Opioid Use Disorder (OUD) Simulation Pre-Work

NOSTIGMA
Building pathways to equitable care

Effective Strategies for Communication with Patients

Establish Trust	Trust helps a person to feel safe. Over time, the person may feel more comfortable talking about information that is critical to their health
Person-First Language	Use person first language, i.e. a person with opioid use disorder, a person in recovery, or a person being treated for substance use disorder
Be Authentic and Present	Give the person your full attention, respond to their questions and concerns
Listen and Validate Concerns	• Listen intently to the person's concerns • Validate what you have heard, by confirming with the person • Ask open ended questions • Ask clarifying questions if needed
Be Empathetic	• Try to understand how chronic OUD and pain maybe impacting the person's quality of life • Validate concerns and emotions • Consider sharing a positive experience • Use empathetic statements "I understand this must be difficult for you"
Be Professional and Nonjudgmental	• Help to normalize the situation by keeping a professional manner • Explain to the person why you need to ask specific questions • Explain you are asking out of concern for their health, so you understand the how to help decrease their risks • Screen all persons for OUD, so it becomes a routine part of your practice. "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"
Emphasize Safety	Show concern for the person's safety and work collaboratively to find safe approaches to improve their overall health
Be Supportive	Use effective communication to help set effective and achievable goals. Be aware of your nonverbal communication cues, such as facial expressions and tone of voice.
Use Direct Communication	• When helping patients manage their pain, you might encounter discordance between a patient's desired treatment options and the clinically recommended treatment regimen. Address these challenges directly with your patients and focus on improving quality of life. • Explain recommendations and compare risks and benefits to the patient's expectations • Discuss alternative plans to reach goals of improved function and lessened pain
Positive Attitude	Positive attitudes and knowledge about OUD lead to better treatment outcomes for patients

Some Facts About OUD

SUD is a complex brain disorder and mental illness that presents as a pattern of behavior involving compulsive use of a substance despite harmful physical, social, and/or psychological consequences.

Signs of acute opioid withdrawal include tachycardia, sweating, restlessness, dilated pupils, bone or joint discomfort, runny nose or tearing, gastrointestinal upset, tremor, yawning, anxiety, irritability, and piloerection of skin (gooseflesh skin).

Patients with mental health conditions, such as depression and anxiety, are more likely to experience OUD and overdose than other patients, especially if they are also taking a benzodiazepine.

Adverse childhood experiences (ACEs) are potentially traumatic events that occur during childhood, including child abuse, neglect, and other violence. Having a history of an ACE is a risk factor for several psychiatric disorders, including substance use disorder.

Many patients who have OUD report a history of childhood trauma. ACEs have been associated with younger age of opioid initiation, injection drug use, and lifetime overdose in adults treated for OUD.

Individuals with ACEs are more likely to report chronic pain symptoms that interfere with daily activities and are also more likely to be prescribed multiple prescription medications.

Patients with chronic pain and depression are at elevated risk for suicide.

Some Facts About Treatment for OUD

Medication-assisted treatment (MAT) is the best evidence-based treatment option for OUD, but stigmatizing attitudes affect retention and adherence to the treatment regimen.

MAT includes the use of buprenorphine, naltrexone, or methadone, in combination with cognitive behavioral therapy. MAT is safe to use for months, years, or even a lifetime.

Buprenorphine (Suboxone, Subutex, Sublocade) is considered the first-line MAT. It is thought to be safer than methadone for overdose risk since it is a partial opioid agonist and has a lower potential for respiratory depression. It suppresses and reduces cravings for opioids. Buprenorphine can be prescribed by healthcare providers without a waiver.

Methadone is a long-acting full opioid agonist and requires outpatient visits for supervised administration. Some patients may be allowed to take methadone at home. The length of treatment is a minimum of 12 months. Methadone helps to reduce craving and withdrawal and blocks the effects of opioids.

Naltrexone is an alternative treatment for highly motivated patients, patients with mild OUD, and patients whose occupation (pilots, healthcare workers, public safety) do not permit the use of methadone or buprenorphine. Naltrexone blocks the euphoric and sedative effects of opioids and prevents feelings of euphoria.

