Tip 1: Understanding Opioid and Stimulant Use Disorders

Description

The National Institute on Drug Abuse (NIDA) defines addiction as a "complex but treatable condition."[30] LTCFs can create supportive care environments by better understanding OUD and StUD by considering the stigmas and myths, how they present, symptoms of withdrawal, and how to manage the conditions appropriately.

Goal

This section aims to help LTCF staff create a supportive care environment by understanding OUD and StUD and how dispelling stigmas and myths can foster better care for residents.

Objectives

At the end of this section, participants will be able to:

- Understand OUD and StUD, the underlying causes, spectrum of disease severity, the biological effects, and how residents present clinically.
- Recognize the stigma of addiction.
- Dispel misconceptions about persons with OUD and StUD.

Policies

- Incorporate harm-reduction principles throughout your organization and in existing policies.
- Incorporate a section on OUD and StUD into your internal discrimination policy to reduce stigma and foster a positive culture that ensures staff sees addiction as a medical condition.
- Integrate the use of the Clinical Opiate Withdrawal Scale (COWS) as a method to help identify opioid withdrawal and guide the care for the resident.
- Understand and differentiate between opioid withdrawal and the symptoms and effects of stimulant withdrawal to support the resident.
- Develop policies regarding naloxone administration.

Presentation, Diagnosis, and Symptoms of Withdrawal

To best care for those with OUD and StUD, it is important to understand the presenting behaviors associated with these two disorders while ensuring resident safety throughout the process.

It is also essential to understand that some residents may have a co-occurrence of both OUD and StUD. While treatment for each of these disorders is different, it is important to take a holistic approach. For example, employing MOUD with counseling and cognitive behavioral therapy and other evidence-based best practices is critical for residents with co-occurring OUD and StUD.

Opioid Use Disorder

Diagnosing Opioid Use Disorder

To be diagnosed with an OUD, a person must have experienced two or more of the following criteria within a 12-month period.

Criteria for OUD Diagnosis:	
1.	Opioids are often taken in larger amounts or over a longer period than was intended.
2.	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3.	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4.	Craving, or a strong desire or urge to use opioids.
5.	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6.	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7.	Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8.	Recurrent opioid use in situations in which it is physically hazardous.
9.	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10.	Exhibits tolerance (*note: alone, not enough to diagnose an OUD. Not considered to be met for individuals taking opioids solely under appropriate medical supervision*).
11.	Exhibits withdrawal (*note: alone, not enough to diagnose an OUD. Not considered to be met for individuals taking opioids solely under appropriate medical supervision*).

Source: American Psychiatric Association (on. (n.d.). Retrieved from Opioid Use Disorder Diagnostic Criteria

Presenting with Opioid Use Disorder

Opioids are a class of drugs, including pain relievers available legally by prescription, the illegal drug heroin, and synthetic opioids such as fentanyl. These drugs bind to and activate opioid receptors on cells located in the brain, spinal cord, and other regions in the body. When opioids attach to the receptors, they block pain signals sent from the brain to the body and release large amounts of dopamine. Opioids make people feel relaxed or "high." They also cause drowsiness, confusion, nausea, constipation, euphoria, and slowed breathing.[31]

Residents presenting with an OUD may appear acutely intoxicated, in opioid withdrawal, or show no acute effects related to their opioid use.[32] If a patient is in active withdrawal, LTCF staff should follow the regulatory restrictions outlined in 105 CMR Section 150.003: Admissions, Transfers, and Discharges on managing active withdrawal. Many health-related consequences may accompany residents presenting with OUD, including infection, opioid-induced bowel syndrome, opioid-induced hyperalgesia, motor-vehicle accidents, opioid amnestic syndrome, overdose, and possibly death.[33]

Symptoms of Opioid Use Disorder Withdrawal

Individuals with OUD may experience cravings, withdrawal, or difficulty in controlling pain. Most of your facility's residents with OUD will already be on MOUD, but they will require additional evaluation by the appropriate provider for dose adjustments. Other residents may have been undiagnosed or diagnosed OUD but have other indications for acute opioid analgesia; monitor these residents for drowsiness, sedation, and overdose. Ask residents about symptoms in non-judgmental ways and develop person-centered plans to optimize resident safety and reduce harm.

