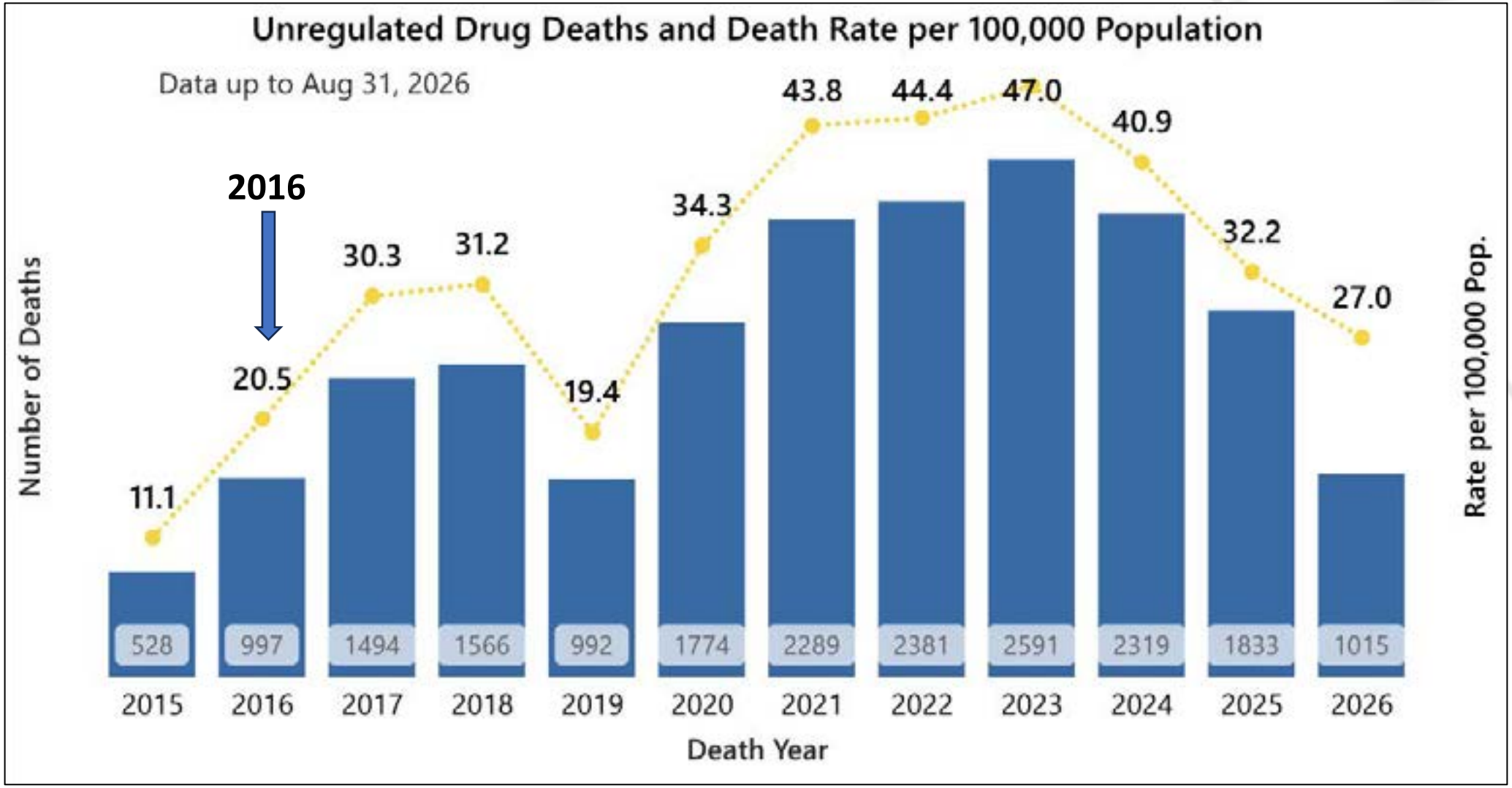
Learning Objectives

01 Understand the opportunities and current limitations of opioid agonist treatment (OAT) as a response to the toxic drug crisis in British Columbia.

02 Appreciate the potential role for primary care providers in improving outcomes by prescribing maintenance buprenorphine therapy, including how to navigate common questions and clinical scenarios.