Particularly Vulnerable Populations with OUD

Lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals are two times more likely to have OUD than their non-LGBTQ+ peers.

Opioid overdose deaths are rising two times faster in Black, Indigenous and People of Color (BIPOC) than in White individuals.

Youth who identify as a sexual or gender minority (LGBTQ+) are twice as likely to experience homelessness than their non-LGBTQ+ peers. LGBTQ+ youth who are also BIPOC are at an ever higher risk of homelessness.

Human Trafficking Concerns

An estimated 24.9 million people in the world are victims of human trafficking in which victims are forced into labor. One such type of human trafficking is sex trafficking in which victims are coerced or forced into sexual acts.

OUD is common among victims of sex-trafficking. Traffickers often exploit individuals with OUD by coercing them into trafficking in exchange for opioids.

Sex trafficking inflicts trauma on these victims which can lead to increased opioid use as a coping mechanism.

LGBTQ+ homeless youth are 2 times more likely to be sex trafficked than non-LGBTQ homeless youth.

The National Human Trafficking Hotline provides resources to victims of sex and labor trafficking to allow them to get help and stay safe. Phone, text, and online chat is available 24/7, 365 days per year. Help is available in over 200 languages.

NATIONAL HUMAN TRAFFICKING HOTLINE

CONTACT THE NATIONAL HUMAN TRAFFICKING HOTLINE

Do you **want to get out of the life**?

Are you being **forced to work** against your will?

Or **threatened or tricked** by your boss?

Do you know someone who may be?

CALL
1-888-373-7888

TEXT
"BeFree" (233733)

- ✓ Get help.
- ✓ Report a tip.
- ✓ Find services.
- ✓ Learn about your options.

LIVE CHAT
HumanTraffickingHotline.org

24/7 • Toll free • Confidential • 200+ languages

Polaris received $1.75 million through competitive funding through the U.S. Department of Health and Human Services, Administration for Children and Families, Grant #90ZV0134-01-00. The project will be financed with 43.75% of federal funds and 56.25% ($2.25 million) by non-governmental sources. The contents of this flyer are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services, Administration for Children and Families.

ACF

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Harm Reduction

Harm reduction approaches have been proven to prevent death, injury, disease, overdose, and substance misuse. Talk to your patients about the serious risks of respiratory depression associated with concurrent use of opioids and benzodiazepines.

Naloxone distribution is associated with decreased opioid overdose deaths at the community level. Naloxone should be offered to patients and their family members when the following factors that increase risk for opioid overdose are present:

- History of nonfatal overdose
- History of substance use disorder
- Higher opioid dosages (> 50 MME/day)
- Concurrent benzodiazepine use
- High risk of returning to a dose to which tolerance is no longer expected

Fentanyl is 50 times more potent than heroin and overdose deaths related to fentanyl have quadrupled in the past decade. Fentanyl is added to other substances because it is cheap to manufacture, so individuals sometimes do not know what they are consuming. Fentanyl strips are distributed by many states and can be used by individuals prior to using a substance. If positive, individuals can choose to take additional precautions to reduce harm such as use less, go slow, snort or smoke instead of inject, and stagger use with a trusted friend.

Harm associated with injecting drug use includes HIV, viral hepatitis, and bacterial and fungal infections. Needle exchange programs can help to reduce infectious disease transmission among people who use drugs, including those who inject drugs by equipping them with new supplies, accurate information, and facilitating referral to resources.

Many people with OUD need help connecting to community recovery services. Recovery support services, including recovery coaches and peer navigators, reduce ED utilization in patients with OUD by connecting patients with community resources. A warm handoff can facilitate healing and help remove some of the burden from the person. At minimum, providing the person with a list of recovery support services in their community should be part of their discharge instructions.

