Tip 1: Understanding Opioid Use Disorder

DESCRIPTION

The misconception that addiction is a choice poses challenges to effective care delivery. A research study by John Hopkins suggests that people are more likely to have a negative attitude towards those with a drug addiction than those with a mental illness.¹ Addiction is defined as “a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences.”² The National Institute on Drug Abuse (NIDA) defines addiction as a “complex but treatable condition”.³ LTCFs can create supportive care environments by better understanding OUD – the stigma and myths surrounding MOUD, how it presents, symptoms of withdrawal, and how to appropriately manage the condition.

GOAL

The goal of this section is to help LTCFs create a supportive care environment by understanding OUD and how dispelling stigma and myths can foster better care for residents.

OBJECTIVES

At the end of this section, participants will be able to:
- Recognize the stigma of addiction
- Dispel misconceptions about persons with OUD
- Understand OUD – The underlying causes, spectrum of disease severity, the biological effects, and how residents present clinically

POLICIES

- Incorporate harm reduction principles throughout your organization and in your existing policies
- Incorporate a section on OUD into your internal discrimination policy to reduce stigma and to help foster a positive culture that strives to ensure that staff see 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
- Develop policies regarding Naloxone administration

https://www.asam.org/resources/definition-of-addiction  
MOUD just trades one addiction for another: MOUD bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat Substance Use Disorders and help sustain recovery. (1)

MOUD is only for the short term: Research shows that patients on MOUD for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MOUD. (2)

My patient’s condition is not severe enough to require MOUD: MOUD utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient (3).

MOUD increases the risk for overdose in patients: MOUD helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. (4)

Providing MOUD will only disrupt and hinder a patient’s recovery process: MOUD has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MOUD helps reduce mortality while patients begin recovery. (5)

There isn’t any proof that MOUD is better than abstinence: MOUD 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, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MOUD as first line treatment. (6)

Addiction is a chronic disease similar to other chronic diseases such as type II diabetes, cancer, and cardiovascular disease.

Source: Adapted from the National Council Infographic; https://www.thenationalcouncil.org/


On an organizational level, recognizing stigma and dispelling misconceptions of persons with OUD is an important first step in creating a supportive care environment where MOUD can be successfully implemented. A few examples of methods include changing your language at the LTCF, launching a campaign to raise awareness of the damaging effect of stigmatizing language, and suggesting alternative language.

**Avoid Stigmatizing Language:**

<table>
<thead>
<tr>
<th>The language we choose shapes the way we treat our patients...</th>
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</thead>
<tbody>
<tr>
<td><strong>Instead of:</strong></td>
</tr>
<tr>
<td>“drug abuse”</td>
</tr>
<tr>
<td>“addict” or “junkie”</td>
</tr>
<tr>
<td>“alcoholic”</td>
</tr>
<tr>
<td>“dirty urine”</td>
</tr>
<tr>
<td>“clean urine”</td>
</tr>
<tr>
<td>“clean (referring to a person)”</td>
</tr>
<tr>
<td>“dirty (referring to a person)”</td>
</tr>
<tr>
<td>“shooting up”</td>
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<tr>
<td>“shooter”</td>
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</table>

**SOURCE:** Boston Medical Center- [https://www.bmc.org/addiction/reducing-stigma](https://www.bmc.org/addiction/reducing-stigma)

Here are some other useful resources to help reduce stigma among providers, staff, residents, and families/resident representatives.

- Impact of stigma videos:
  - Watch [Stephanie’s Story](https://www.bmc.org/addiction/reducing-stigma) to see the impact of stigma on treatment (1min).  
  - Review “Misperceptions and the Misused Language of Addiction: Words Matter” (1hr).


- Challenge the myths associated with MOUD, infographic and videos - [The National Council for Behavioral Health](https://www.nationalcouncil.org)

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Harm Reduction Principles

“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.”\(^{11}\) 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 and tailored to the culture and linguistic needs of the residents.

### Example Harm Reduction Principles

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


How Persons with OUD are Diagnosed

To be diagnosed with an OUD, a person must have two or more of the following criteria from the American Psychiatric Association:12

<table>
<thead>
<tr>
<th>Criteria for OUD Diagnosis:</th>
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<tbody>
<tr>
<td>1. Opioids are often taken in larger amounts or over a longer period than was intended.</td>
</tr>
<tr>
<td>2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.</td>
</tr>
<tr>
<td>3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.</td>
</tr>
<tr>
<td>4. Craving, or a strong desire or urge to use opioids.</td>
</tr>
<tr>
<td>5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.</td>
</tr>
<tr>
<td>6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.</td>
</tr>
<tr>
<td>7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.</td>
</tr>
<tr>
<td>8. Recurrent opioid use in situations in which it is physically hazardous.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>10. Exhibits tolerance (note: alone, not enough to diagnose an OUD).</td>
</tr>
<tr>
<td>11. Exhibits withdrawal (note: alone, not enough to diagnose an OUD).</td>
</tr>
</tbody>
</table>