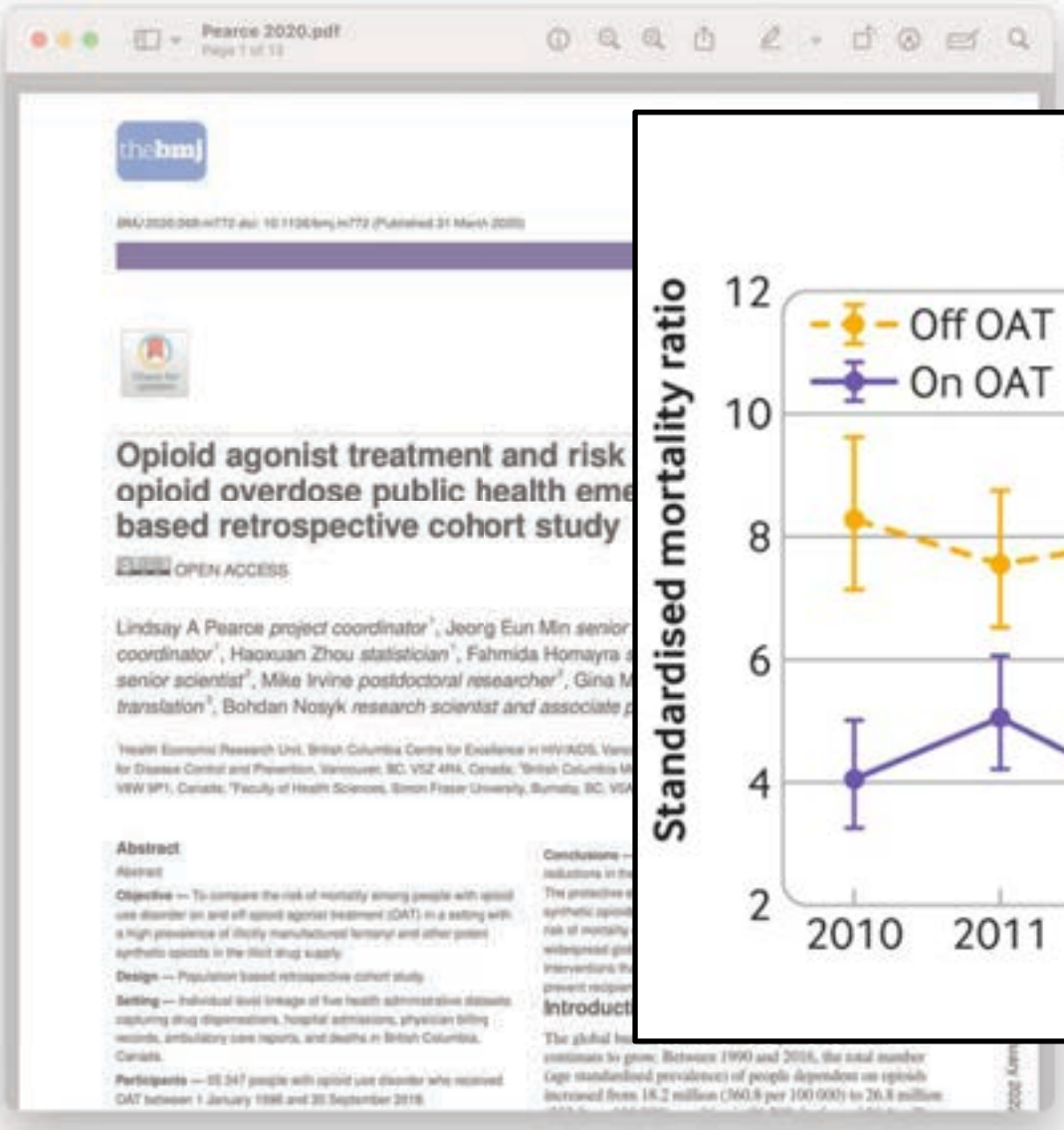
03 Describe further clinical resources and educational opportunities to improve access to comprehensive treatment for people with opioid use disorders (OUD).

BC is in a Public Health Crisis



BC Coroner Service, October 2026.

OAT Still Demonstrates a Mortality Benefit


Pearce 2020.pdf

thebmj

Opioid agonist treatment and risk
opioid overdose public health eme
based retrospective cohort study

OPEN ACCESS

Lindsay A Pearce *project coordinator*, Jeong Eun Min *senior coordinator*, Haoxuan Zhou *statistician*, Fahmida Homayra *senior scientist*, Mike Irvine *postdoctoral researcher*, Gina M *translation*, Bohdan Nosyk *research scientist and associate p*

