Medication for Addiction Treatment (MAT): the Standard of Care for Opioid Use Disorder (OUD)

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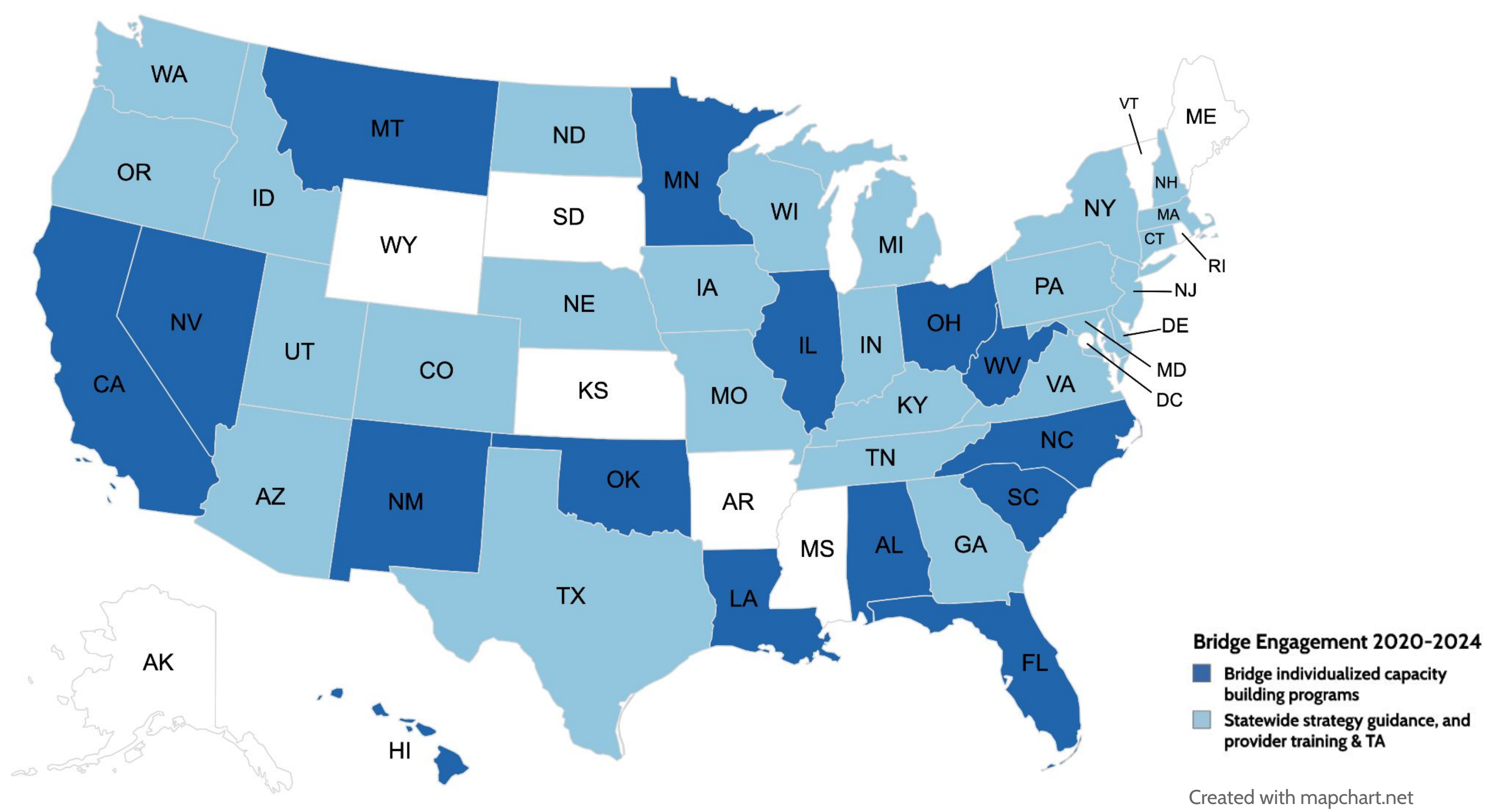
National reach as of May 2024



As Opioid Prescribing Decreased, Overdose Deaths Increased

Reductions in opioid prescribing have not led to reductions in drug-related mortality

Overdose deaths:
94,134*

Opioid prescriptions:
143,390,951[1]
(44.4% decrease since 2011)

2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

*Provisional data for the 12-month period Jan. 2020–Jan. 2021
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Kentucky has one of the highest opioid *prescribing* rates in the nation.

Opioid Dispensing Rate (per 100 persons)

- <36.1
- 36.1 - 42.7
- 42.8 - 52.8
- >52.8

www.cdc.gov – Most recent data: 2022

Kentucky has the 7th highest *drug overdose mortality* in the nation.

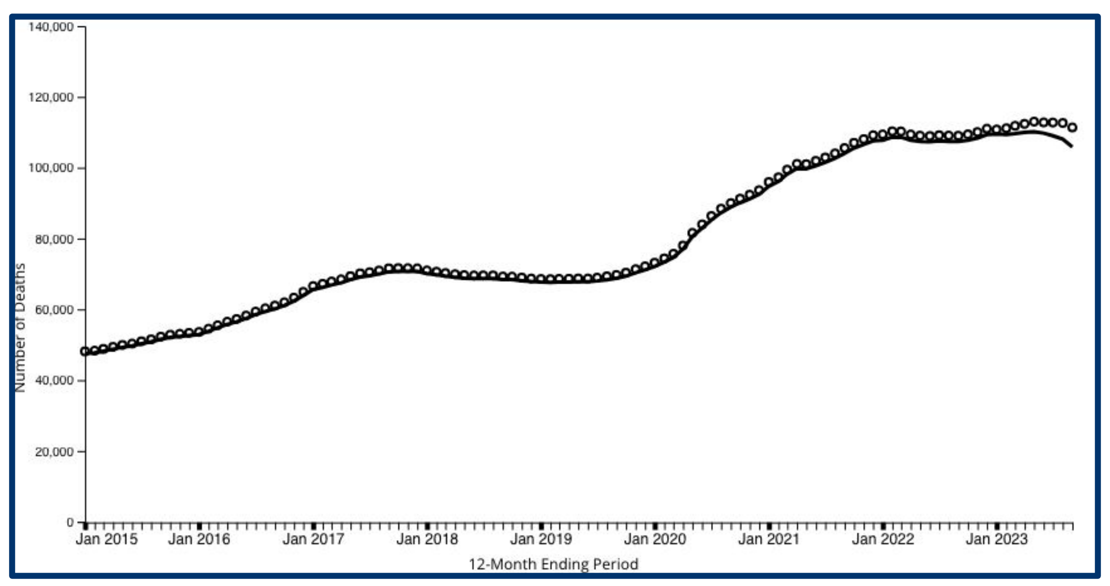
Age-Adjusted Death Rates[1]

- 0 - < 18.18
- 18.18 - < 36.36
- 36.36 - < 54.54
- 54.54 - < 72.72
- 72.72 - 90.9

www.cdc.gov – Most recent data: 2022

Study: 42% of US adults know someone who died by overdose

12 Month-ending Provisional Number and Percent Change of Drug Overdose Deaths



1. Howard J. About 42% of us adults know someone who died by overdose, new survey finds. CNN. February 22, 2024. Accessed February 26, 2024. https://www.cnn.com/2024/02/21/health/us-adults-overdose-survey/index.html.

Why treat OUD in the Emergency Department?