SAMHSA
Substance Abuse and Mental Health Services Administration

BUPRENORPHINE
QUICK START GUIDE

Important Points to Review With the Patient

Specifically discuss safety concerns:

- **Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.**
- **Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death.**
- **Understand the importance of informing providers if they become pregnant.**
- **Tell providers if they are having a procedure that may require pain medication.**

Facts About Buprenorphine

- FDA approved for Opioid Use Disorder treatment in an office-based setting.
- For those with tolerance to opioids as a result of OUD, buprenorphine is often a safe choice.
- Buprenorphine acts as a partial mixed opioid agonist at the μ-receptor and as an antagonist at the κ-receptor. It has a higher affinity for the μ-receptor than other opioids, and it can precipitate withdrawal symptoms in those actively using other opioids.
- It is dosed daily, has a long half-life, and prevents withdrawal in opioid dependent patients.
- Can be in tablet, sublingual film, or injectable formulations.
- Many formulations contain naloxone to prevent injection diversion. This formulation is the preferred treatment medication. The buprenorphine only version is often used with pregnant women to decrease potential fetal exposure to naloxone.
- There is a "ceiling effect" in which further increases above 24mg in dosage does not increase the effects on respiratory or cardiovascular function.
- Buprenorphine should be part of a comprehensive management program that includes psychosocial support. Treatment should not be withheld in the absence of psychosocial support.
- Overdose with buprenorphine in adults is less common, and most likely occurs in individuals without tolerance, or who are using co-occurring substances like alcohol or benzodiazepines.

Checklist for Prescribing Medication for the Treatment of Opioid Use Disorder

1

Assess the need for treatment

For persons diagnosed with an opioid use disorder,* first determine the severity of patient's substance use disorder. Then identify any underlying or co-occurring diseases or conditions, the effect of opioid use on the patient's physical and psychological functioning, and the outcomes of past treatment episodes.

Your assessment should include:

- A patient history
- Ensure that the assessment includes a medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports.
- Access the patient's prescription drug use history through the state's Prescription Drug Monitoring Program (PDMP), where available,

to detect unreported use of other medications, such as sedative-hypnotics or alcohol, that may interact adversely with the treatment medications.
- A physical examination that focuses on physical findings related to addiction and its complications.
- Laboratory testing to assess recent opioid use and to screen for use of other drugs. Useful tests include a urine drug screen or other toxicology screen, urine test for alcohol (ethyl glucuronide), liver enzymes, serum bilirubin, serum creatinine, as well as tests for hepatitis B and C and HIV. Providers should not delay treatment initiation while awaiting lab results.

2

Educate the patient about how the medication works and the associated risks and benefits; obtain informed consent; and educate on overdose prevention.

There is potential for relapse & overdose on discontinuation of the medication. Patients should be educated about the effects of using opioids and other drugs while taking the prescribed medication and the potential for overdose if opioid use is resumed after tolerance is lost.

3

Evaluate the need for medically managed withdrawal from opioids

Those starting buprenorphine must be in a state of withdrawal.

4

Address co-occurring disorders

Have an integrated treatment approach to meet the substance use, medical and mental health, and social needs of a patient.

5

Integrate pharmacologic and nonpharmacologic therapies

All medications for the treatment of the opioid use disorder may be prescribed as part of a comprehensive individualized treatment plan that includes counseling and other psychosocial therapies, as well as social support through participation in mutual-help programs.

6

Refer patients for higher levels of care, if necessary

Refer the patient for more intensive or specialized services if office-based treatment with buprenorphine or naltrexone is not effective, or the clinician does not have the resources to meet a particular patient's needs. Providers can find programs in their areas or throughout the United States by using SAMHSA's Behavioral Health Treatment Services Locator at www.findtreatment.samhsa.gov.

*See The Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association, page 541.

Induction Considerations

The dose of buprenorphine depends on the severity of withdrawal symptoms, and the history of last opioid use (see flowchart in appendix for dosing advice).

- **Long acting opioids, such as methadone, require at least 48-72 hours since last use before initiating buprenorphine.**
- **Short acting opioids (for example, heroin) require approximately 12 hours since last use for sufficient withdrawal to occur in order to safely initiate treatment. Some opioid such as fentanyl may require greater than 12 hours.**
- **Clinical presentation should guide this decision as individual presentations will vary.**

Determine Withdrawal

Objective withdrawal signs help establish physical dependence

The risk with initiating buprenorphine too soon is that buprenorphine has a very high affinity for the mu receptor and will displace any other opioid on the receptor, thereby causing precipitated opioid withdrawal.

