Shared Decision-Making for Medication for Opioid Use Disorder

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ADAI

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Conflict of Interest Disclosure

I have no conflicts of interest to report.
I have never received funding from pharmaceutical companies.

Current funding includes

WA Health Care Authority (State funds & US DHHS SAMHSA)

SOR TA; Nurse care manager; Epi/OD educ/Web; Drug checking

NIH National Institute on Drug Abuse
Paul G. Allen Family Foundation

Learning objectives

- Educate attendees on the rationale for shared decision making for MOUD
- Share the SDM tool and processes and how they can be used across the care team
- Provide attendees an orientation to the content of shared decision making for MOUD
- Provide examples of real world implementation and impacts of shared decision making for MOUD

Presenter's Background

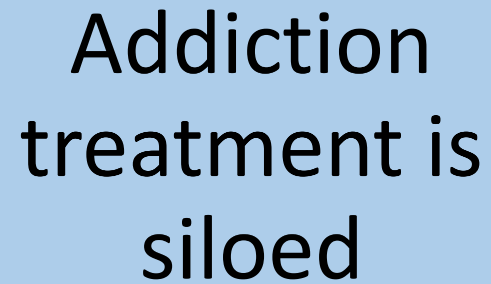
MSW- trained in a methadone clinic/OTP & medical social work at the VA

MPH- maternal and child health, public health research methods

ADAI

- Research assistant-medical anthropology on meth and HIV risk; program evaluation youth diversion programs
- Epidemiologist- emerging meth trends, then methadone, Rx opioids, heroin, non-pharmaceutical fentanyl; surveys and qualitative interviewing with people who use drugs
- Health services research (PhD 2008) OUD care needs and interventions. Buprenorphine access and utilization. Shared decision making. New meds for OUD- interest and access. Meds first…
- Implementation support- SAMHSA-naloxone; SAMHSA State Opioid Response; Meds first for MOUD; www.stopoverdose.org www.learnabouttreatment.org ; Health engagement hus
- Practice/policy advisory committees- County, state and federal

Why Shared Decision-Making for MOUD?



People are usually not given choices when it comes to addiction treatment

Treatment for OUD

Medications are proven to work the best at treating opioid use disorder. They help:

- Manage craving and withdrawal,
- Reduce illicit opioid use,
- Decrease the risk of having an overdose.

- Counseling and other recovery supports are helpful for many people with substance use disorder. However, research indicates that **counseling and support groups should be offered, but not required, along with medications for OUD**.

Counseling & recovery supports include

- Substance use disorder counseling
- Mental health counseling
- Certified peer counselors and recovery coaches
- Care navigators
- Peer support groups

If you're ready for treatment and/or recovery supports, or just want to learn more, connect with the ***Washington Recovery Help Line.***