Abstract

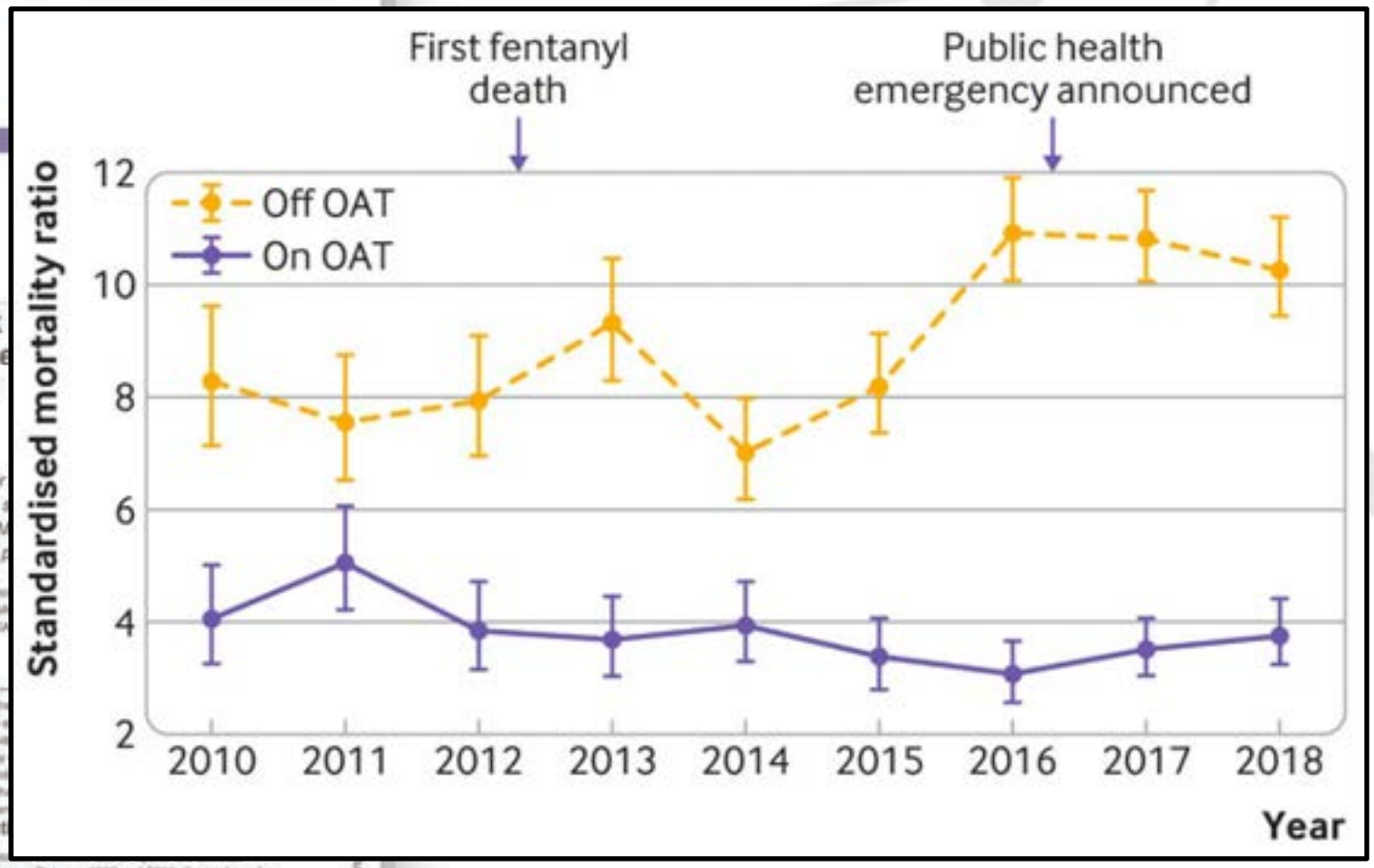
Objective — To compare the risk of mortality among people with opioid use disorder on and off opioid agonist treatment (OAT) in a setting with a high prevalence of illicitly manufactured fentanyl and other potent synthetic opioids in the illicit drug supply

Design — Population based retrospective cohort study

Setting — Individual level linkage of five health administrative datasets capturing drug dispensations, hospital admissions, physician billing records, ambulatory care reports, and deaths in British Columbia, Canada

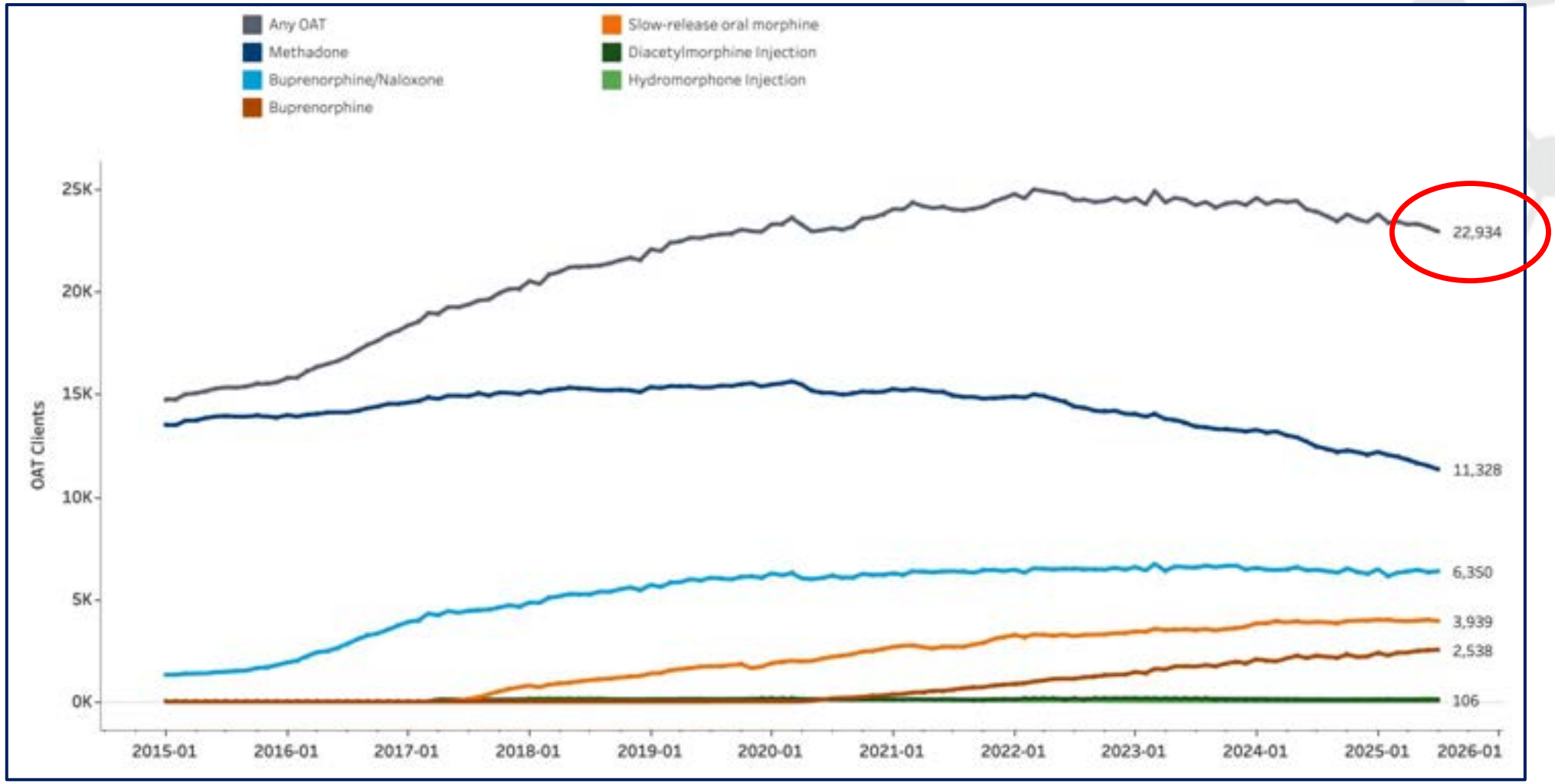
Participants — 65 347 people with opioid use disorder who received OAT between 1 January 1996 and 30 September 2018