The ED is the Ultimate Safety Net

Visible, easily accessible, and near public transport

Offers all-hours access, acute psychiatric stabilization, same-day treatment, and navigation to ongoing care

Critical link to shelters and community treatment programs

28%

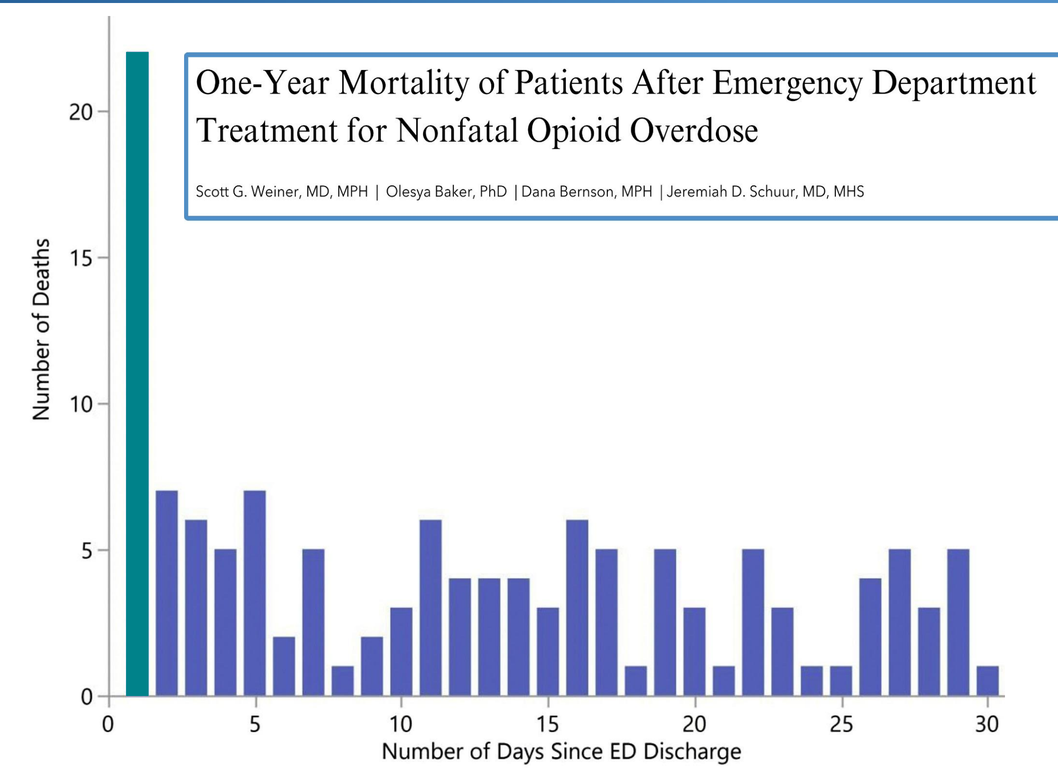
of adult ED patients screen positive for SUD.

Elder et al., 2020

OUD is an Emergency

Significant increased mortality risk post-ED discharge

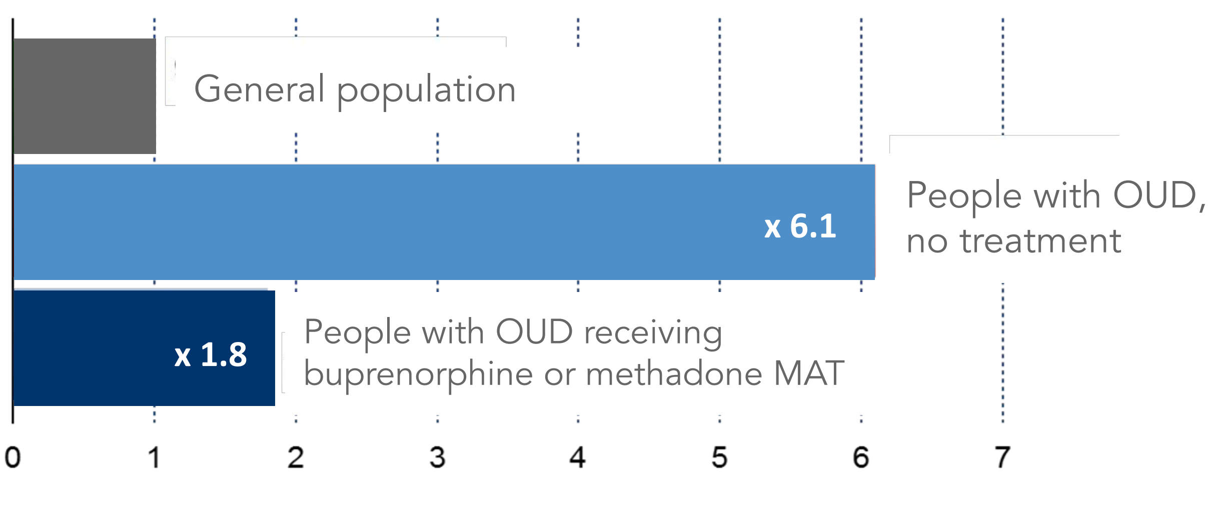
- 20% of patients who died did so in the first month
- 22% of those who died in the first month died within the first 2 days



Weiner et al., 2019

Buprenorphine Saves Lives

Mortality Risk Compared to the General Population



Evans et al., 2015.

Treatment in the ED

Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial

Gail D'Onofrio, MD, MS | Patrick G. O'Connor, MD, MPH | Michael V. Pantalon, PhD | Marek C. Chawarski, PhD | Susan H. Busch, PhD | Patricia H. Owens, MS | Steven L. Bernstein, MD | David A. Fiellin, MD

78% vs. 37%

stayed in treatment if MAT started in ED

D'Onofrio et al., 2015

Number Needed to Treat (NNT)

Treatment	NNT
Aspirin in STEMI	**42** to save a life
Warfarin in Afib	**25** to prevent a stroke
Steroids in COPD	**10** to prevent tx failure
Defibrillation in Cardiac Arrest	**2.5** to save a life
Buprenorphine in Opioid Use Disorder	**2** to retain in treatment

Sean P. Kane, P. D. (n.d.). Number needed to treat. Number Needed to Treat (NNT) Calculator. Retrieved August 3, 2022, from https://clincalc.com/Stats/NNT.aspx

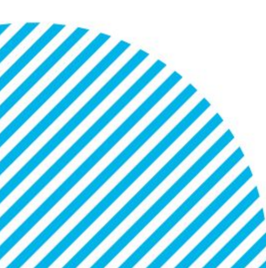
NNT by Buprenorphine Dose

NNT	Buprenorphine (Bup) Dose
1 in 4	low dose bup (2-6mg)
1 in 3	medium dose bup (7-16mg)
1 in 2	high dose bup (≥ 16mg)

Mattick RP et al. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2014;(2):CD002207.

Addiction is NOT a moral failing.

It is a chronic disease that requires medical treatment.