To do this, your behavioral health services (contracted or non-contracted) should conduct an assessment, then conference with the physician and physician assistant to determine the appropriate care plan. If the resident connects with an OTP or OBOT/OBAT, include them in the conversation and development of the care plan.

Symptoms of opioid withdrawal can include:[34]

- Nausea, vomiting, diarrhea
- Anxiety
- Insomnia
- Hot and cold flushes
- Perspiration
- Muscle cramps
- Watery discharge from eyes and nose

Use the COWS to determine the stage or severity of opiate withdrawal (Exhibit 2). The COWS score will help determine the next steps in caring for your resident. Add a decision tree into your LTCF policy based on COWS scores (5-12= mild; 13-24= moderate; 25-36= moderately severe; 36= severe withdrawal). Always communicate with the resident's physician, OTP, or OBOT/OBAT regarding suspected withdrawal symptoms and COWS score to determine the next steps and when or if the resident should go to a higher level of care.

Exhibit 2: 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 >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 and/or 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 per 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 or 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 opioid withdrawal is scored

- **0** not present
- **1** mild diffuse discomfort
- **2** patient reports severe diffuse aching of joints or muscles
- **4** patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh Skin:

- **0** skin is smooth
- **3** piloerection of skin can be felt, hairs standing up on arms
- **5** prominent piloerection

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, 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
- ➢ **36** = severe withdrawal

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9.

Signs of Opioid Overdose and What to Do if You Suspect an Overdose

Signs of an overdose include:

- Nonresponsive to voice or sternal rub
- Pulse slow, erratic, or absent
- Breathing slow, irregular, or has stopped
- Grey or lighter lips and fingertips for dark skinned individuals, blue lips and fingertips for light skinned individuals
- Limp and pale
- Small, pin-point pupils

If you suspect a resident has overdosed, follow guidelines from the SAMHSA Opioid Overdose Prevention Toolkit.[35]

Residents cannot go through acute withdrawal in LTCFs. Transfer resident to hospital after administering naloxone.

DO	DON'T
Attend to the person's breathing and cardiovascular support needs by administering oxygen or performing rescue breathing and/or chest compressions. This is the most critical step and should be continued until Emergency Medical Services (EMS) arrives.	Slap or forcefully try to stimulate the person; it will only cause further injury. If you cannot wake the person by shouting, rubbing your knuckles on the sternum (center of the chest or rib cage), or light pinching, the person may be unconscious.
Administer naloxone and use a second dose if no response to the first dose.	Put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock.
Put the person in the "recovery position" on the side, if you must leave the person unattended for any reason.	Inject the person with any substance (e.g., saltwater, milk, stimulants). The only safe and appropriate treatment is naloxone.
Stay with the person and keep the person warm.	Try to make the person vomit drugs that may have been swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

STOP AN OVERDOSE

TAKE THESE STEPS:

1. Check for overdose
2. Call 9-1-1
3. Give Narcan®
4. Give breaths
5. Stay until help arrives

1 CHECK FOR OVERDOSE

Signs of overdosing:
- Not breathing well
- Turning blue/gray
- Not reacting when you rub your knuckles on their chest

2 CALL 9-1-1

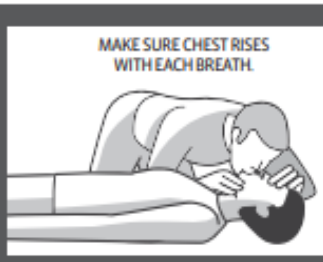
- Call 9-1-1
- Say "someone isn't breathing" and/or "I think it's an overdose"
- Stay until help arrives, even if they seem better*

3 GIVE NARCAN®

- Push pump only after tip is in nose
- Go to Step 4
- If no response in 3 minutes, give another dose

4 GIVE BREATHS/CPR

- Make sure mouth is clear
- Tilt head back, lift chin, pinch nose
- Give 1 breath every 5 seconds
- Try CPR if you've been trained



5 STAY UNTIL HELP ARRIVES

- If breathing well, put on side
- If not breathing well, repeat Steps 3 and 4
- Stay until help arrives*

HelplineMA.org
800-327-5050

mass.gov/narcan

*Good Sam Law protects people who overdose or seek help for someone overdosing from being charged or prosecuted for simple drug possession.