Introduct



Pearce L, et al. BMJ. 2020.

Number of OAT Recipients in BC



~100-125,000

BC Centre for Disease Control, September 2025.

OAT Discontinuation in BC (2010 – 2020)

Nosyk 2024.pdf

Research

JAMA | Original Investigation

Buprenorphine/Naloxone vs Methadone
of Opioid Use Disorder

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Brenda Carolina Guerra-Alejos, MD, MPH; Ruyu Yan, BA; Micah Piske, MScPH; Sha
Paxton Bach, MD, MSc; Sander Greenland, MA, MS, DrPH; Mohammad Ehsanul Ka
Uwe Siebert, MD, MPH, MSc, ScD; Julie Bruneau, MD, MSc; Paul Gustafson, PhD; K
P. Todd Korthuis, MD, MPH; Thomas Loughin, PhD; Lawrence C. McCandless, PhD;
Kevin T. Schnepel, PhD; M. Eugenia Socias, MD, MSc

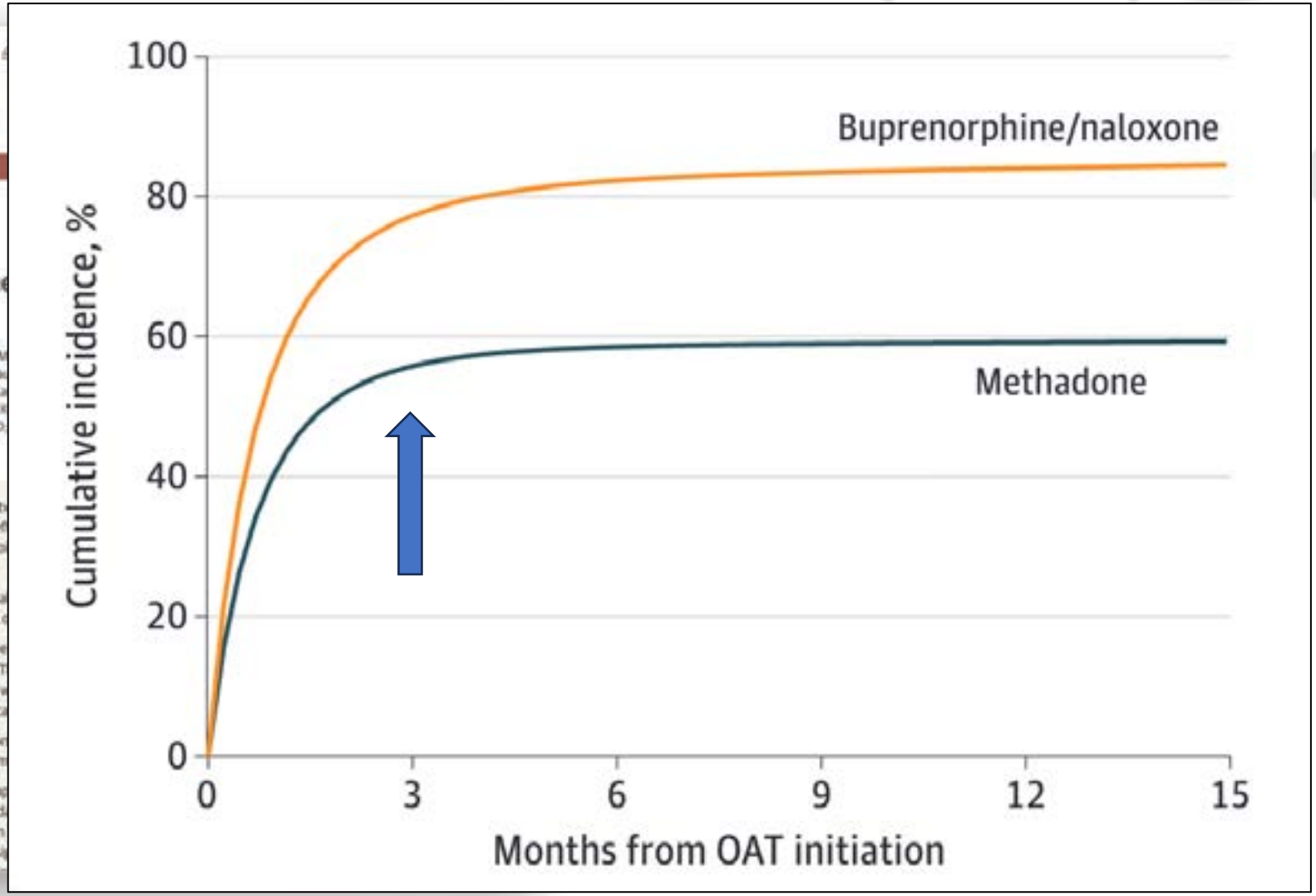
IMPORTANCE Previous studies on the comparative effectiveness bet
methadone provided limited evidence on differences in treatment ef
subgroups and were drawn from populations who use primarily hero
opioids, although fentanyl use is increasing across North America.