Revolutionizing the System of Care

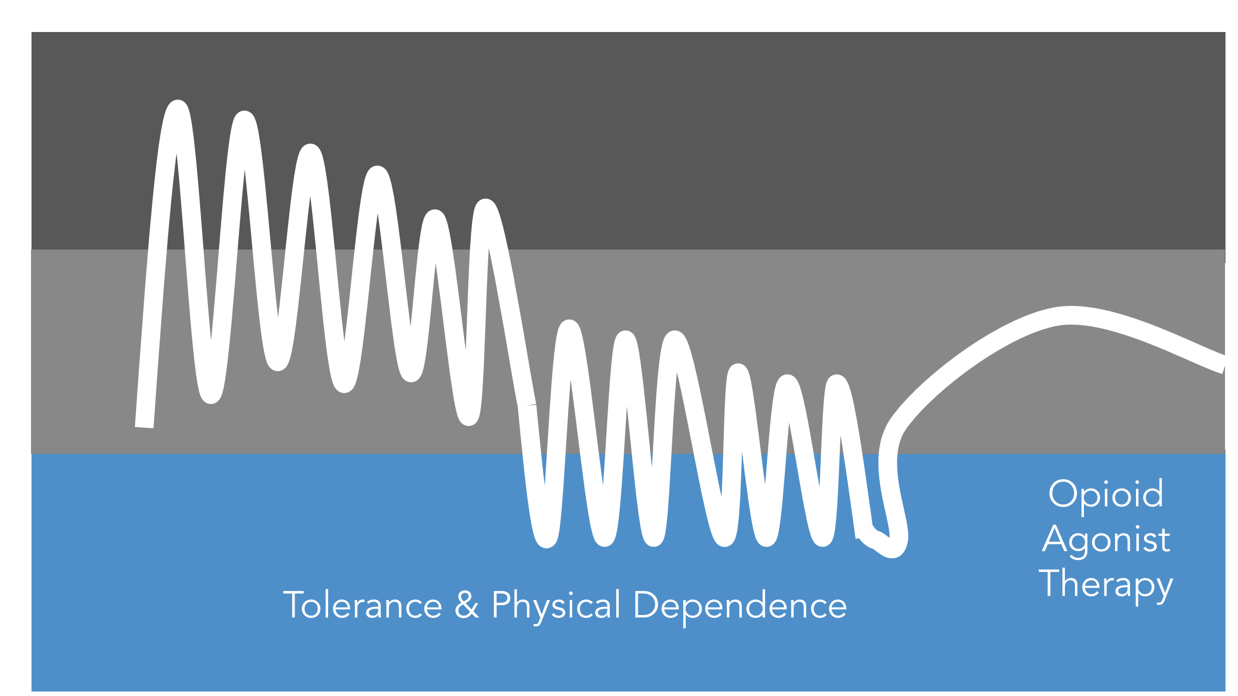
Low-Barrier Treatment

Connection to Care and Community

Culture of Harm Reduction

Prioritizing Treatment

Opioid Use Natural Progression

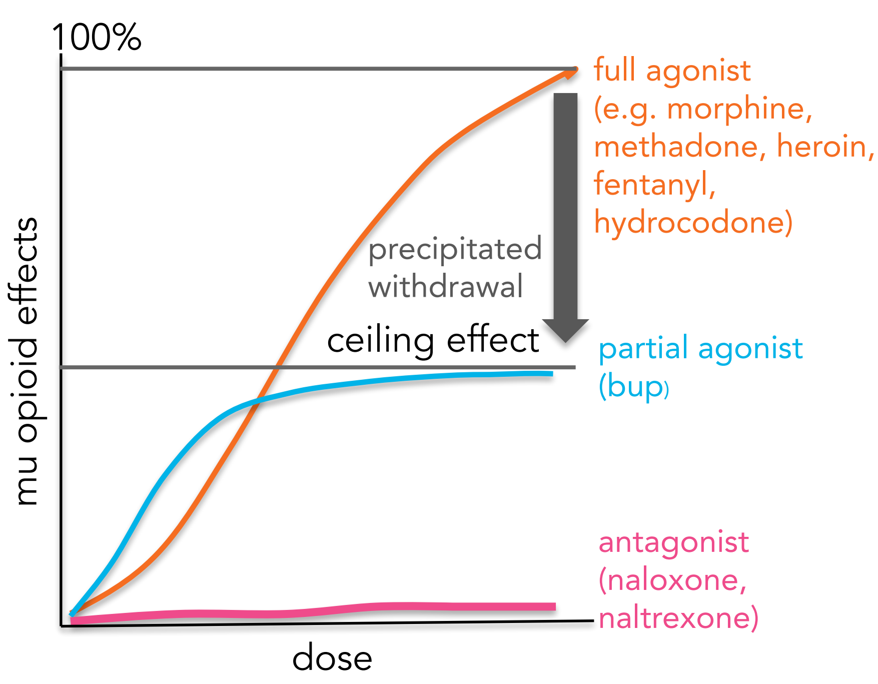


Medications for OUD

Methadone	Buprenorphine ± Naloxone	Naltrexone
Full mu (opioid) receptor agonist	Partial mu receptor agonist	Mu receptor <u>ant</u>agonist (blocker)
Oral (often solution)	Sublingual (tab, film), IV, IM, subcutaneous injection, transdermal patch	Intramuscular injection (extended release) or oral Ex: "Vivitrol," "ReVia"

Understanding Buprenorphine ("Bup")

- Treats withdrawal, cravings, & overdose
- Partial agonist → less respiratory depression & sedation
- High affinity
  - Blocks & displaces other opioids
  - Can precipitate withdrawal
- Half-life ~ 24-36 hours (long acting)



Good News:

MAT Works

Buprenorphine (Bup) Emergency Department Quick Start

View or download on your device

CA BRIDGE

Emergency Department Buprenorphine (Bup) Quick Start

Connect with your patient: Accurate diagnosis and treatment requires trust, collaboration, and shared decision making.

Opioid withdrawal* — NO → **Rx self-directed start:**
- Wait for severe withdrawal then start with 8–24+ mg SL.
- Rx per "Discharge" box below.

YES ↓

16 mg bup SL** (range 8–24+ mg)

30-60 minutes ↓

Withdrawal improved? — NO → **If no improvement or worse, consider:**

Worsening withdrawal (common): Occurs with lower starting doses and heavy tolerance; improves with more bup (additional 8–16 mg SL).

Other substance intoxication or withdrawal: Continue bup and manage additional syndromes.

Bup side-effects: e.g., nausea or headache. Continue bup and treat side-effects with supportive medications.

Medical illness: Continue bup and manage underlying condition.

If sudden & significant worsening, consider precipitated withdrawal (rare): See box below.

30-60 minutes, YES ↓

Administer 2nd dose
Additional 8–24+ mg SL bup

↓

Discharge

- **Prescribe at least a 2 week supply of 16-32 mg SL bup per day.**
- **Example 2 week order:** buprenorphine/ naloxone 8/2 mg film 1 film SL TID #42,1 refill. Notes to pharmacy: OK to substitute tablets or monoproduct. Bill Medicaid FFS, ICD 10 F11.20.
- **Dispense/distribute naloxone** in-hand from the ED.

*Diagnosis Tips for Opioid Withdrawal:

1. **Look for at least two clear objective signs not attributable to something else:** large pupils, yawning, runny nose & tearing, sweating, vomiting, diarrhea, gooseflesh/piloerection, tachycardia.
2. **Confirm with the patient that they feel 'bad' withdrawal** and they **feel ready to start bup.** If they feel their withdrawal is mild, it is likely too soon.
3. **As needed, consider using the COWS (clinical opioid withdrawal scale).** Start if COWS ≥ 8 with ≥ 2 objective signs.
4. Withdrawal sufficient to start bup typically occurs 24–36 hrs after decreased/stopped use, but can vary from 6–72 hrs. Methadone withdrawal commonly takes longer.

**Bup Dosing Tips:

1. Respect patient preference. Shared decision making, flexibility, and collaboration are essential.
2. Heavy dependence/tolerance (e.g., fentanyl) may need higher doses of bup.
3. Low dependence/tolerance may do well with lower doses of bup.
4. Starting bup may be delayed or modified if there complicating factors:
   - Altered mental status, delirium, intoxication
   - Severe acute pain, trauma, or planned surgery
   - Severe medical illness
   - Long-term methadone maintenance

Treatment of bup precipitated withdrawal

(Sudden, significant worsening of withdrawal soon after bup administration.)

Act quickly → **16 mg bup SL** AND **2 mg lorazepam PO**

30 minutes → **Symptoms improved?** — YES → **Observe & DC**; NO → **16 mg bup SL**

30 minutes → **Continued severe withdrawal?** — YES ↓

Adjuvants:
OK but should not delay or replace bup. Use sparingly with appropriate caution.

Benzodiazepines:
- Lorazepam 2 mg PO/IV

Antipsychotics:
- Olanzapine 5 mg PO/IM

Alpha-agonists:
- Clonidine 0.1-0.3 mg PO

D2/D3 agonists:
- Pramipexole 0.25 mg PO

Gabapentinoids:
- Pregabalin 150 mg PO

Escalate level of care to manage potential moderate to deep sedation including cardiac, pulse oximetry, and end tidal CO2 monitoring:

1. Ketamine (0.3 mg/kg IV slow push q 15 minutes and/or infusion).
2. Fentanyl 200 mcg IV q10 minutes. Total dose of > 2000 mcg has been reported.