Source: www.mass.gov/narcan, visit for Spanish version

Case Study: Opioid Use Disorder

Managing residents who have OUD requires attentive care from physicians and other providers due to the complexity of their disorders. An individualized treatment plan is necessary to provide the resident with a patient-centered approach to proper care. Below we present a case example of a man prescribed opioids for a back injury (adapted from CDC Guidelines for Prescribing Opioids for Chronic Pain[36]). Following the scenario is a set of questions for you to consider.

Identifying DSM-5 OUD Criteria Scenario 1: Resident Chart

Nelson, John, DOB: 4/11/1984

- Medical history: Lower back pain that began after a fall at work three years ago; lifting heavy objects at work exacerbated the injury; currently takes extended-release morphine 45 milligrams twice daily to treat pain.
- Prescription drug monitoring program (PDMP) data does not show any additional controlled substance prescriptions other than the extended-release morphine prescription described above.
    - [Doctor] Hi John, it's nice to meet you. I see you recently moved to the area, and you are looking to establish care. Can you tell me what is going on?
    - [Resident] Well, I had a fall at work a few years ago and I've been taking pain medications for it, but they've run out. Since I ran out, I've had some really bad nausea and diarrhea, and I feel really achy. I've run out of my pain medications before, and I felt the same way. I have tried to cut down on the amount of pills I take so that I can get to my next refill, but I need more pills to make these symptoms go away.
    - [Doctor] Okay, can you tell me more?
    - [Resident] I am currently taking 45 milligrams of extended-release morphine twice a day, but it doesn't seem to be working and I feel I need a bigger dose. In fact, I've had to skip work several times because my symptoms get so bad after running out of my medicine.
    - [Doctor] Have you tried any methods for pain relief that didn't involve opioids?
    - [Resident] My prior doctor recommended I try working some regular exercise into my day and even try things like yoga and acupuncture, but that's just not for me so I haven't done it. Ibuprofen just didn't cut it either.

Identifying DSM-5 OUD Criteria Scenario 1: Check Your Knowledge

Based on the information shared so far, is it correct to suspect John meets the criteria for OUD?

- Yes
- No

Yes, based on the information John shared, OUD should be suspected. He has met two or more of the DSM-5 criteria within a year:

- He has taken the opioids longer than intended.
- He has tried unsuccessfully to cut down or control opioid use.
- His opioid use seems to be resulting in his being unable to function at work.

In this scenario, not all the OUD criteria were assessed. Further discussion at this appointment and during future visits should assess whether he meets additional criteria suggesting moderate (4-5 criteria) or severe (6 or more criteria) OUD.

Stimulant Use Disorder

Diagnosing Stimulant Use Disorder

Diagnosis of a StUD is based on the occurrence of at least two of the following within a 12-month period.[37]

Criteria for StUD Diagnosis:			
1.	Taking more stimulants than intended.		
2.	Failing to cut down or control use of stimulants, despite wanting to do so.		
3.	Spending excessive amounts of time in activities surrounding stimulant use.		
4.	Experiencing urges and cravings for stimulants.		
5.	Failing to meet the obligations of home, school, or work.		
6.	Continuing to take stimulants, even if it has led to relationship or social problems.		
7.	Giving up or reducing important recreational, social, or work-related activities because of stimulant use.		
8.	Using stimulants in situations in which it is physically hazardous.		
9.	Continuing to use stimulants even if there is an awareness that it is causing or worsening a physical or psychological problem.		
10.	Experiencing an increase in tolerance to stimulants.		
11.	Having withdrawal symptoms when not taken.		
Severity Scale:	*Mild if 2-3 symptoms*	*Moderate if 4-5 symptoms*	*Severe if >6 symptoms*