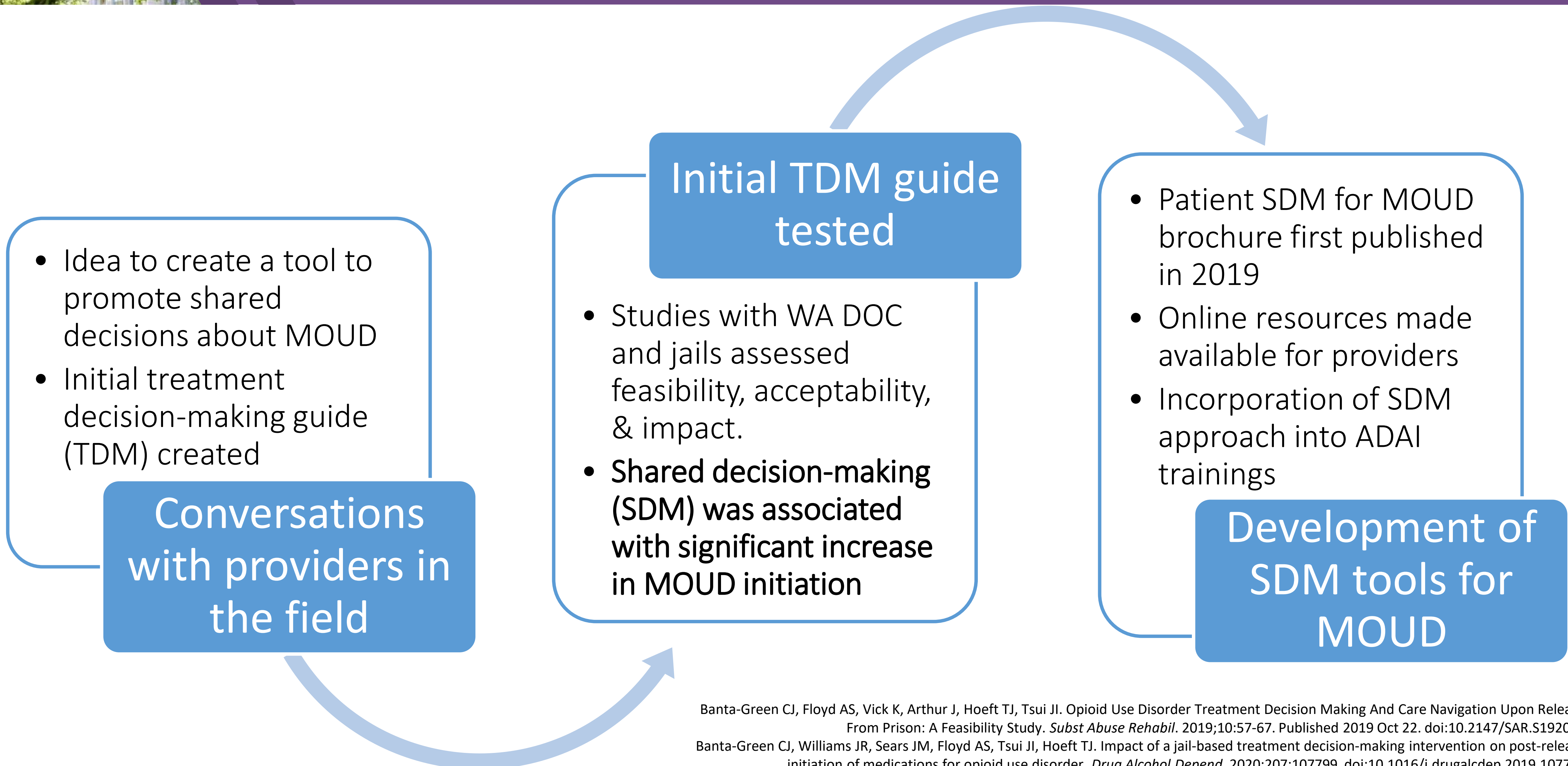
Why Shared Decision-Making for MOUD?

Recognizes patient as experts on their own lives (Understanding motivations for use are essential)

Considers the medication, treatment setting, visit frequency, other requirements

Improves patient engagement & adherence

ADAI Patient Aid Development



Banta-Green CJ, Floyd AS, Vick K, Arthur J, Hoeft TJ, Tsui JI. Opioid Use Disorder Treatment Decision Making And Care Navigation Upon Release From Prison: A Feasibility Study. *Subst Abuse Rehabil*. 2019;10:57-67. Published 2019 Oct 22. doi:10.2147/SAR.S192045
Banta-Green CJ, Williams JR, Sears JM, Floyd AS, Tsui JI, Hoeft TJ. Impact of a jail-based treatment decision-making intervention on post-release initiation of medications for opioid use disorder. *Drug Alcohol Depend*. 2020;207:107799. doi:10.1016/j.drugalcdep.2019.107799

The MOUD Brochure

- First, I'll give you an overview of the brochure for context
- Second, we'll go through the different sections of the brochure/ the different elements of shared decision making

Patient Aid: Brochure

What's next?