After clinical resolution, observe and discharge with bup Rx and/or XR-bup

Bup Rx Notes

- The X-waiver program has ended. Only a DEA license is needed to prescribe (schedule III).
- Either bup or bup/nx SL films or tab are OK.
- Bup monoproduct or bup/nx OK in pregnancy.

For pregnancy: Bup in Pregnancy
For post-overdose: Bup Opioid Overdose

For minors: Caring for Youth
For self-directed starts: Bup Self-Start

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California Substance Use Line (844) 326-2626

NATIONAL CLINICIAN CONSULTATION CENTER — Warmline (M-F 6am-5pm EST; Voicemail 24/7) 1-855-300-3595

CSAM CALIFORNIA SOCIETY OF ADDICTION MEDICINE

CAPA

CALIFORNIA ACEP

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Identify Withdrawal

* **Diagnosis Tips for Opioid Withdrawal:**

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COWS Clinical Opiate Withdrawal Scale

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9

Resting Pulse Rate: ________ beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat on brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* Able to sit still Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms 5 Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score ________ The total score is the sum of all 11 items Initials of person completing Assessment: ____________

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

At least two 'Hard Signs'

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Include 2+ *objective* sign(s):

- Dilated pupils
- 'Goose bumps'
- Vomiting
- Tachycardia
- Yawning
- Runny nose & eyes

Rule Out Contraindications

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   - Altered mental status, delirium, intoxication
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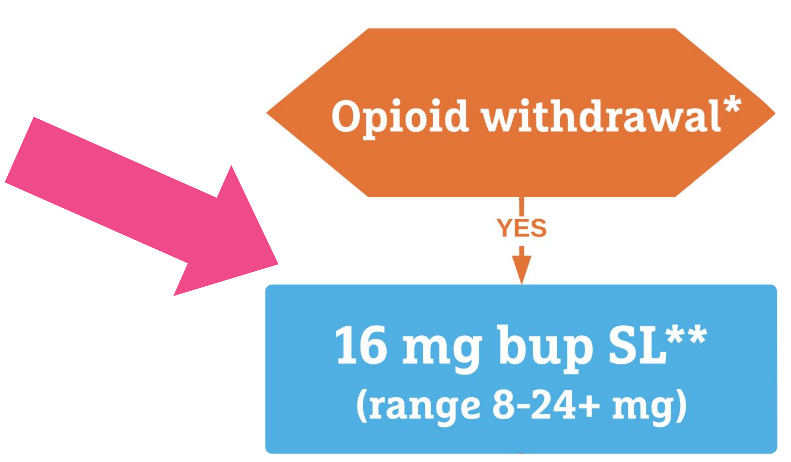
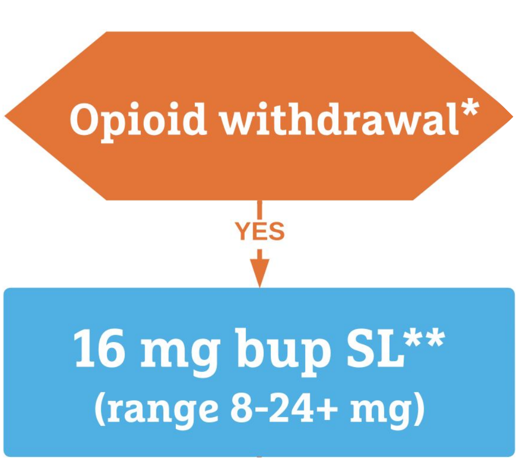
Patient in Moderate to Severe Withdrawal & Interested in Bup?



Bup is given as a sublingual, *dissolvable* dose.

No PO for 15-20 minutes.

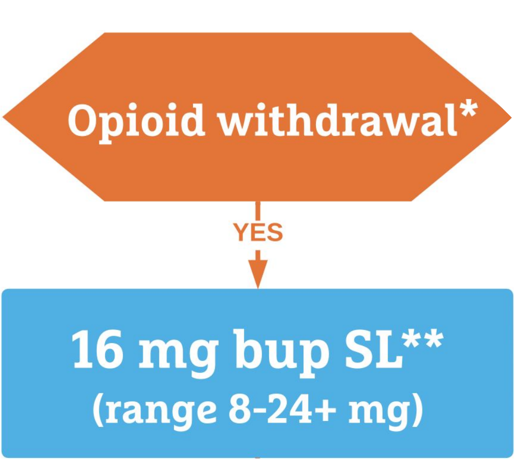
Patient in Moderate to Severe Withdrawal & Interested in Bup?



No methadone for at least 72 hours.

CAUTION: Benzodiazepines, alcohol, and other respiratory suppressants.

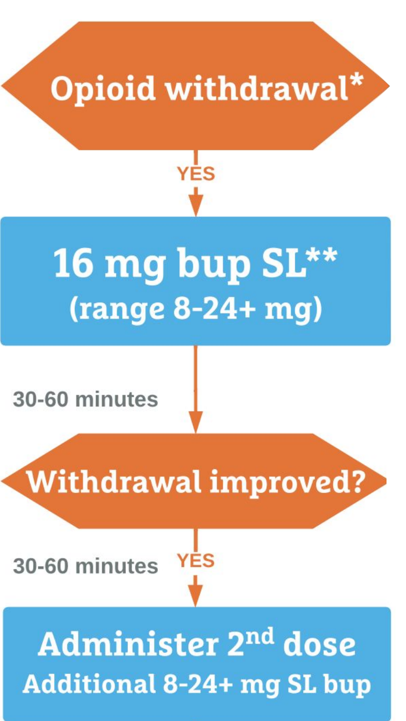
Patient in Moderate to Severe Withdrawal & Interested in Bup?



Typically start with 16mg bup SL.

Fentanyl is widespread and often requires higher dose, e.g., 16-24+ mg.

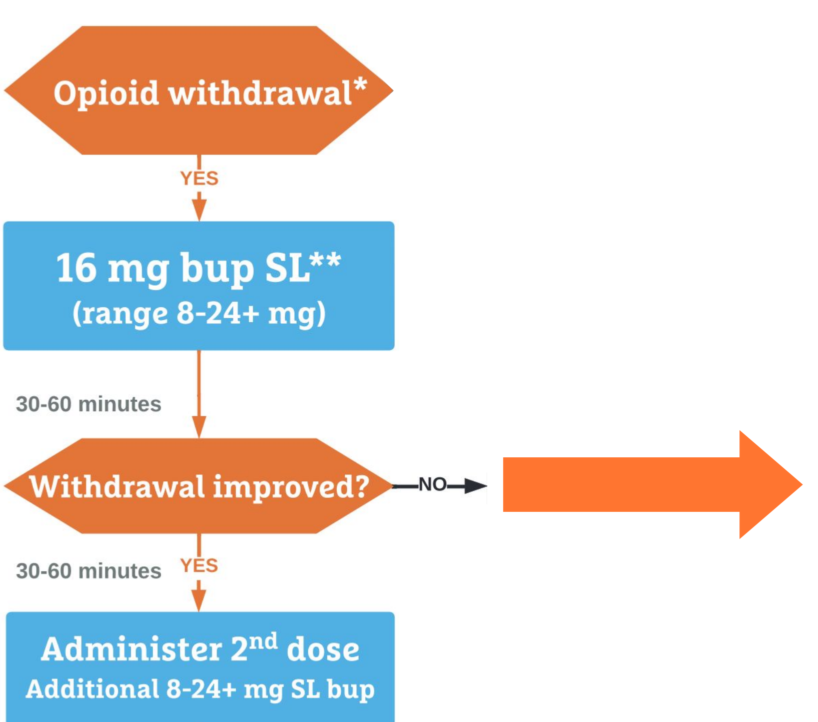
Wait 30-45 min. Reassess.
Better? Give another dose.