OBJECTIVE To assess the risk of treatment discontinuation and morta
receiving buprenorphine/naloxone vs methadone for the treatment

DESIGN, SETTING, AND PARTICIPANTS Population-based retrospective
linked health administrative databases in British Columbia, Canada. T
treatment recipients between January 1, 2010, and March 17, 2020,
older and not incarcerated, pregnant, or receiving palliative cancer ca

EXPOSURES Receipt of buprenorphine/naloxone or methadone amon
users and prevalent new users (including first and subsequent treatm

MAIN OUTCOMES AND MEASURES Hazard ratios (HRs) with 95% comp
intervals were estimated for treatment discontinuation (lasting ≥5 d
≥6 days for buprenorphine/naloxone) and all-cause mortality within
discrete-time survival models for comparisons of medications as assi



Nosyk B, et al. JAMA. 2026.

Key Challenges

01 **OAT remains a lifesaving intervention**

Despite an increasingly toxic unregulated drug supply, opioid agonist treatment (OAT) continues to reduce mortality and save lives.

02 **Access and retention to treatment in BC remain suboptimal**

Many people face barriers to initiating and remaining on OAT, with disproportionately greater challenges for rural populations.

OAT in Primary vs. Specialty Care

7 randomized trials • 1,992 participants • USA, France & Ukraine

TREATMENT RETENTION (50 WEEKS)

73% vs 68%

RR 1.15 (95% CI 0.98–1.34)

Very low certainty • Difference uncertain

ABSTINENCE FROM OPIOIDS (46 WEEKS)

55% vs 34%

RR 1.59 (95% CI 1.03–2.46)

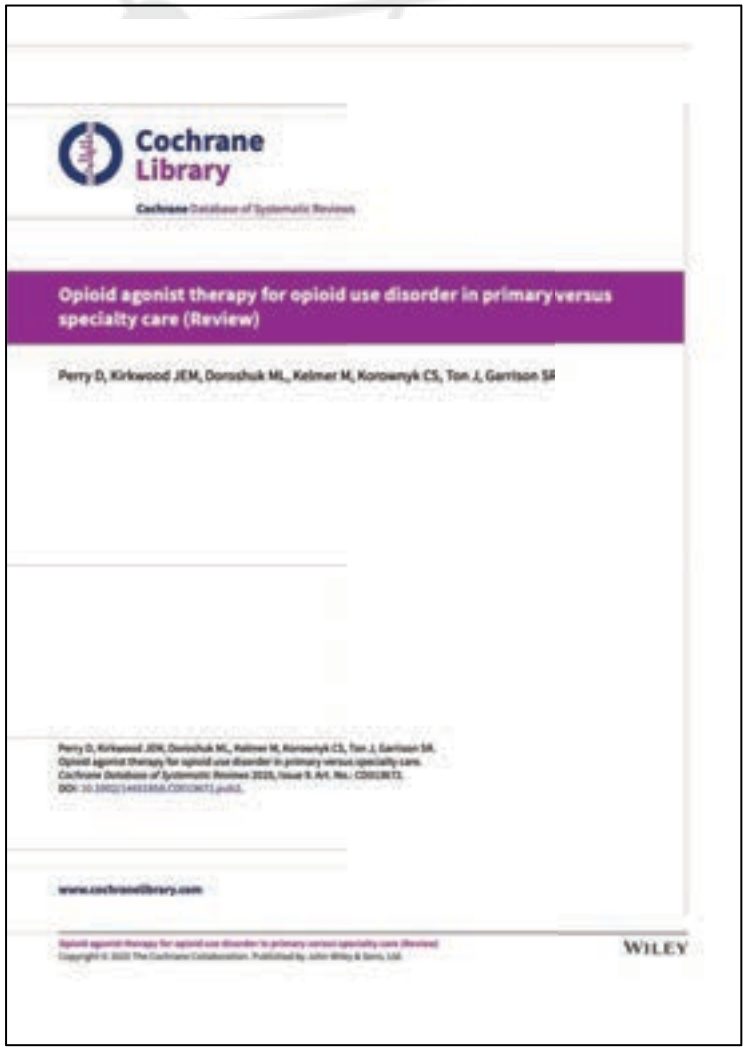
Low certainty • May favour primary care

SAFETY & SATISFACTION

Sparse adverse-event data

Major events: RR 0.26 (0.03–2.20)

Safety uncertain; satisfaction may be higher



"We do not review that evidence here, but provide practical, evidence-informed guidance to improve access to and continuation of OAT in primary care in BC"

Perry D, et al. Cochrane Database Syst Rev. 2025.

TI Letter 163: Buprenorphine for OUD

Therapeutics Initiative

Better prescribing. Better health.