Learn more about OUD and how to use this brochure:
learnabouttreatment.org

Connect to medication options near you:
warecoveryhelpline.org

Find naloxone and overdose info:
stopoverdose.org

More info on medications:
samhsa.gov/medication-assisted-treatment

CENTER FOR COMMUNITY-ENGAGED DRUG EDUCATION, EPIDEMIOLOGY, AND RESEARCH

UNIVERSITY of WASHINGTON
PSYCHIATRY & BEHAVIORAL SCIENCES
School of Medicine

This brochure provides basic information for educational purposes. Speak with a health care professional to make an informed decision that best fits your needs including learning the risks and benefits of all treatment options.
Revised January 2023.

Your preferences

Setting:______

Dosing frequency:______

Clinic visit frequency:______

Counseling:______

Support group:______

Medication options:______

______

Other:______

______

______

______

______

Call the **Washington Recovery Help Line** to talk about your options for medications, counseling and support groups, and connect to care.

Washington Recovery Help Line
24-Hour Help for Substance Abuse, Problem Gambling & Mental Health
1.866.789.1511
warecoveryhelpline.org

About OUD

What is opioid use disorder?

Opioid use disorder (OUD) is a long term medical condition. People with the condition are physically dependent on opioids and have brain changes that affect their thinking, priorities, and relationships.

OUD can come back if not treated properly. You may need to try more than one type of treatment to find what works best for you.

What can medications do for me?

Medications are proven to work the best at treating opioid use disorder.

They help:

- Manage craving and withdrawal.
- Reduce illicit opioid use.
- Decrease the risk of having an overdose.

Medications can provide stability, allowing people to address other things in their lives.

You can be in recovery and be on medications at the same time.

Medications for Opioid Use Disorder

Patient Aid: Brochure

Treatment options

There are **three** places where you can get medications for opioid use disorder:

Opioid treatment program (OTP)

- **Methadone**, **buprenorphine**, or **naltrexone** available.
- Highly structured—counseling and supervised dosing may be required.

Medical office/Primary care

- **Buprenorphine** or **naltrexone** available.
- Familiar medical office setting.
- Less structure (often weekly or monthly visits, some don't require counseling).
- Appointment often needed.

Community program

- **Buprenorphine** or **naltrexone** available.
- Other services may be offered (syringe exchange, housing supports, etc.).
- May have drop-in visits.

	Methadone	Buprenorphine	Naltrexone
How does this medication work?	• Methadone is a **full** opioid medication. • The more you take the **more you will feel** its effects. • Manages cravings and withdrawal by binding to opioid receptors.	• Buprenorphine is a **partial** opioid medication. • Has a ceiling effect, so above a certain dose you **stop feeling more** of its effects. • Manages cravings and withdrawal by binding to opioid receptors.	• Naltrexone is an opioid **blocker**. • It is not an opioid, so you **won't feel** an opioid effect. • Helps manage cravings for some people.
Does it lower my risk of dying? *Based on research that tracked outcomes in the real world.*	• **Lowers** risk of death by about 50%.	• **Lowers** risk of death by about 50%.	• Has **not been shown** to lower the risk of death.
How long does it last, and how do I take it?	• Lasts about **24 hours** and is taken by **mouth**.	• **Oral form** lasts about **24 hours**, **injectable form** lasts **7-28 days**.	• An **injection** that lasts for **28 days**. You can't use any opioids for 7-10 days before taking naltrexone.
Where can I get it, and how often do I need to go?	• Dispensed only at **opioid treatment programs**. • Dosing can start up to **6 days a week**, but usually becomes less often over time during treatment.	• **Prescribed** by a medical provider and **picked up** at a pharmacy (*oral*) or **given** at an appointment (*injection*). Both are available at some **opioid treatment programs**. • Visits vary from near daily to monthly.	• **Prescribed and given** by a medical provider, or provided at an **opioid treatment program**. • Visits vary from weekly to monthly.
Will I need to go to counseling?	• Requires regular urine drug testing and counseling.	• Most providers require urine drug testing and some require counseling.	• Some providers require urine drug testing and counseling.