Don't be afraid to repeat dose!
Fentanyl use may take *more* doses.

Note: *Most* patients will *still* do great with 16-32 mg total buprenorphine.

Wait 30-45 min. Reassess. Not better? Widen your ddx.



If no improvement or worse, consider:

Worsening withdrawal (common): Occurs with lower starting doses and heavy tolerance; improves with more bup (additional 8-16 mg SL).

Other substance intoxication or withdrawal: Continue bup and manage additional syndromes.

Bup side-effects: E.g., nausea or headache. Continue bup and treat side-effects with supportive medications.

Medical illness: Continue bup and manage underlying condition.

If sudden & significant worsening, consider precipitated withdrawal (rare): See box below.

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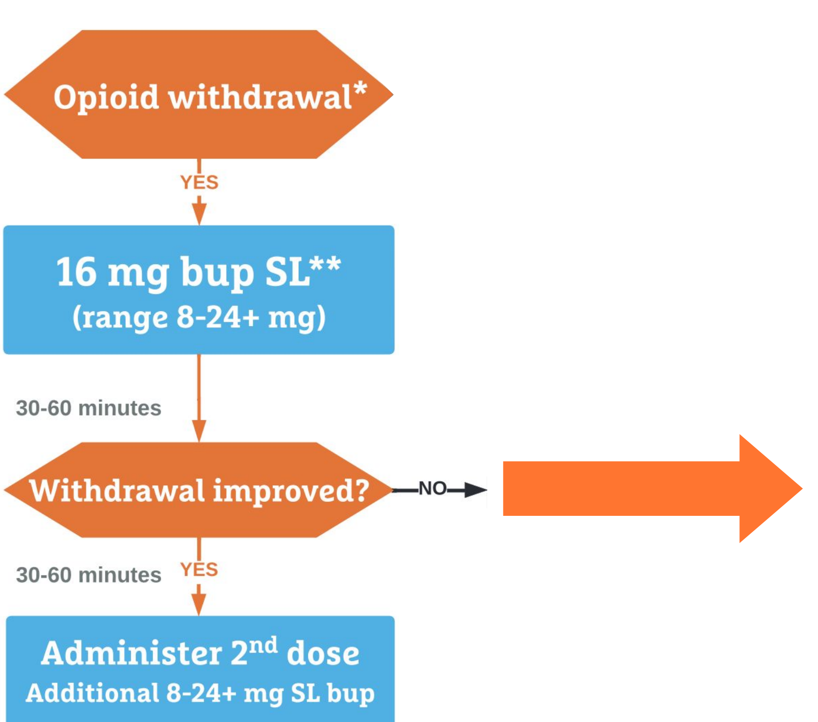

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Undertreated Withdrawal

Small bup doses given to pt with high tolerance → ongoing sxs

Incomplete treatment of sxs

As time goes on between doses, sxs get worse – from ***not enough*** bup; not ***because*** of it

Can be a *normal* part of the bup induction experience

Precipitated Withdrawal

- Very rare! (<1% in National Institute on Drug Abuse data)
- How? *"Too little bup, too soon"*
- What? Rapid, *significant* & *sudden* worsening withdrawal sxs
- Pain, unpleasant, agitated, "excited delirium"
- Note: this is what happens *on purpose* when we give naloxone!

Why the Hype?!

- A rough patient experience – patients talk to each other.
- A rough provider experience – providers do not want to lose patient trust.

We need to normalize the experience of withdrawal for patients.

It may take some time for the medication to work;
I'm here for you
and will help you
no matter what happens.

I know going through withdrawal is terrible and painful. I'm here to help make this the *best withdrawal experience ever!* With *SUPPORT* and *MEDICATION* to ease your pain.

Have you ever tried buprenorphine before? Do you know anybody who has? What concerns do you have?

If you *do* precipitate withdrawal…

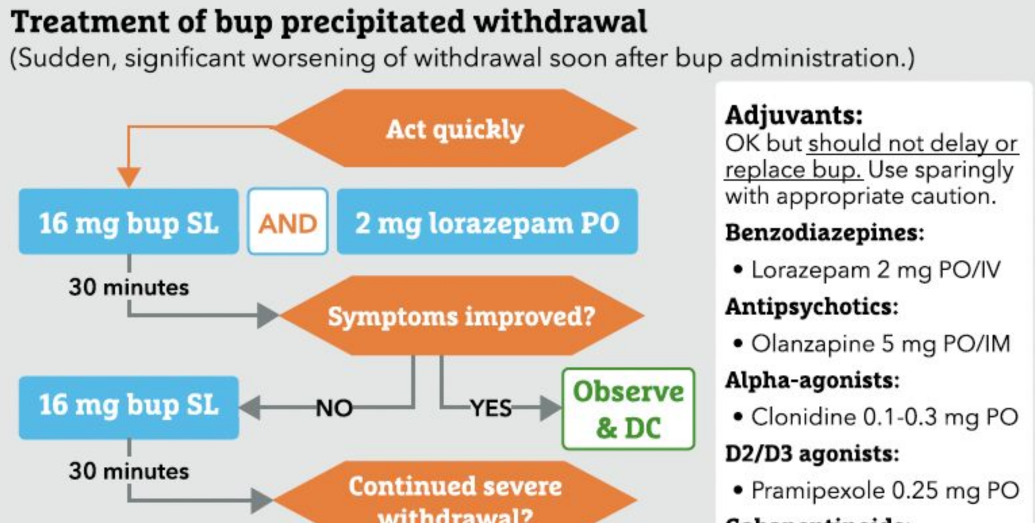
If you *do* precipitate withdrawal…

KEEP
CALM
AND
GIVE
BUP

If you *do* precipitate withdrawal…

KEEP
CALM
AND
GIVE
BUP*…and more bup!*

Treat precipitated withdrawal.



Give 16+mg more bup.

Add a benzo.

Use adjuvant therapy.

For Discharge:

Maintenance Treatment

- Rx bup 1-2 doses SL/day
- Titrate to suppress cravings
- Usual dose 16-32 mg/day or BID
- Prescribe sufficient quantity to bridge to outpatient care *(recommend 14 days)*

Discharge

- **Prescribe at least a 2 week supply of 16-32 mg SL bup per day.**
- **Example 2 week order:** buprenorphine/ naloxone 8/2 mg film 1 film SL TID #42,1 refill. Notes to pharmacy: OK to substitute tablets or monoproduct. Bill Medicaid FFS, ICD 10 F11.20.
- **Dispense/distribute naloxone** in-hand from the ED.

X-ing the X-waiver!

As of Jan 1, 2023, an X-waiver is no longer required by federal law.

Buprenorphine for medication for opioid use disorder no longer requires an X-waivered prescriber.

Need Help?