Presenting with Stimulant Use Disorder

Stimulants are substances that affect the central nervous system through their ability to cause an increase in dopamine throughout the body.[38] When consumed, stimulants have the effect of causing a sense of euphoria, make a person more alert, and may increase one's energy.[39] Furthermore, stimulants can also affect a person's physiological processes by causing an increase in heart rate, breathing, and blood pressure.[40] Typical and prominent stimulants include cocaine, methamphetamine, and prescription stimulants (amphetamine, methylphenidate).[41]

Residents who have used stimulants may exhibit behavior changes, agitation, paranoia, increased energy, and fast breathing. For illegal stimulants, like other substances, there are different modes of administration. Residents who inject stimulants may present with skin or bacterial infections. Residents who snort stimulants may present with sinus infections or nosebleeds. Residents who smoke stimulants may present with chronic coughing, wheezing, or shortness of breath. The symptoms and effects of stimulants may present differently depending on the person.[42] To optimize resident safety and reduce harm, ask residents about their symptoms in non-judgmental ways, and develop person-centered plans.[43]

Symptoms of Stimulant Use Disorder Withdrawal

If a resident is in active withdrawal, LTCF staff should follow the regulations outlined in 150.003: Admissions, Transfers, and Discharges, on managing active withdrawal. In stimulant withdrawal, the resident may experience fatigue, insomnia, depression, and anxiety, or minimal effects related to their stimulant use.[44]

People using stimulants for a sustained period may become distressed or agitated, which may progress to include symptoms that resemble psychosis. Acute stimulant intoxication may result in the person presenting as a danger to themselves or others.[45] Symptoms may include auditory, visual, and hallucinations, delusions, and paranoia.[46] Physical symptoms may include rapid heart rate, elevated body temperature and shortness of breath. There is no validated withdrawal scale.[47] Taking more stimulants than the body can handle can result in cardiac arrest or stroke.

Care should focus on comfort and de-escalation. De-escalation starts with ensuring a safe, calm space, and safety. Designate one person to interact with the resident calmly and reassuringly.

Ten Domains of De-escalation	
1. Respect personal space	6. Listen actively and respond appropriately
2. Do not be provocative	7. Agree or agree to disagree
3. Establish verbal contact	8. Lay down the law and set clear limits
4. Be concise	9. Offer choices and optimism
5. Identify wants and feelings	10. Debrief the patient and staff.

Source: Richmond JS, Berlin JS, Fishkind AB, et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. West J Emerg Med. 2012;13(1):17-25.

When danger to self or others persists despite de-escalation efforts, involve psychiatric crisis services if applicable or transfer the patient to the emergency room.[48]

To do this, have an assessment conducted by your behavioral health services (contracted or non-contracted), who should then conference with a provider to determine the appropriate care plan. If the resident works with a behavioral health program, include it in the coordination of the care plan. Some of the most common stimulant withdrawal side effects and symptoms include:

- Fatigue and increased need for sleep
- Increased appetite
- Anhedonia
- Slowed reaction and movement
- Aches and pains
- Mood lability
- Depression
- Suicidal ideation

Like opioid withdrawal, if you suspect a resident is experiencing stimulant withdrawal, communicate with the resident's physician or other providers to determine the next steps, if or when the resident should go to a higher level of care.

Signs of Stimulant Overamping and What to Do if You Suspect Overamping[49]

Overamping is a term used to describe an overdose of a stimulant, such as cocaine, speed, and methamphetamine. Overamping can occur regardless of amount used or length of use. Overamping can happen when the body feels run down, sleep deprivation, or when stimulant is taken with other drugs.

Signs and symptoms of overamping[50] include:

- Paranoia, anxiety, panic
- Hallucinations
- Psychosis
- Increased heartrate/chest pain
- Increased sensory awareness
- Hyperthermia
- Dilated pupils
- Grinding jaw or spastic movements

If you suspect a resident is experiencing stimulant overamping:

- Assess the scene
- Assess the resident
- Call 911
- Attempt to de-escalate the resident, if appropriate
- Stay with the resident until help arrives
- Should the resident become unresponsive, perform CPR until help arrives

Case Study: Stimulant Use Disorder

An individualized treatment plan is required to provide the resident with person-centered care.