LearnAboutTreatment.org

LEARN ABOUT TREATMENT — ABOUT | THE BASICS | TREATMENT | PROFESSIONALS | FAMILY/FRIENDS | RESOURCES

TALKING TO CLIENTS ABOUT OUD

Learn About Treatment ▷ For Professionals ▷ Talking to clients about OUD

Here are some resources to help you educate and provide or connect people to medications for opioid use disorder.

To find resources on overdose response and naloxone, visit **stopoverdose.org**.

SDM implementation support available on “Client Engagement” page at LearnAboutTreatment.org

Provider Guidance

Medications for Opioid Use Disorder

Guide to Using the Brochure

What is Treatment Decision Making?

All people deserve to be actively involved with decisions about their health. This includes people with opioid use disorder (OUD). They should be provided with accurate information about all possible options for treatment so they can make an informed decision about the kind of care *they* want.

Similar to other health conditions, opioid use disorder can be treated with medications. Research shows that medications work best for most people to:

- Help stabilize their lives
- Reduce relapse
- Cut their chances of dying.

Medications have also been shown to:

- Reduce criminal activity and incarceration
- Improve functioning
- Lower the risk of getting HIV and HCV
- Substantially reduce costs

(Clark et al., 2011; MacArthur et al., 2012; Nolan et al., 2014; Nordlund et al., 2004; Tkacz et al., 2014; Tsui et al., 2014; White et al., 2014).

Patients and many healthcare providers may have incomplete knowledge about medications to treat OUD and they may not know about new, easier ways to access medications. Talking about OUD and medications is an opportunity to address any misconceptions people have and fill in any gaps in knowledge.

Talking about medications

Ask

Start by asking about someone's specific goals, interest, and experience with trying to cut back or stop their opioid use. If they give a vague answer like "get healthy," ask them "what that would look like for you?" Try to use the same language they use to talk about their goals for cutting back or stopping. Language like "treatment" or "recovery" may be helpful for some clients and not for others.

Developed by Caleb Banta-Green, PhD
University of Washington | Alcohol & Drug Abuse Institute | 2020

ADAI | ALCOHOL & DRUG ABUSE INSTITUTE

Guide to Talking to Someone About Medications for Opioid Use Disorder

OPEN GUIDE   DETAILS

What is Treatment Decision Making?

Talking About Medications

Sample Conversation Script

Brochure Talking Points

Shared decision making

How to use the brochure as part of a conversation

Treatment Challenges

- Stigma
- Health care systems- access
- Incomplete or incorrect knowledge

Treatment Decision Making

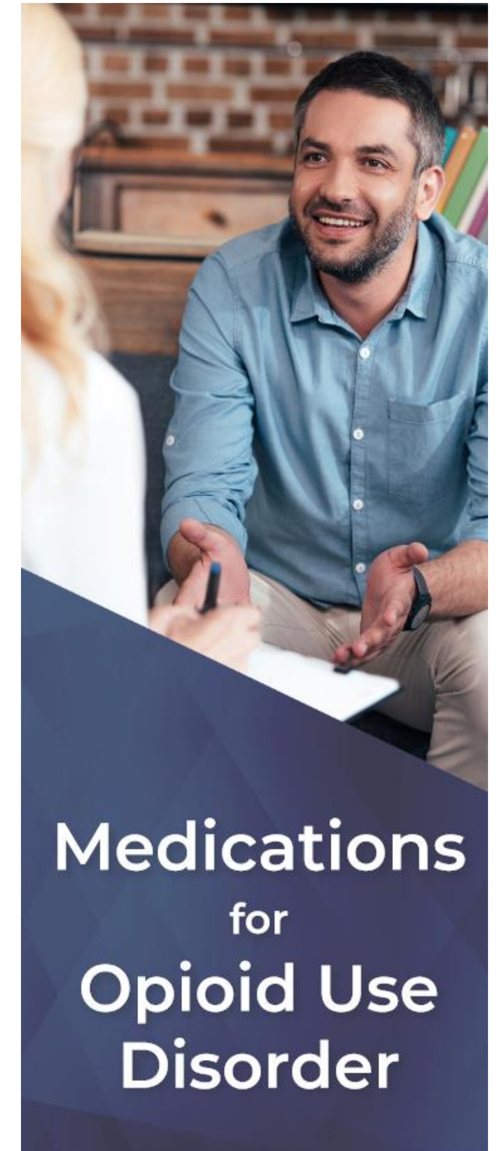
- People with a serious health care condition deserve to:
  - Understand the condition
  - Understand treatment options
  - Understand they can make choices about their care
  - Be actively involved in deciding their own care