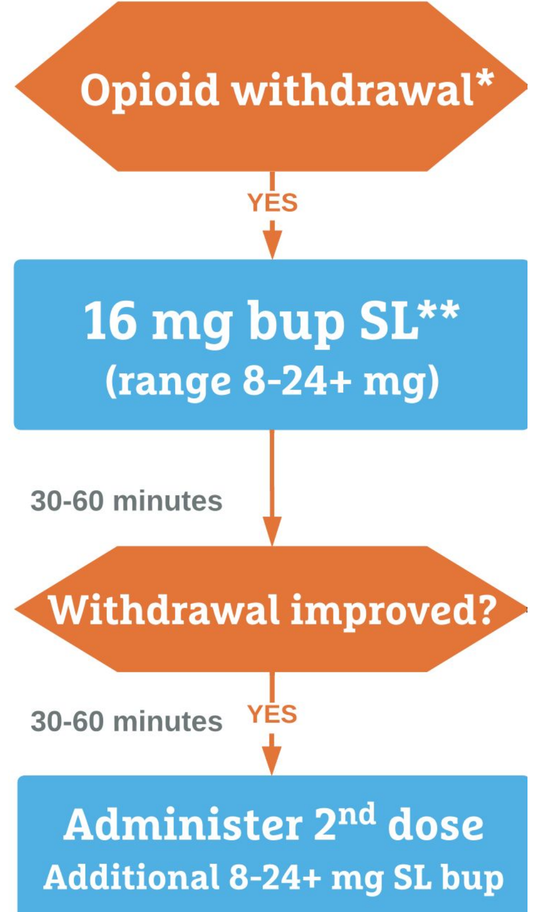
Bridge Program
NEAT Slack Channel

https://bit.ly/Join-NEAT-2024

National Clinician
Consultation Center
Substance Use Warmline
M-F 6 am-5 pm
Voicemail 24/7
(855) 300-3595

Step 1: Medication First Approach

- Pt in moderate to severe withdrawal?
- Wants to try bup?
- Give 16+mg SL



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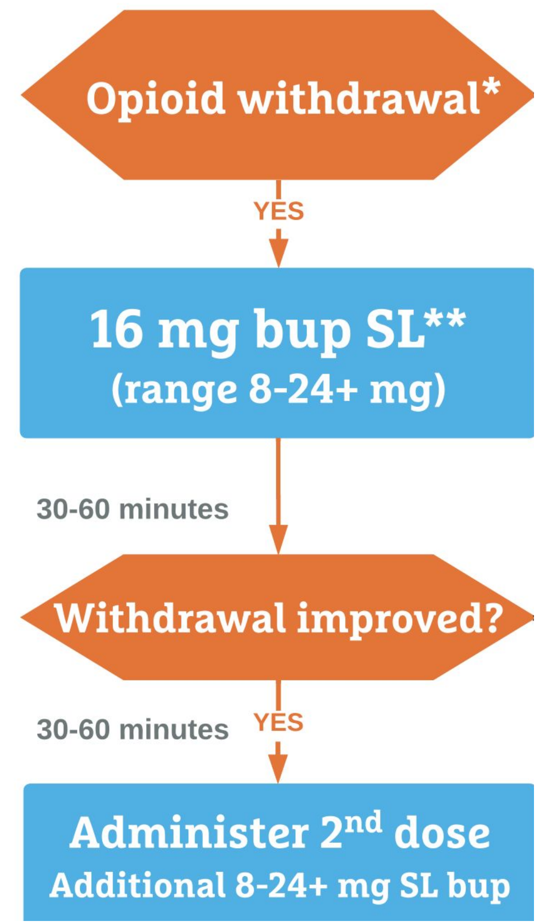
Step 1: Medication First Approach

- Pt in moderate to severe withdrawal?
- Wants to try bup?
- Give 16+mg SL

Step 2: Reassess in 30-45 min.

- Better? Give another dose.
- No? Widen your ddx.



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What if the patient is interested in treatment, but not yet in withdrawal?

Patients Can Self-Start on Bup

- Studies show patient's self-rating for withdrawal is more accurate than COWS.
- Instructions mimic ED start.
- Safe, effective option.

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

Place dose under your tongue (sublingual).

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.

If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin a day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

Not going well? Have questions? Contact your Navigator for help!

Call or text your Navigator for help at ______________________________

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What if my patient is pregnant?

Bup is Safe in Pregnancy

- There are more pregnancy related deaths from overdose than hemorrhage or pre-eclampsia
- MAT is safe in pregnancy & breastfeeding & is recommended by ACOG
  - Buprenorphine, bup/naloxone (combo), & methadone are all safe
  - Reduces risk of neonatal abstinence syndrome
- Pregnant bup starts mirror non-pregnant bup starts
- Bup starts alone do *not* require admission or fetal monitoring
- May need increased doses in 3rd trimester; do *not* stop during labor

What if my patient taking bup is in pain?

Bup & Acute Pain

- Most important: *Do not stop buprenorphine!*
- Use multimodal anesthesia
- Divide 24 hr bup total into more frequent doses; can increase dose.
  - Ex: Home dose bup 16 mg daily → bup 4mg Q6hrs
- Can use full agonist opioids – *give bup first!*
- *Do not be afraid or hesitate to treat the pain!*

Full protocol available at bridgetotreatment.org/resources.

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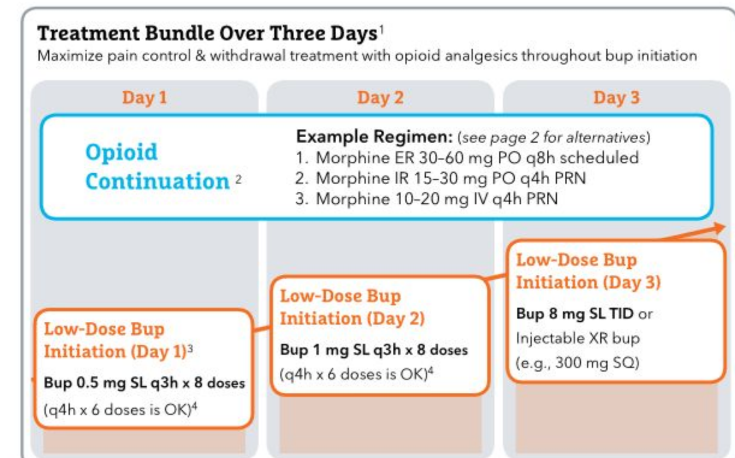
What if my patient is being admitted?

Buprenorphine (Bup) Hospital Start

Buprenorphine (Bup) Hospital Start: Low-Dose Bup Initiation with Opioid Continuation



Footnotes

1. **A rapid three-day bup up-titration schedule is presented here** that may not be appropriate for some patients such as patients receiving high-dose (e.g., ≥100 mg daily) methadone. Extend initiation schedule by lengthening the dose interval to q4h, q6h, or q8h+ and/or increasing the number of doses to be given at each step prior to advancing. **Example:** bup 0.5 mg SL q4h for 12 doses. *(See page 2 for Example Five Day and Eight Day Ramp schedules.)*

2. **Opioid Analgesic (full agonist) Dosing: The doses presented here assume a very high opioid tolerance.** Use clinical judgment to tailor opioid dose to match expected level of opioid tolerance. Morphine doses are presented as a guide for conversion to preferred opioid. *(See page 2 for Alternative Full Agonist Opioids.)* Combine opioids with a multimodal analgesic strategy for optimized comfort and pain control (e.g., NSAIDs, ketamine, and regional anesthesia. (See CA Bridge Acute Pain Management guide.)

3. **Bup Dosing:** SL film doses are presented here as a guide for conversion to preferred bup formulation. If bup 0.5mg SL (quartering a 2 mg SL film) is a pharmacy barrier, most patients will tolerate bup 1 mg SL or an alternative formulation can be used. **Example:** bup buccal film 300 mcg, or bup 0.15 mg IV. *(See page 2 for Alternative Bup Formulations.)*

4. **Bup Frequency: It is OK to hold doses for sleep**. Continue dosing when awake. If nursing capacity limits q3h dosing intervals increasing to q4h or q6h is generally well tolerated. Most patients will tolerate 1-2 missed doses per step.