Below, we present a case example of a scenario, followed by a set of discussion questions.

Case Study-Stimulant Use Disorder[51]

43 year-old female patient presents to urgent care complaining of three to four week history of shortness of breath, fatigue, restlessness at night, and chest "pressure" that has been unrelenting for the past 12-hours.

Admitted from urgent care to the cardiovascular care unit for evaluation.

Day 1: Cardiac enzymes were cycled, and she ruled-out for an acute coronary syndrome. Echocardiogram (EKG) was performed.

Day 2: She underwent diuresis with furosemide infusion and was asymptomatic. Angiotensin-converting-enzyme (ACE)-inhibitor and beta-blocker therapies were started using lisinopril and carvedilol.

Day 3: Patient was clinically opti-volemic. Heart failure (HF) management program evaluated patient. Aldosterone antagonist therapy started with spironolactone. HF education was started and included discussion of methamphetamine use as cause of her cardiomyopathy. HF nutrition counseling provided by registered dietician.

Psychiatric/addictions care also evaluated patient. She refused inpatient and outpatient addiction treatment.

Day 4: Discharged to home in care of her son. To follow up in the heart failure clinic (HFC) in four days.

Case Study-Stimulant Use Disorder[51]

Subsequent HFC Follow Up

- Patient seen weekly for next six weeks.
- Carvedilol titrated to 25 mg BID.
- Furosemide decreased to 40 mg daily overtime.
- Remained abstinent from methamphetamine (UDS negative) but started smoking again after eight weeks.
- Three months after HFC therapy was initiated, EKG was repeated: LV systolic function NORMAL. EF 72%.
- Two months after the echocardiogram, patient failed follow up with HFC.
- She did return for one visit at which she admitted that she used methamphetamine one time in the previous week after the death of her grandmother. She again refused addictions treatment/counseling.
- She has not returned to HFC since that visit.
- Multiple attempts have been made to locate and contact patient via telephone and mail. She has moved and all her emergency contacts reported not to know her whereabouts.

Discussion

- Consider methamphetamine (and cocaine) use when a person presents with new-onset heart failure associated with significant hypertension.
- Refusal to participate in clinical addictions recovery and counseling programs is common in people with SUD.
- Several studies have documented adverse effects of beta-blockade in patients with ongoing cocaine or amphetamine use. The hazard lies in the potential for deadly ventricular arrhythmias with unopposed beta-blockade concomitantly with amphetamine agents. Though no large-scale randomized studies exist, using alpha and beta-blocking agents (such as carvedilol) is widely felt to reduce this population's potential for adverse cardiac events.
- Methamphetamine-induced cardiomyopathy can be successfully treated with significant improvement in systolic function with a combination of abstinence from the drug and a medication regimen of beta-blocker, ACE-inhibitor, and aldosterone antagonist.
- The disease of addiction cannot be ignored. There is great potential for relapse. As addiction research shows, people with SUD are at risk of relapse and interruptions to therapeutic medication regimens.

Opioid Use Disorder and Stimulant Use Disorder

Prescribing Opioids and Stimulants

Physicians prescribe opioids for short durations to treat severe pain, often after surgery or an injury.[52] Prescription opioids increase the activity of dopamine in the brain.[53] People misuse opioids by taking more than prescribed, taking someone else's prescription, or taking the medication to become intoxicated.[54] They may also take the medication by crushing a pill to smoke, snort, or inject to get immediate effects.[55] Take particular caution when a person is prescribed an opioid and a benzodiazepine together. Taking both an opioid and a benzodiazepine can be unsafe because both medications have sedative properties that suppress breathing and impact cognitive functions.[56] And may lead to dependence, SUD, and other health issues, including hypoxia and neurological effects.