Principles of TDM

- Client empowerment
- Improved effectiveness and connection to treatment
- Importance in sharing a common language around treatment and OUD

Treatment Decision Making Tool

- Adapted from multiple projects
- Used in real world situations-
  - Prison, jail, WA Recovery Helpline, primary care, low barrier care at community sites
- Audience is clients and care team



Interactive Approach

- Client-centered
- Actively engage client in process
- Prepare them to take next step

Understand Their Prior Experiences

Need to understand prior positive *and* negative experiences with each of the medications

- Opportunity to correct mis-information
  - “What didn’t you like about taking the medication?”
  - “Was the medication prescribed?”

Treatment Options

- Clarify important differences in three settings:
  - Medication options
  - Other supports
  - Visit frequency

There are **three** places where you can get medications for opioid use disorder:

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Medical office/Primary care

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Community program

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- May have drop-in visits.

Methadone

- Explore entrenched opinions e.g “liquid handcuffs”
- Determine which care components they like and don’t
  - e.g. medication, counseling, visit frequency, OTP setting
- Can be highly effective

Recently

- Increased interest in methadone for those using fentanyl
- New rules/reg’s and access points in process

Buprenorphine

- Clarify difference between "street use" vs. under medical management
- Multiple models of care
- Different dosing approaches (to discuss w/ prescriber)
- Comfort meds can help (to discuss w/ prescriber)
- Highly effective
- Suboxone/Subutex- oral daily
- Sublocade/Brixadi- injectable 7-28+days

Naltrexone

- Limited awareness
- Multiple barriers to starting and staying on
- Clarify motivations
  - “non-addictive drug”, abstinence idealism, perceived stigma of taking opioid agonist medication

Client Preferences

- Coach client to get specific
- Explore areas of doubt or confusion
- Encourage them to write down their wishes
- If ready, make a plan

Your preferences

Setting:______________________________

Dosing frequency:________________________

Clinic visit frequency:____________________

Counseling:___________________________

Support group:_________________________

Medication options:_____________________

Other:_______________________________

Person-Centered Planning

A collaborative process between the person and his/her supporters, resulting in the development and implementation of an action plan to assist the person in achieving his or her unique, personal goals along a journey of recovery

Setting Goals

Rather than asking *"What are your goals?"* try:

- How do you want to spend your days?
- What gives you pleasure or a sense of success?
- What would make your life better?
- What are your dreams and aspirations?

Active Invitation for Involvement

Rather than asking "*Any questions?*" try:

- "I want to make sure that you've understood everything that I have been telling you"
- "People normally have questions because it's very complicated to make decisions about treatment when you are faced with such a complicated disease"
- "Can you tell me what you understand and then I can help clarify?"

What's Next

- Encourage them to initiate contact with Recovery Helpline or Provider or _________
- Problem solve barriers to starting medication or other treatments
- Offer ongoing assistance

What's Next?