Warmline (M-F 6am-5pm PST; Voicemail 24/7)
1-855-300-3595

CAPA

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March 2024

Treatment Bundle Over Three Days[1]

Maximize pain control & withdrawal treatment with opioid analgesics throughout bup initiation

Day 1

Day 2

Day 3

Opioid Continuation [2]

Example Regimen: (*see page 2 for alternatives*)

1. Morphine ER 30–60 mg PO q8h scheduled
2. Morphine IR 15–30 mg PO q4h PRN
3. Morphine 10–20 mg IV q4h PRN

Low-Dose Bup Initiation (Day 1)[3]

Bup 0.5 mg SL q3h x 8 doses
(q4h x 6 doses is OK)[4]

Low-Dose Bup Initiation (Day 2)

Bup 1 mg SL q3h x 8 doses
(q4h x 6 doses is OK)[4]

Low-Dose Bup Initiation (Day 3)

Bup 8 mg SL TID or
Injectable XR bup
(e.g., 300 mg SQ)

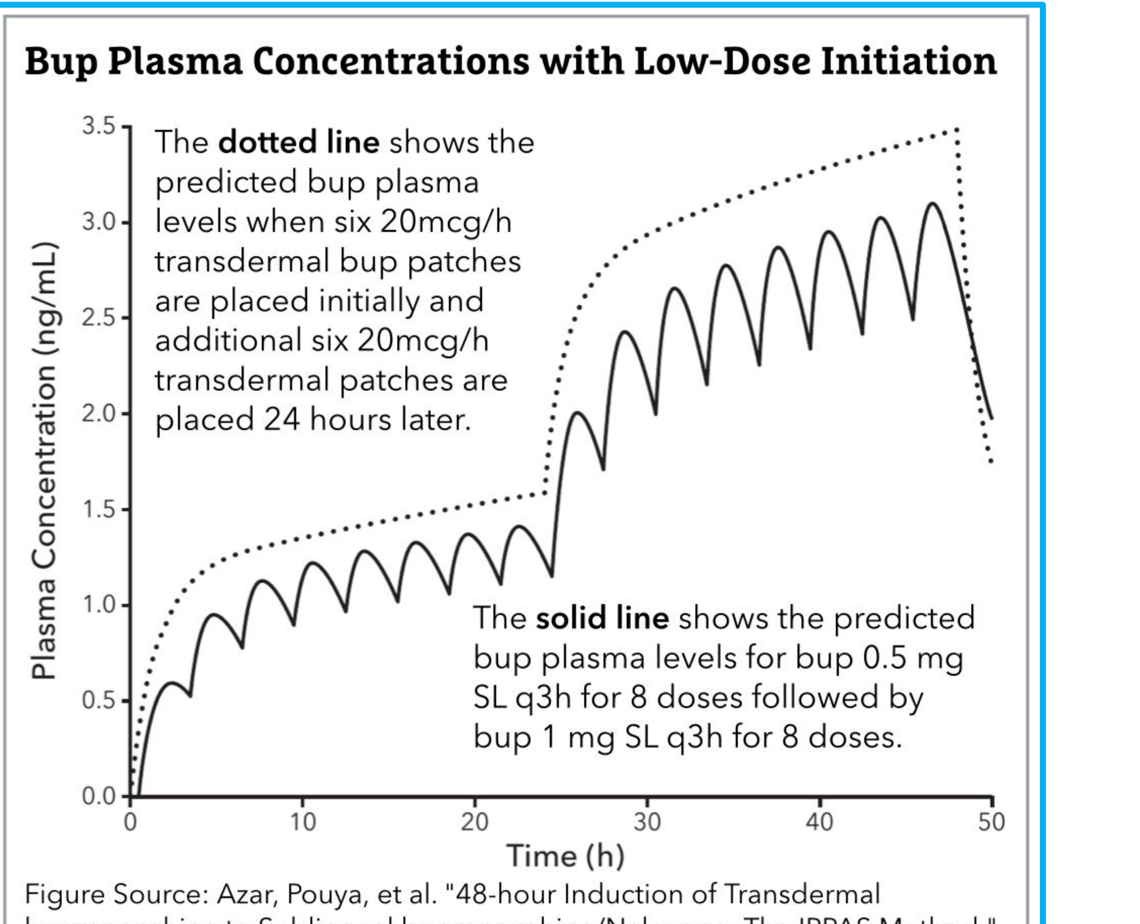
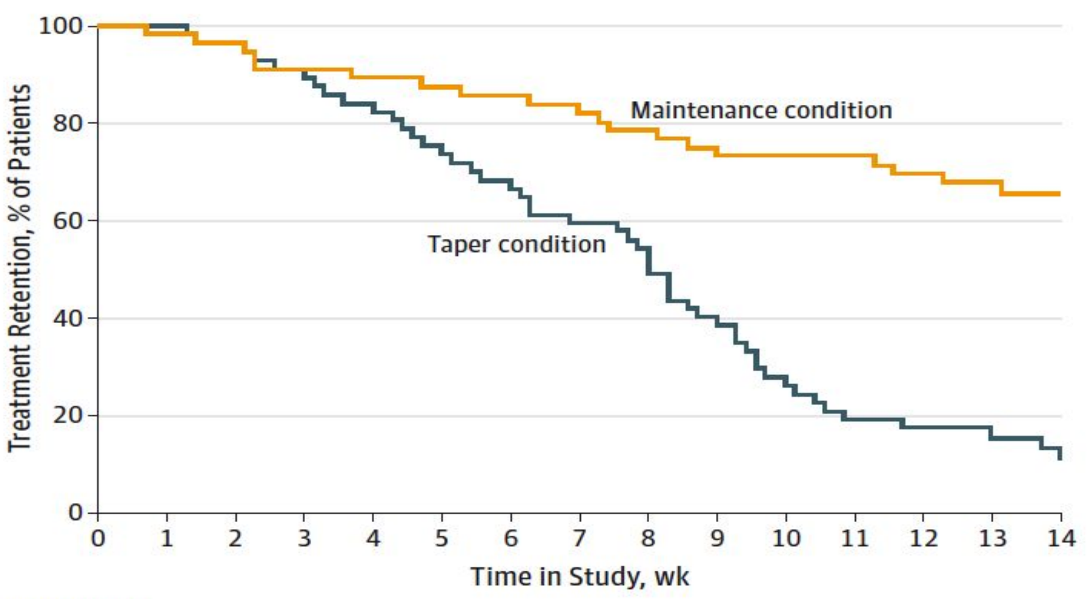


Figure Source: Azar, Pouya, et al. "48-hour Induction of Transdermal buprenorphine to Sublingual buprenorphine/Naloxone: The IPPAS Method." *Journal of Addiction Medicine* (2022): 10-1097.

When should a patient *stop* or *come off* bup?

Bup Taper vs. Maintenance

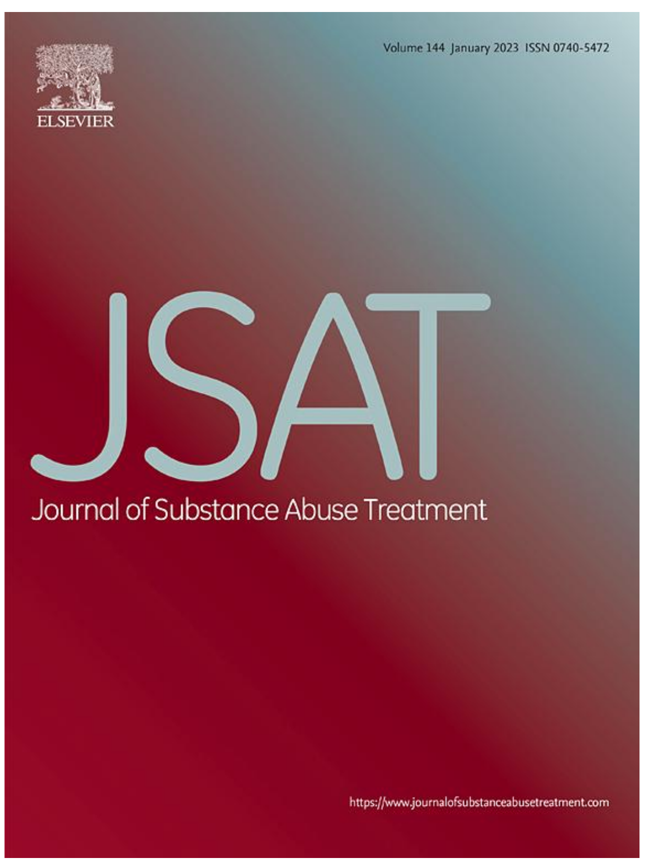


Mean buprenorphine dosage, mg/d

Maintenance condition	14.9	15.1	15.2	15.3	15.3	16.0	15.9	16.2	16.2	16.6	16.8	16.2	16.1	15.8	14.6
Taper condition	15.6	15.6	15.4	15.3	14.2	9.7	5.7	3.1	0.6	0.2	0	0	0	0	0

Fiellin DA, et al. Primary care-based buprenorphine taper vs. maintenance therapy for prescription opioid dependence: a randomized clinical trial. JAMA Intern Med. 2014 Dec;174(12):1947-54. PMID: 25330017.