How OUD May Present

Residents presenting with an OUD may appear acutely intoxicated, in opioid withdrawal, or show no acute effects related to their opioid use.13 If a patient is in active withdrawal LTCF should follow the regulatory restrictions as outlined in 150.003: Admissions, Transfers and Discharges, on how to manage active withdrawal. There are many health-related consequences that may accompany residents presenting with OUD, including infection, opioid-induced bowel syndrome, opioid-induced hyperalgesia, motor-vehicle accidents, opioid

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amnestic syndrome, overdose, and possibly death. In a LTCF, individuals with OUD may experience cravings, withdrawal, or difficult to control pain. Some residents with OUD will already be on MOUD but require additional evaluation by the appropriate provider for dose adjustments. These residents may report increased cravings or withdrawal. Other residents may have undiagnosed OUD or have diagnosed OUD, but also have other indications for acute opioid analgesia. These residents should be monitored for drowsiness, sedation, and overdose. Residents should be asked about these symptoms in non-judgmental ways, and person-centered plans should be developed to optimize resident safety and reduce harm. To do this, have an assessment conducted by your behavioral health services (contracted or non-contracted) who should then conference with provider (MD/PA) to determine the appropriate care plan. If the resident is connected with an OTP or OBOT, they should also be included in the conversation and development of the care plan.

**Symptoms of Withdrawal**
Symptoms of opioid withdrawal can include:

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

Use the Clinical Opiate Withdrawal Scale (Figure 4). This will help determine 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, and OTP or OBOT regarding suspected withdrawal symptoms and COWS score to best determine next steps and when/if the resident should go to a higher level of care.

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The table below is adapted from CDC Guideline for Prescribing Opioids for Chronic Pain.16

| Case Example from the Centers for Disease Control and Prevention (CDC): |
| Identifying DSM-5 OUD Criteria “Scenario 1 - Resident Chart” |

**Nelson, John, DOB: 4/11/1984**

- Medical history: Lower back pain: Began after a fall at work 3 years ago; Lifting heavy objects at work exacerbated the injury; Currently takes extended-release morphine 45 mg 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 meds 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 meds 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?

Select the correct answer.

- Yes
- No

Yes, based on the information John shared, OUD should be suspected, because he has met two or more of the DSM-5 criteria within a year:
  - He has taken the opioids longer than was 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 of 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.”

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## Talking with Residents about OUD

Review the following videos from Boston Medical Center’s Grayken Center for Addiction\(^7\):
- [Challenging Patient Conversations](https://www.bmcobat.org/resources/?category=8)
- [Intersection of Pain and Addiction](https://www.bmcobat.org/resources/?category=8)

### Also consider using statements such as:
- "Trouble controlling the use of opioid medication makes it unsafe, and long-term risk over time is substantial."
- "The medicine has become a problem in itself. You have developed a known complication of therapy that we should not ignore."
- "Continuing the current medication is not a reasonable option due to the risks, but there are options for treating what we call opioid use disorder, also known as OUD."
- "Sometimes people become too comfortable with the medications and start to take them for reasons other than pain."
- "You meet the criteria for opioid use disorder, 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."

### Here are some specific strategies you can use to help residents understand their diagnosis of OUD.

- **Communication Strategies**
  - Approach residents with compassion, use statements such as:
    - "Sometimes the medications cause problems that we cannot anticipate."
    - "All kinds of people have problems with opioids."
    - "You are not alone. All kinds of people can have problems with opioids."

- **Relationship-Building Skills** include reflective listening and empathetic statements to destigmatize OUD diagnosis and treatment, use statements such as:
  - "I understand you have been struggling and know that discussing change can be distressing."
  - "My primary motivation is to provide care that leads to the healthiest version of ‘you’ in the long term."
  - "Getting help for this is like getting help for any other chronic medical problem."
  - "I want you to have the best possible care, and this difficult but productive conversation is a first step for us."

- **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."

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\(^7\) OBAT TTA. (2020). Resources. Retrieved from Videos from Our Experts: [https://www.bmcobat.org/resources/?category=8](https://www.bmcobat.org/resources/?category=8)
## Strategies for Managing Difficult Reactions

The table below is adapted from the WHO Clinical Guidelines\(^8\) and provides examples of specific strategies that can be used to manage difficult reactions. Also please review Tip 3 on a trauma-informed care approach.