Patients diagnosed with attention deficit hyperactivity disorder (ADHD) and narcolepsy are commonly prescribed stimulant medications. Prescription stimulants increase the activity of dopamine and norepinephrine in the brain as well as alertness, attention, and energy.

People misuse stimulant medications by taking more than prescribed, taking someone else's prescription, or taking the medication to become intoxicated. They may also take the medication by crushing a pill to smoke, snort, or inject to get immediate effects. Stimulants increase alertness and create enhanced focus and can improve mental performance. There is prevalent use in teens and college students to improve focus, and productivity; older people may use stimulants to enhance memory or to lose weight. Dependence, SUD, and other health issues such as psychosis and heart problems may develop.

Some residents who develop OUD and/or StUD initially were prescribed these medications for medical needs such as pain, ADHD, and narcolepsy—balancing the approach to address the medical need while managing addiction can be challenging. Identifying alternative treatment methods (e.g., acupuncture or non-opioid medications) to care for residents should be part of the care plan.

Talking with Residents about Opioid and Stimulant Use Disorders

Review the following videos from Boston Medical Center's Grayken Center for Addiction[57]:

- Challenging Patient Conversations
- Intersection of Pain and Addiction

Also consider using statements such as:

- "Trouble controlling opioid medication use makes it unsafe. The long-term risk, over time, is substantial."
- "The medicine prescribed to you for [pain, ADHD, or narcolepsy] became a problem. You developed a complication of therapy that we should not ignore."
- "Continuing the current medication is not a safe option due to the risks, but there are options for treating what we call OUD."
- "Sometimes people become too comfortable with medications and start to take them for reasons other than pain."
- "You meet the criteria for OUD, also known as OUD. It's helpful to put a name on it because it opens up a variety of approaches to help with your specific circumstance."
- "You developed what we call OUD and/or StUD. We have treatment for these conditions that can be integrated with your other healthcare needs."
- "Stimulants may be helpful for many people, but they can also cause harm in some individuals."

Specific Strategies to Help Residents Understand Their Diagnosis

Communication strategies, approach residents with compassion, use statements such as:

- "Sometimes the medications that we use to treat one condition may cause issues in other ways. It is difficult to anticipate who will develop a SUD, but it can happen to anyone."
- "SUD is common, and long-term recovery is possible for everyone."
- "SUD can develop for a variety reasons: genetic differences, environmental factors, and differences in brain chemistry. They are not moral failings, but rather chronic medical conditions that can be treated. We can help you."
- "You are not alone. All kinds of people can have problems with stimulants."

Relationship-building skills include reflective listening and empathetic statements to destigmatize OUD and StUD diagnoses. Use statements such as:

- "I understand you have been struggling and know that discussing change can be distressing."
- "It is our goal to partner with you to become the healthiest you, as you see yourself in the long term."
- "Getting help for this is like getting help for any other chronic medical condition."
- "I want you to have the best possible care, and this difficult, but productive, conversation is a first step."

Explain treatment methods, use statements such as:

- "There are a number of treatment options. Let's explore them together."
- "We will work together to find a treatment plan that works best for you."

Strategies for Managing Difficult Reactions

The table below provides examples of specific strategies to manage difficult reactions from residents with OUD or co-occurring OUD and StUD. Also please review Tip 3 for a trauma-informed care approach.

Reactions	Management Strategy
The resident is anxious, agitated, or panicking.	• Approach the resident in a calm and confident manner. • Reduce the number of people attending to the resident. • Carefully explain any interventions and what is going on. • Minimize the risk of self-harm.
The resident is confused or disoriented.	• Ensure the resident is frequently supervised. • Explain to the resident where they are and what is happening.
The resident is experiencing hallucinations.	• Create a safe space and de-stimulate the environment (e.g., dimming lights and limiting noise pollution). • Protect the resident from harming him or herself and others.
The resident exhibits anger or behavior that appears aggressive or agitated.	• Ensure that staff and other residents are protected and safe. • When interacting with the resident remain calm and reassuring. • Listen to the resident. • Use the resident's name to personalize the interaction. • Use calm open-ended questions. • Use a consistent, even tone of voice, even if resident becomes hostile and shouts. • Acknowledge the resident's feelings. • Do not challenge the resident. • Remove source of anger if possible.