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

COWS Clinical Opiate Withdrawal Scale

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* 0 Able to sit still 1 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

Information on Precipitated Withdrawal

- Precipitated withdrawal can occur due to replacement of full opioid receptor agonist (heroin, fentanyl, or morphine) with a partial agonist that binds with a higher affinity (Buprenorphine).
- Symptoms are similar to opiate withdrawal.
- Avoid by ensuring adequate withdrawal before induction (COWS > 12; Fentanyl may require higher COWS score and lower initial dosing), starting Buprenorphine at a lower dose (2.0mg/0.5 mg), and reassessing more frequently.
- Should precipitated withdrawal occur, treatment includes:
  - Providing support and information to the patient
  - Management of acute symptoms
  - Avoid the use of benzodiazepines
  - Encourage the patient to try induction again soon

Buprenorphine Side Effects

- **Buprenorphine's side effects may be less intense than those of full agonists. Otherwise, they resemble those of other mu-opioid agonists.**
- **Possible side effects include: Oral numbness, constipation, tongue pain, oral mucosal erythema, vomiting, intoxication, disturbance in attention, palpitations, insomnia, opioid withdrawal syndrome, sweating, and blurred vision**
- **Buprenorphine FDA labels list all potential side effects**

Co-prescribing of overdose reversal agents such as Naloxone is also recommended

Maintenance Therapy

Goal = once-daily dosing, no withdrawal between doses. Ideally, average dosing does not exceed 16 mg/4 mg (See flowchart in appendix)

- **Check PDMP regularly to ensure prescriptions are filled, and to check other prescriptions.**
- **Order urine drug testing (UDT) and consider confirmatory testing for unexpected results. UDT can facilitate open communication to change behavior.**
- **Assess for readiness for extended take-home dosing**

Psychosocial Therapies

- **Although people often focus on the role of medications in MAT, counseling and behavioral therapies that address psychological and social needs may also be included in treatment. To find treatment, please consult www.findtreatment.gov.**

Diversion

Diversion is defined as the unauthorized rerouting or misappropriation of prescription medication to someone other than for whom it was intended (including sharing or selling a prescribed medication); misuse includes taking medication in a manner, by route or by dose, other than prescribed.

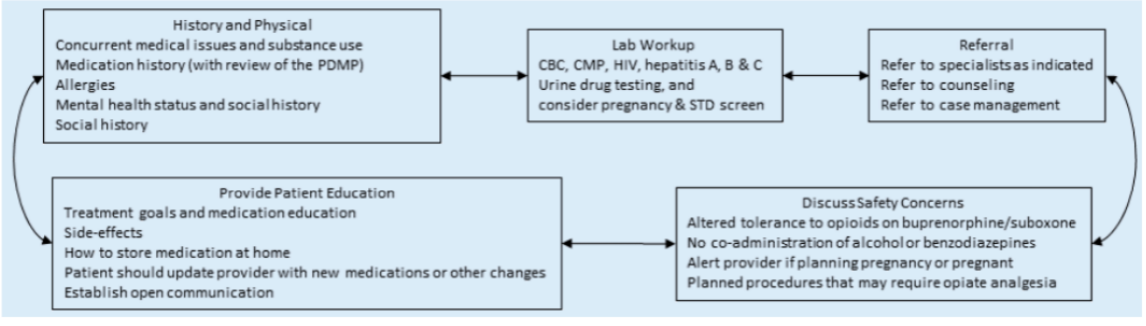
How can providers minimize diversion risk?