What about diversion?



Buprenorphine in the United States: Motives for Abuse, Misuse, and Diversion

Howard D. Chilcoat | Halle R. Amick | Molly R. Sherwood | Kelly E. Dunn

Reasons for using diverted buprenorphine:

(cited by patients with OUD)

- 63% – to abstain from other drugs
- 50% – to treat symptoms of withdrawal
- 50% – treatment/management of pain
- 33% – management of psychiatric issues
- 2% – as drug of choice to get high

Chilcoat et al., 2019

The studies in this review consistently suggested that patients using illicit buprenorphine did so to treat symptoms of opioid withdrawal and that lack of formal access to buprenorphine MAT contributed to their illicit buprenorphine use.

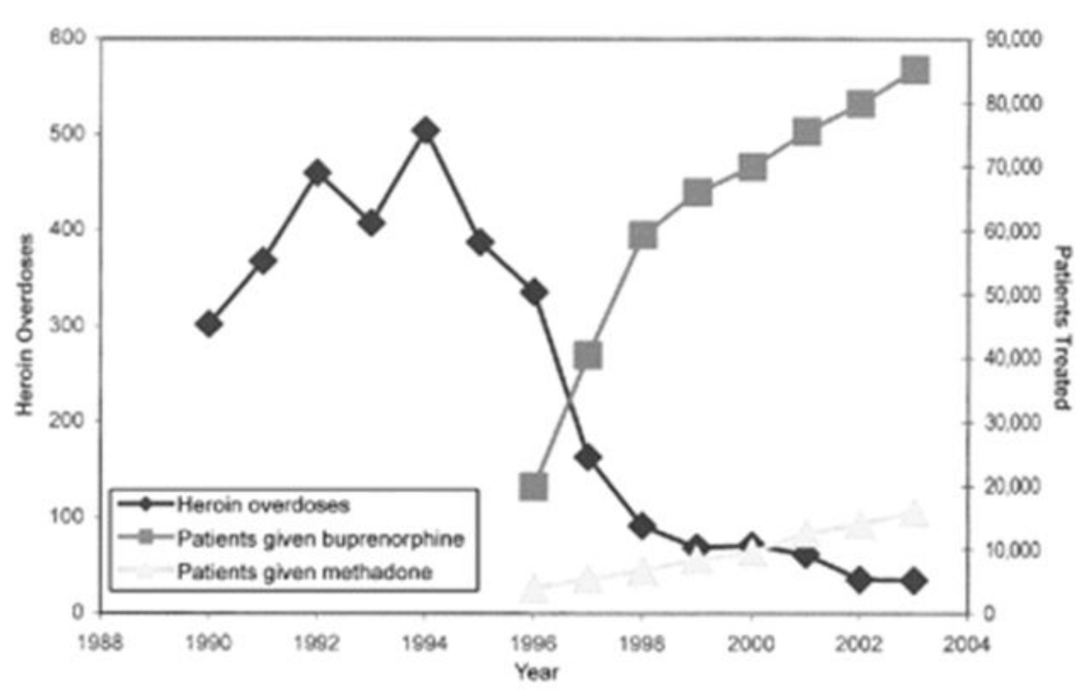
Chilcoat et al., 2019

French Field Experience with Bup

Bup saturation resulted in a

79% decrease in overdose

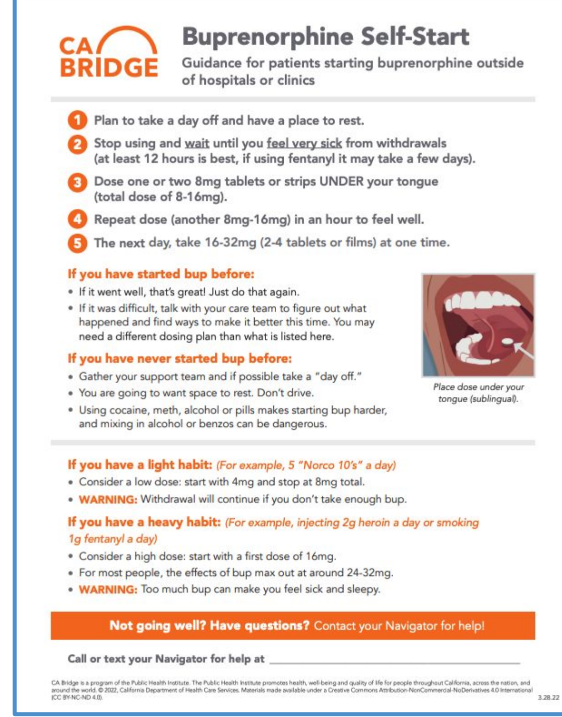
even with 20% bup diversion



Auriacombe et al., 2004

Patients Can Self-Start on Bup

- Studies show patients' self-rating for withdrawal is similar to COWS
- Instructions mimic hospital start
- Safe, effective option
- Patient-facing handout available at bridgetotreatment.org/resources



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Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.

Place dose under your tongue (sublingual).

If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin a day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

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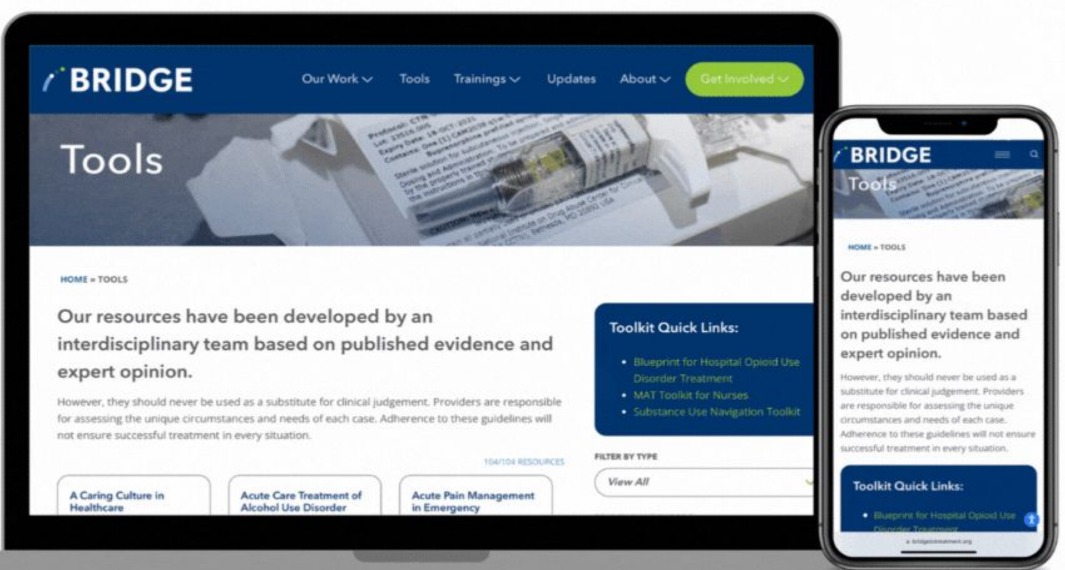
Bottom line:

MAT saves lives.

Resources



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