Source: World Health Organization. (2009). Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings, Table 2

Address Stigma

The misconception that addiction is a choice poses challenges to effective care delivery. A Johns Hopkins University research study suggests people are more likely to have a negative attitude towards those with a drug addiction than those with a mental illness.[58] It is important to be aware of how stigma influences treatment of your residents. The Anti-Stigma Project characterizes stigma as a "pervasive and damaging influence on the quality of services, treatment outcomes, and therapeutic, professional, and personal relationships."[59]

On an organizational level, recognizing stigma and dispelling misconceptions of persons with OUD and StUD is an important first step in creating a supportive care environment. Examples of reducing stigma include changing language used at the facility, launching a campaign to raise awareness of the damaging effect of stigmatizing language, and suggesting alternative language. The table below provides examples of appropriate language to reduce stigma.

Avoid Stigmatizing Language

The language we choose shapes the way we treat our patients …	
Instead of:	**You can say …**
"Drug abuse"	Substance use disorder
"Addict" or "Junkie"	Person with a substance use disorder
"Alcoholic"	Person with alcohol use disorder
"Dirty urine"	Abnormal, positive, or unexpected urine test result
"Clean urine"	Normal or negative urine test result
"Clean" (Referring to a person}	Abstinent, in remission, or in recovery
"Dirty" (Referring to a person}	In a period disease exacerbation or relapse
"Shooting up"	Injection
"Shooter"	Person who injects drugs
"Tweaker"	Person under the influence of methamphetamine
"Aggressive"	Person experiencing protective behaviors
"Delusional"	Person experiencing altered perception of reality

Source: Adapted from the Boston Medical Center Grayken Center for Addiction, Reducing Stigma.

Resources to help reduce stigma among providers, staff, residents, families and resident representatives include:

- Impact of stigma videos:
  - Watch Stephanie's Story to see the impact of stigma on treatment (1 minute)[60]
  - Review "Misperceptions and the Misused Language of Addiction: Words Matter" (1 hour)[61]
- A Guide to Reducing Addiction-Related Stigma – Anti-Stigma Toolkit[62]
- Challenge myths associated with MOUD, infographic & videos (Figure 3)[63]

Many false assumptions also exist about MOUD that put residents with OUD at risk. Examples include methadone or other opioid agonists as a crutch, MOUD trades one addiction for another, and medications should be discontinued as soon as possible (Figure 3).

However, MOUD bridges the biological, and behavioral components of addiction and research has shown that persons on MOUD for at least one to two years have highest rates of long-term success.[64] It is important to recognize that "addiction is a chronic disease similar to other chronic diseases, such as type II diabetes, cancer, and cardiovascular disease."[65] Adapted from the National Council, Figure 3 illustrates common challenges to myths related to MOUD (formerly called medication-assisted treatment, MAT).

Figure 3: Challenging the Myths Associated with Medication-Assisted Treatment (MAT)

MAT trades one addiction for another MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery.	**MAT is only for the short term** Research shows that patients on MAT for at least one to two years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT.	**My patient's condition is not severe enough to require MAT** MAT utilizes a multitude of different medication options (agonists, partial agonists, and antagonists) that can be tailored to fit the unique needs of the patient.
MAT increases the risk for overdose in patients MAT helps prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. After detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression.	**Providing MAT will disrupt and hinder recovery process** MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery.	**There isn't any proof that MAT is better than abstinence** MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, SAMHSA, National Institute on Alcohol Abuse and Alcoholism, CDC, and other agencies emphasize MAT as first-line treatment.

Harm-Reduction

"Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on belief in, and respect for, the rights of people who use drugs."[66]

Below are examples adapted from the Harm Reduction Coalition of principles central to harm reduction practice. Organizations can implement harm reduction specific to individual, LTCF, and community needs tailored to the cultural and linguistic needs of the residents.