Buprenorphine maintenance treatment for opioid use disorder

Vignette: *Will is a 35-year-old male with a severe opioid use disorder (OUD). He reports smoking ¼ g of fentanyl per day for more than four years, and has experienced two non-fatal overdoses that required intervention with take-home naloxone. He recently sought help from the provincial opioid treatment access phone line, which started and titrated him to a dose of 24 mg of buprenorphine-naloxone SL once daily. His symptoms are well controlled on this dose and he is seeing you as his primary care provider for maintenance therapy.* ***What will you do?***

THERAPEUTICS LETTER 163
October 2026

In British Columbia (BC), OAT prescribing rose from 15,774 patients per month in 2016 to over 22,000 per month in 2026, without a significant change in the overall prevalence of OUD. This shift was accompanied by an increase in OAT prescribers (Figure).[1] However, a significant majority of eligible OUD patients are still not engaged in OAT. While this gap may be due in part to personal preferences and motivations, numerous health system factors also contribute to under-prescribing, including strict OUD program requirements,

Key messages

- **Opioid use disorder (OUD) has a prevalence between 1-2% of the adult population in BC, similar to the prevalence of other chronic conditions commonly managed in primary care settings.**
- **Opioid agonist treatment (OAT) such as buprenorphine-naloxone is the gold standard therapy that reduces mortality and improves**

Therapeutics Initiative: Therapeutics Letter 163. October, 2026.

TI Letter 163: Buprenorphine for OUD

Key Messages:

1. Opioid use disorder (OUD) has a **prevalence between 1-2%** of the adult population in BC
2. Opioid agonist treatment (OAT) such as buprenorphine-naloxone is the **gold standard therapy**
3. Without additional training or qualifications, family physicians and nurse practitioners can **safely and routinely facilitate maintenance buprenorphine-naloxone therapy**
4. Additional training available in British Columbia enables family physicians and nurse practitioners to prescribe additional OAT agents

Therapeutics Initiative: Therapeutics Letter 163. October, 2026.

Buprenorphine Pharmacology

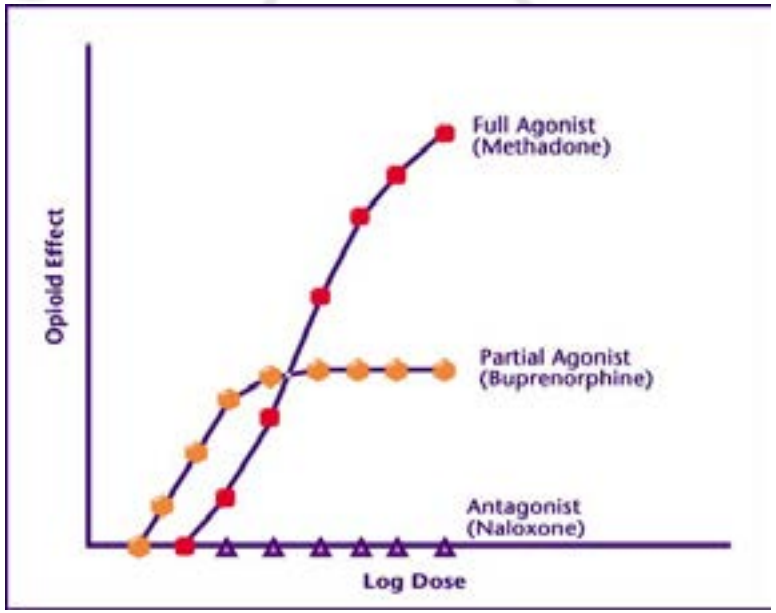
PHARMACOLOGY

Long-acting partial μ-opioid receptor agonist
High receptor affinity (can displace other opioids)

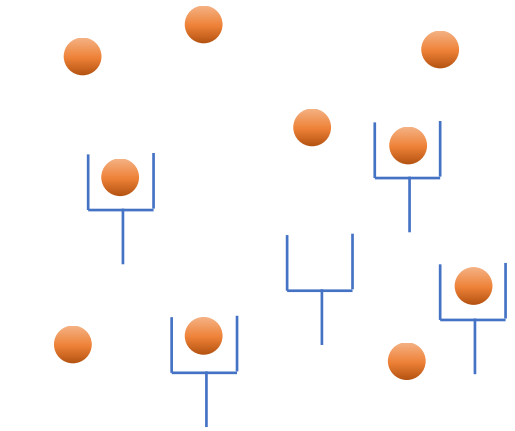
CLINICAL IMPLICATIONS

Ceiling effect on respiratory depression
Administered sublingually, co-formulated with naloxone to reduce injection use/insufflation