Connect to medication options near you:

Washington Recovery Help Line
1.866.789.1511
www.warecoveryhelpline.org

Find naloxone and overdose info:
www.stopoverdose.org

Learn more about medication:
www.samhsa.gov/medication-assisted-treatment

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September 2018

WA State study of SDM MOUD

Drug and Alcohol Dependence 207 (2020) 107799

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

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Impact of a jail-based treatment decision-making intervention on post-release initiation of medications for opioid use disorder

C.J. Banta-Green[a,b,*], J.R. Williams[a], J.M. Sears[b,c,d,e], A.S. Floyd[a,f], J.I. Tsui[g], T.J. Hoeft[h]

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ARTICLE INFO

Keywords:
Opioid
Jail
Decision-making
Treatment

ABSTRACT

Introduction: Opioid use disorder (OUD) is common among people in jail and is effectively treated with medications for OUD (MOUD). People with OUD may have an incomplete or inaccurate understanding of OUD and MOUD, and of how to access care. We evaluated an OUD treatment decision making (TDM) intervention to determine whether the intervention increased MOUD initiation post-release.

- **Introduction:** Opioid use disorder (OUD) is common among people in jail and is effectively treated with medications for OUD (MOUD). People with OUD may have an incomplete or inaccurate understanding of OUD and MOUD, and of how to access care. We evaluated an OUD treatment decision making (TDM) intervention to determine whether the intervention increased MOUD initiation post-release.
- **Methods:** We conducted an observational retrospective cohort study of the TDM intervention on initiation of MOUD, individuals with records data indicating confirmed or suspected OUD incarcerated in four eligible jails were eligible to receive the intervention. Time-to-event analyses of the TDM intervention were conducted using Cox proportional hazard modeling with MOUD as the outcome.

WA State study of SDM MOUD

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- **Results:** Cox proportional hazard modeling, with the intervention modeled as having a time-varying effect due to violation of the proportionality assumption, indicated that those receiving the TDM intervention (n = 568) were significantly more likely to initiate MOUD during the first month after release from jail (adjusted hazard ratio 6.27, 95 % C.I. 4.20-9.37), but not in subsequent months (AHR 1.33 95 % C.I. 0.94-1.89), adjusting for demographics, prior MOUD, or felony or gross misdemeanor arrest in the prior year compared to those not receiving the intervention (n = 3174).
- **Conclusion:** The TDM intervention was associated with a significantly higher relative hazard of starting MOUD, specifically during the first month after incarceration. However, a minority of all eligible people received any MOUD. Future research should examine ways to increase initiation on MOUD immediately after (or ideally during) incarceration.

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MOST RECENT OPIOID USE DISORDER TREATMENT HISTORY						
Type	Program name(s)/location(s)	Date(s)	Helpful overall			Why (i.e., convenience, effectiveness, others)
			Yes	No	Somewhat	
Supervised detox			☐	☐	☐	
Outpatient			☐	☐	☐	
Inpatient			☐	☐	☐	
Social support			☐	☐	☐	
Methadone			☐	☐	☐	
Buprenorphine			☐	☐	☐	
Naltrexone			☐	☐	☐	

TREATMENT DECISION MAKING

Consider the following when determining appropriate treatment

Chronic pain | Impact on housing requirements | Convenience/visit frequency
Overdose risk | How s/he will feel | Impact on relationships
Other (e.g., employment, school, self-help groups):

Methods	Pros	Cons
Watchful waiting		
Social support		
Counseling		
Methadone		
Buprenorphine		
Naltrexone		

Fig. 1.
Treatment decision making tool.