<table>
<thead>
<tr>
<th>Reactions</th>
<th>Management Strategy</th>
</tr>
</thead>
</table>
| 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  
Provide reality orientation – explain to the resident where they are and what is going on |
| The resident is experiencing hallucinations  | Talk to the resident about what they are experiencing and explain what is and isn't real  
Ensure the environment is simple, uncluttered and well lit  
Protect the resident from harming him or herself and others |
| The resident is angry or aggressive          | 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 and even tone of voice, even if the resident becomes hostile and is shouting  
Acknowledge the resident's feelings  
Do not challenge the resident  
Remove source of anger if possible |

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

**Signs of an overdose**
- Blue lips and fingertips
- Limp and pale
- Small pupils
- Breathing slow, irregular, or has stopped
- Pulse slow, erratic, or absent
- Nonresponsive to voice or sternal rub

If you suspect a resident has overdosed, follow the guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA) Opioid Overdose Prevention Toolkit.\(^\text{19}\)

<table>
<thead>
<tr>
<th>DO</th>
<th>DON’T</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 EMS arrives.</td>
<td>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.</td>
</tr>
<tr>
<td>Administer naloxone and if there is no response in 3 minutes, administer a second dose if no response to the first dose.</td>
<td>Put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock.</td>
</tr>
<tr>
<td>Put the person in the “recovery position” on the side, if you must leave the person unattended for any reason.</td>
<td>Inject the person with any substance (e.g., saltwater, milk, stimulants). The only safe and appropriate treatment is naloxone.</td>
</tr>
<tr>
<td>Stay with the person and keep the person warm.</td>
<td>Try to make the person vomit drugs that may have been swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.</td>
</tr>
</tbody>
</table>

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/grey
    - 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*

MAKE SURE CHEST Rises WITH EACH BREATH.

HAND SUPPORTS HEAD
KNEE STOPS BODY FROM ROLLING ONTO STOMACH

Source: [www.mass.gov/narcan](http://www.mass.gov/narcan), visit for Spanish version
Opportunities to Increase Screening & Treatment of OUD Among Healthcare Professionals - Report

Harm Reduction Coalition – Harm Reduction Principles

Review the BMC “Words Matter” Pledge and consider adapting for your organization

Clinical guidelines for withdrawal management

American Psychiatric Association – Opioid Use Disorder

American Hospital Association and Centers for Disease Control and Prevention – Factsheet

American Academy of Family Physicians – Opioid Addiction

National Alliance on Mental Illness Anti-Stigma Resources

Review OBAT T/TA training calendar for relevant training opportunities

Review the BMC “Words Matter” pledge and consider adapting for your organization

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20 Shatter Proof. (2019). Retrieved from In It Together: Opportunities to increase screening and treatment of opioid use disorder among Massachusetts healthcare professionals: https://www.shatterproof.org/inittogether


## IMPLEMENTATION KEY POINTS

<table>
<thead>
<tr>
<th>Tip 1:</th>
<th>Understanding Opioid Use Disorder</th>
</tr>
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| **Policies** | 1. Incorporate harm reduction principles throughout your organization and within your existing policies.  
2. Incorporate a section on OUD into your internal discrimination policy to reduce stigma and to help foster a positive culture that strives to ensure that staff see addiction as a medical condition.  
3. 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.  
4. Develop policies regarding Naloxone administration. |

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Topic</th>
<th>Potential Staff</th>
</tr>
</thead>
</table>
| **A) Addressing Stigma** | □ Develop an assessment of staff perceptions of OUD and MOUD  
□ Show Stephanie’s Story: [https://www.mass.gov/state-without-stigma](https://www.mass.gov/state-without-stigma)  
□ Review Misperceptions and the Misused Language of Addiction: Words Matter, [https://escholarship.umassmed.edu/ner/48/](https://escholarship.umassmed.edu/ner/48/) (1hr)  
□ Review myths associated with MOUD  
□ Post anti-stigma posters for staff, resident, and family to view | • Leadership team (DON, Administrator)  
• All staff |
| **B) Harm Reduction Principles** | □ Develop harm reduction principles to incorporate through LTCF that are relevant to your organization, visit: [https://harmreduction.org/about-us/principles-of-harm-reduction/](https://harmreduction.org/about-us/principles-of-harm-reduction/) for help with development.  
□ Review potential scenarios with staff, see toolkit for information | • Leadership team or champion, identify relevant harm reduction principles  
• All staff |
| **C) Understanding of how OUD presents and screening** | □ Review criteria from American Psychiatric Association: [https://www.aoaam.org/](https://www.aoaam.org/)  
□ Review case example from CDC: [https://www.cdc.gov/drugoverdose/training/oud](https://www.cdc.gov/drugoverdose/training/oud)  
□ Review how to talk with a resident about OUD, BMC videos: [https://www.bmcobat.org/resources/](https://www.bmcobat.org/resources/) | • All staff  
• All staff  
• All staff |
| **D) Recognize Symptoms of Withdrawal** | □ Use COWS score to determine state or severity  
□ Follow organization protocols  
  ▪ Alert hospital  
□ Communicate with OTP/OBOT | • Clinical nurse or DON  
• Clinical nurse or DON  
• Clinical nurse or DON |
| **F) What to do if suspected overdose** | □ Review how to identify an opioid related overdose  
□ Review emergency response for OUD  
□ Conduct naloxone training with all staff | • All staff  
• DON or designated trainer |

**Regulatory Considerations** Residents cannot go through active withdrawal in LTCFs; after Naloxone administration the resident needs to be transferred to hospital.