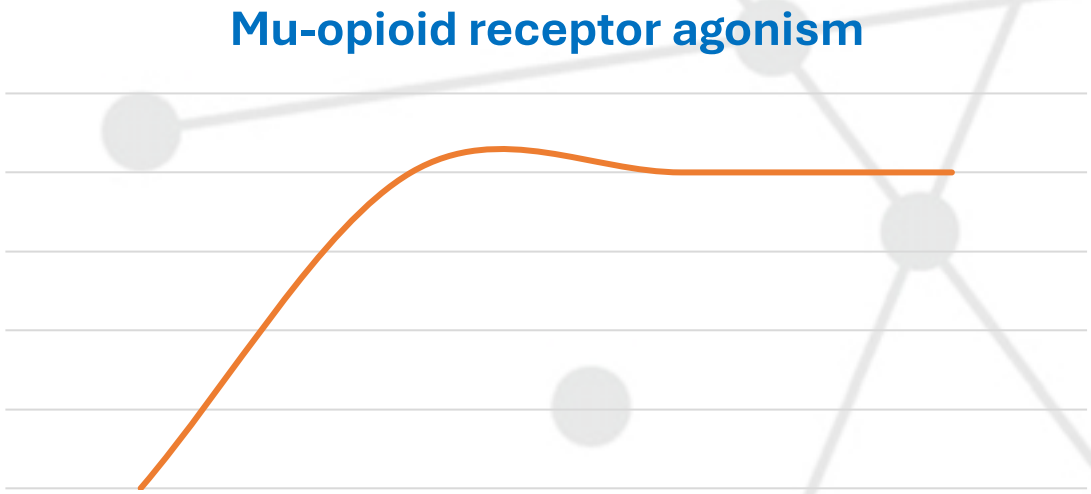
Prescribing does not require additional certification

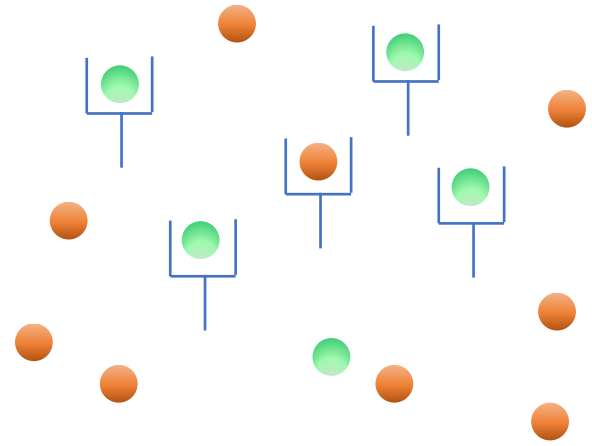


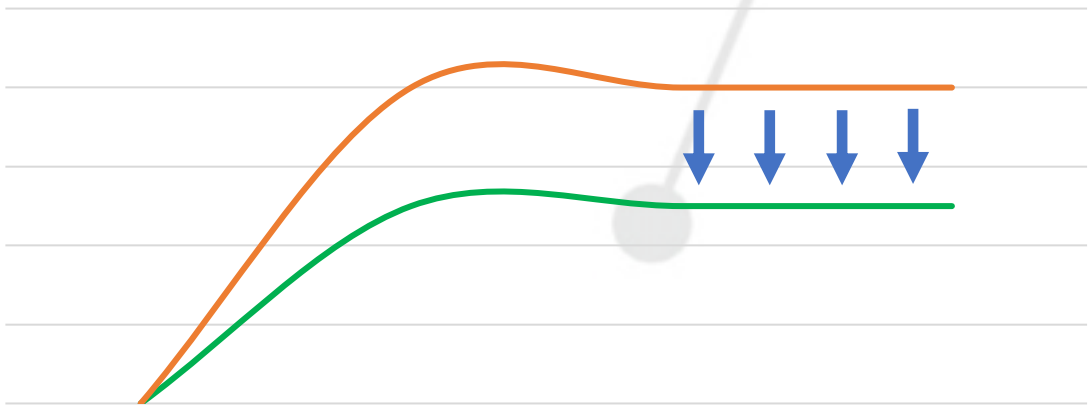
Precipitated Withdrawal



= opioid = bup







Practical Management Questions

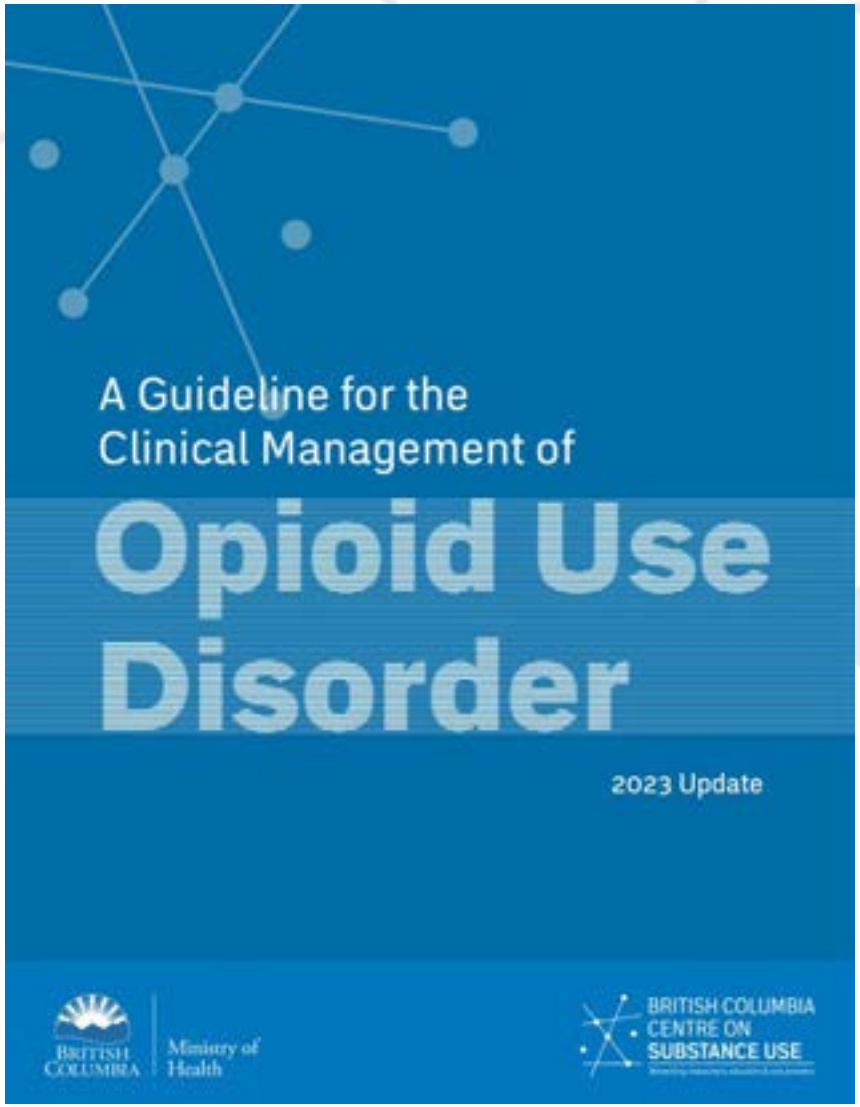
01 IS THE DOSE WORKING?