1. Early in treatment patients should be seen often, and less frequently only when the provider determines they are doing well.
2. Providers should inquire about safe and locked storage of medications to avoid theft or inadvertent use, especially by children. Patients must agree to safe storage of their medication. Counsel patients about acquiring locked devices and avoiding storage in parts of the home frequented by visitors.
3. Limit medication supply. Prescribe an appropriate amount of medications until the next visit. Do not routinely provide an additional supply "just in case."
4. Use buprenorphine/naloxone combination products when medically indicated. Reserve daily buprenorphine monoproducts for pregnant patients and/or patients who could not afford treatment if the combination product were required.
5. Counsel patients on taking their medication as instructed and not sharing medication.
6. Ensure that the patient understands the practice's treatment agreement and prescription policies. Providers can utilize the sample treatment agreement in SAMHSA's TIP 63, Page 3-78. A treatment agreement and other documentation are clear about policies regarding number of doses in each prescription, refills, and rules on "lost" prescriptions.
7. Directly observe ingestion randomly when diversion is suspected.
8. Providers should order random urine drug testing to check for other drugs and for metabolites of buprenorphine. Providers should also consider periodic point of care testing.
9. Doctors should schedule unannounced pill/film counts. Periodically ask patients to bring in their medication containers for a pill/film count.
10. Providers should make inquiries with the Prescription Drug Monitoring program in their state to ensure that prescriptions are filled appropriately and to detect prescriptions from other providers.
11. Early in treatment, providers can ask the patient to sign a release of information for a trusted community support individual, such as a family member or spouse, for the purpose of communicating treatment concerns including diversion.

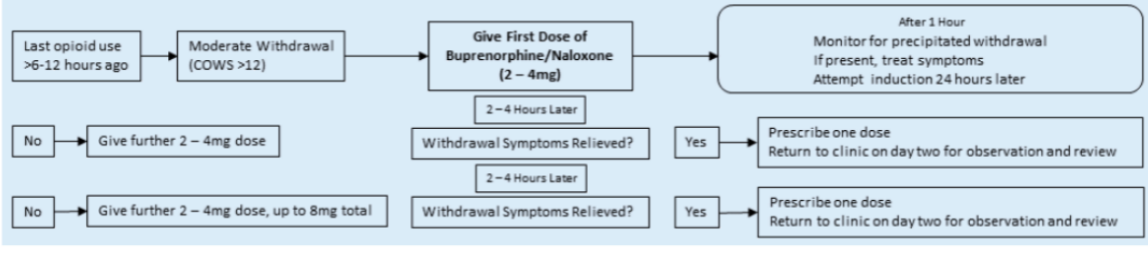
TRANSMUCOSAL BUPRENORPHINE/ NALOXONE QUICK START GUIDE

Algorithm for In-Office Induction (for home induction prescriptions may be given)

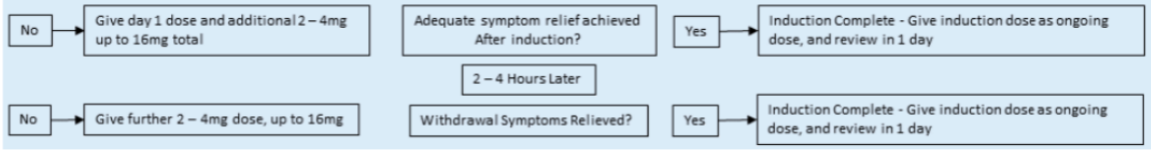
INITIAL ASSESSMENT



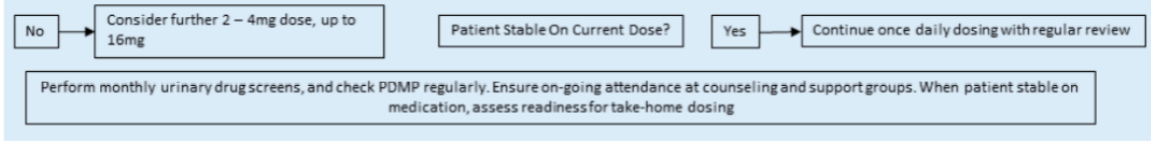
DAY ONE (INDUCTION)