Example: Harm-Reduction Principles

This Facility…		
Accepts drug misuse is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.	Understands drug use is a complex, multi-faceted phenomenon that encompasses a continuum of behaviors.	Establishes quality of individual and community life and well-being for successful interventions and policies.
Ensures residents have a real voice in the creation of programs and policies designed to serve them.	Empowers people who use substances to share information and support each other in strategies which meet their actual conditions of use.	Does not attempt to minimize or ignore the real and tragic harm and danger associated with drug misuse.

Source: Harm Reduction Coalition. (2019). Retrieved from Principles of Harm Reduction

Education and Resources

- GE Foundation and RIZE Massachusetts Foundation: Opportunities to Increase Screening and Treatment of OUD Among Healthcare Professionals Report[67]
- Harm Reduction Coalition: Harm-Reduction Principles[68]
- Boston Medical Center: Words Matter Pledge[69]
- World Health Organization: Clinical Guidelines for Withdrawal Management [70]
- American Psychiatric Association: Opioid Use Disorder[71]
- American Hospital Association and Centers for Disease Control and Prevention: Factsheet[72]
- American Academy of Family Physicians: Opioid Addiction[73]
- National Alliance on Mental Illness Anti-Stigma: Resources[74]
- Boston Medical Center: OBAT T/TA Training Calendar[75]
- SAMHSA Treatment for Stimulant Disorders: Manifestations of Stimulant Withdrawal/Abstinence[76]
- Harm Reduction Coalition: Stimulant Overamping Basics[77]
- Here to Help: Stigma and Discrimination[78]
- Appendix 13: Additional Resources

Implementation: Key Points

Tip 1:	Understanding Opioid Use Disorder and Stimulant Use Disorder
Policies	1. Incorporate harm-reduction principles throughout your organization and within your existing policies. 2. Incorporate a section on OUD and StUD into your internal discrimination policy to reduce stigma and foster a positive culture that strives to ensure that staff see addiction as a medical condition. 3. Integrate COWS to identify opioid withdrawal and guide the care of residents. 4. Develop policies regarding naloxone administration.
Interventions	***Topic and Potential Staff***
Addressing Stigma	☐ **Director of Nursing or Administrator** ▪ Develop an assessment of staff perceptions of OUD, MOUD, and StUD. ▪ Post anti-stigma posters for staff, residents, and family to view. ☐ **All Staff** ▪ Show Stephanie's Story. ▪ Review Misperceptions and Misused Language of Addiction: Words Matter (1 hour). ▪ Review myths associated with OUD, MOUD, and StUD.
Harm-Reduction Principles	☐ **Director of Nursing, Administrator, or Champion** ▪ Develop and incorporate harm-reduction principles that are relevant to your organization. Visit the National Harm Reduction Coalition for help. ☐ **All Staff** ▪ Review potential scenarios with staff, see page 14 and page 17 for information.
Understanding how OUD and StUD Presents and Screening	☐ **All Staff:** ▪ Review American Psychiatric Association criteria. ▪ Review SAMHSA Treatment for StUD criteria. ▪ Review CDC case example. ▪ Review BMC videos to learn how to talk with a resident about OUD.
Recognize Symptoms of Withdrawal	☐ **Clinical Nurse or Director of Nursing** ▪ Use COWS score to determine state or severity. ▪ Assess stimulant use and withdrawal severity. ▪ Follow organization protocols and alert hospital. ▪ Communicate with OTP or OBOT/OBAT.
Managing Difficult Reactions	☐ **Nurse, Certified Nursing Assistant, or Activities Coordinator** ▪ Review World Health Organization Clinical Guidelines.
What to do for a Suspected Overdose	☐ **All Staff** ▪ Review how to identify an opioid related overdose. ▪ Review emergency response for OUD and StUD. ▪ Responding to overamping. ☐ **Director of Nursing or Trainer** ▪ Conduct naloxone training with all staff.
Regulatory Considerations	Residents cannot go through acute withdrawal in LTCFs. The resident needs to be transferred to a hospital after naloxone administration. See page 10 and page 15 for information.