02 WHAT IF DOSES ARE MISSED?

03 WHAT ADVERSE EFFECTS CAN BE EXPECTED?

04 WHAT OTHER PSYCHOSOCIAL SUPPORTS?

05 WHAT ABOUT ROTATIONS AND/OR TAPERING?



Therapeutics Initiative: Therapeutics Letter 163. October, 2026.

Is The Dose Working?

01

TARGET

A dose that suppresses withdrawal symptoms and cravings for a full 24 hours.

02

TYPICAL DOSE RANGE

8–24 mg sublingually once daily; up to 32 mg may benefit some individuals.

03

WHEN TO INCREASE

If experiencing persistent or recurrent cravings, consider gradual increases (e.g., 2–4 mg/day or more), guided by clinical response.

04

WHEN TO REDUCE

Once symptoms are controlled, adjustments are usually unnecessary. If reducing, taper slowly (e.g., 1–2 mg/week) and monitor for cravings or withdrawal.

What If Doses Are Missed?

ONE MISSED DOSE

Resume the usual daily dose, do not double up. Withdrawal is uncommon after one missed dose.

EXPLORE BARRIERS

Discuss why the dose was missed and address potential barriers to adherence.

>2–3 MISSED DOSES

Assess for breakthrough cravings, withdrawal, and/or return to unregulated opioid use.

IF OPIOID USE HAS RESUMED

May require a re-initiation, especially if 4 or more days of medication have been missed.

Missed days without return to full opioid agonist use	
≤5 days	Resume without dose reduction
≥6 days	Re-titration is recommended to be individually tailored to achieve previous stable dose within a few days
Missed days with return to full opioid agonist use	
≤3 days	Safe to continue buprenorphine-naloxone without re-titration
4 days	Discuss the risk of precipitated withdrawal and weigh them against the benefits of continuing buprenorphine-naloxone
≥5 days	New induction may be required

What Adverse Effects Can Be Expected?

Buprenorphine has fewer side effects than other full-agonist opioids.

Common adverse effects

Constipation → osmotic laxatives
Sedation/drowsiness → cautious dose reduction
Blunted effect of other opioids → be aware and manage accordingly in acute care settings

Long-term considerations

Risk of dental caries, possible opioid class-effect risks including OSA, hypoandrogenism

* Evidence and OUD-specific management guidance remain limited

Drug-drug interactions

CYP3A4 inhibitors/inducers may change buprenorphine levels.
Use caution with sedatives/hypnotics and other opioids

Cardiac considerations*

QT prolongation is much less common than with methadone. Consider ECG only when combining with other QT-prolonging drugs.

What Other Psychosocial Supports Are Available?

OUD care extends beyond medication and may also include a range of common supports, including:

Physical & mental health

Co-occurring conditions, chronic pain, etc.

Counselling & psychotherapy

Individualized psychological support

Peer-led support groups

Community and recovery-oriented groups

Residential treatment

Bed-based treatment where appropriate

Support options depend on local availability, context, past history, and patient preferences.

What About Rotations And/Or Tapering?

Alternative OAT options

If buprenorphine is ineffective or poorly tolerated, consider methadone or slow-release oral morphine.

Support long-term treatment

Encourage ongoing OAT (open-ended treatment); optimize dosing and address adverse effects to support retention.

Discuss risks of stopping

Counsel about return to unregulated opioid use and increased overdose risk following discontinuation.

If tapering is requested

For stable patients (>1 year) who understand the risks: consider a slow, individualized taper over months, with close monitoring and experienced OAT guidance.

Facilitate specialist referral for medication transitions or tapering, when needed.

Clinical Support and Education Resources

24/7 Addiction Medicine Clinician Support Line

Real-time addiction medicine advice for BC healthcare providers, including assessment, medication and treatment planning.

24/7 • 778-945-7619

OPEN RESOURCE ↗

RACE — Rapid Access to Consultative Expertise

Connects BC and Yukon primary care clinicians with specialists for timely advice, typically within 2 hours.

Weekdays 9-5pm • 1-877-696-2131

OPEN RESOURCE ↗

POATSP — Opioid Addiction Treatment Training

BCCSU online education and training pathways supporting evidence-based opioid agonist treatment prescribing.

Online modules • Discipline-specific pathways

OPEN RESOURCE ↗

Questions?

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