DAY TWO



MAINTENANCE

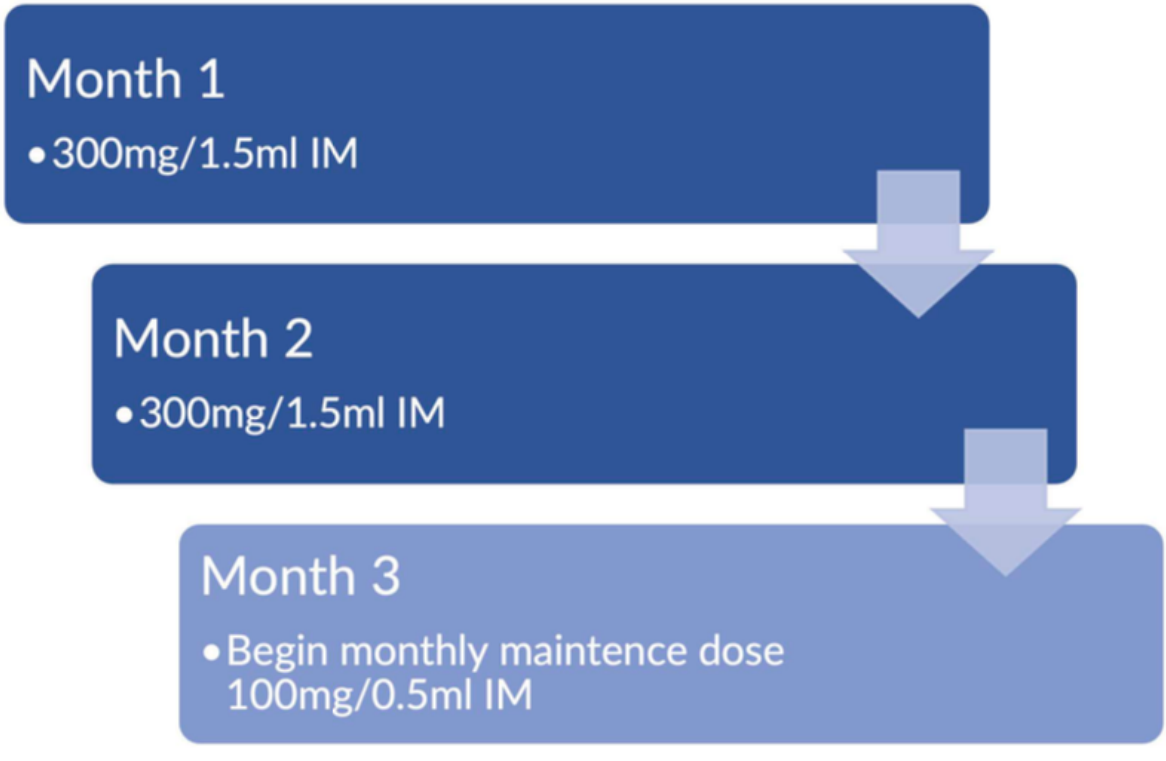


(Adapted from Substance Abuse and Mental Health Services Administration (2022). Buprenorphine quick start guide. https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf)

INJECTABLE BUPRENORPHINE TRANSITION GUIDE

- Patients with moderate to severe OUD who have stabilized on a buprenorphine-containing product (at least 7 days on a stable dose) may switch to extended-release injectable buprenorphine.

- Injectable buprenorphine is available in two doses: 300 mg/1.5 mL and 100 mg/0.5 mL prefilled syringes.



(Adapted from Substance Abuse and Mental Health Services Administration (2021). Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings. https://store.samhsa.gov/sites/default/files/pep21-06-01-002.pdf)

BUPRENORPHINE MONITORING

- Once stable, visits should occur every two to four weeks via in-person or telehealth.
- Patients on injectable buprenorphine should visit the clinic in person every 26-28 days for their monthly injection.
- Maintenance clinic visits include the following elements, as well as telehealth support as needed.
  - ✓ Urine drug testing to identify the level of buprenorphine or presence of other substances
  - ✓ Indicated lab testing (e.g., liver function tests)
  - ✓ Patient assessment
    - Medication status: dosage, adherence, side effects, cravings, withdrawal symptoms, safe storage
    - Medical, psychiatric, and social issues
    - Other elements of recovery (engagement in counseling, peer support meetings, recovery groups, etc.)

Opioid Withdrawal Symptom Management

Anxiety	Clonidine	0.1mg PO Q4H PRN
	Quetiapine	25mg PO QHS PRN
Sleep	Trazodone	50-100mg PO QHS PRN
Pain	Ibuprofen	600mg PO Q6H PRN
Nausea	Dimenhydrinate	50mg PO Q6H PRN
	Ondanestron	4mg PO Q6H PRN
Diarrhea	Loperamide	4mg PO, followed by 2mg after each loose stool (do not exceed 16mg/day)

Funding for the NO STIGMA project by the FORE Foundation.

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