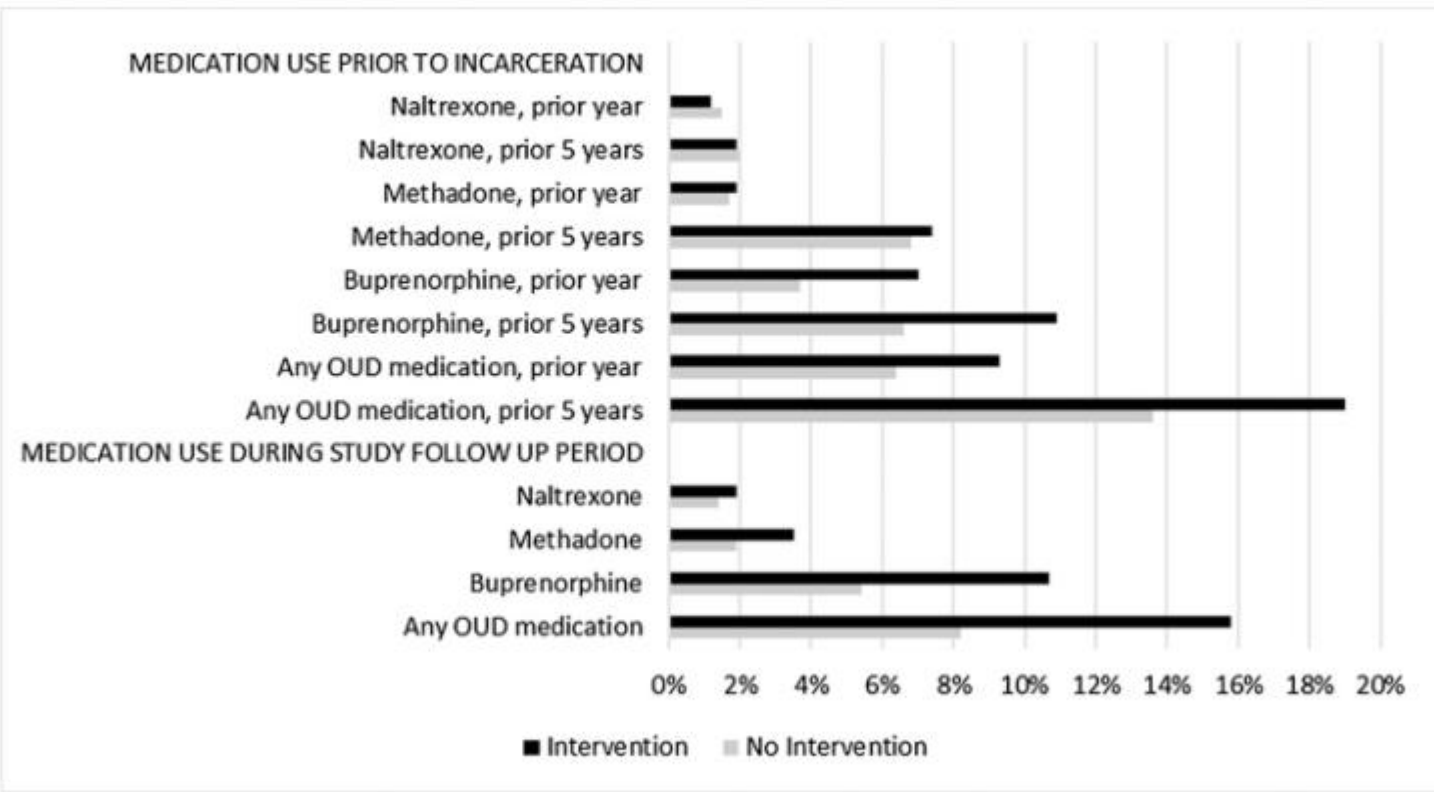

Fig. 3.
Types of medications used before and after incarceration.

ADAI

Additional context and So what

Perspectives of People Who Use Fentanyl

- 30 syringe services program (SSP) participants in WA State who reported recent fentanyl use. Interviewed in Q1 2023.

- Many were interested in or had previous positive experiences with **methadone or buprenorphine** for opioid use disorder. However, administrative and other barriers limited access to these medications.
-
- The combination of healthcare barriers, social determinants of health, the strength and half-life of fentanyl, and individual physical and mental pain produce a **significant challenge for care systems** to respond to the complex needs of many people who use fentanyl.

Persistent treatment & harm reduction gaps

- The minority of people with substance use disorder are receiving any treatment, let alone evidence based treatment
- Treatment capacity has expanded recently. Many lessons learned during scale up.
- Methamphetamine use, use disorder, and fatal overdoses are increasing to new highs in the West & emerging in the Eastern US. Cocaine use and consequences persist.
- Fentanyl & methamphetamine use and consequences are still overwhelming our services

Recovery gaps

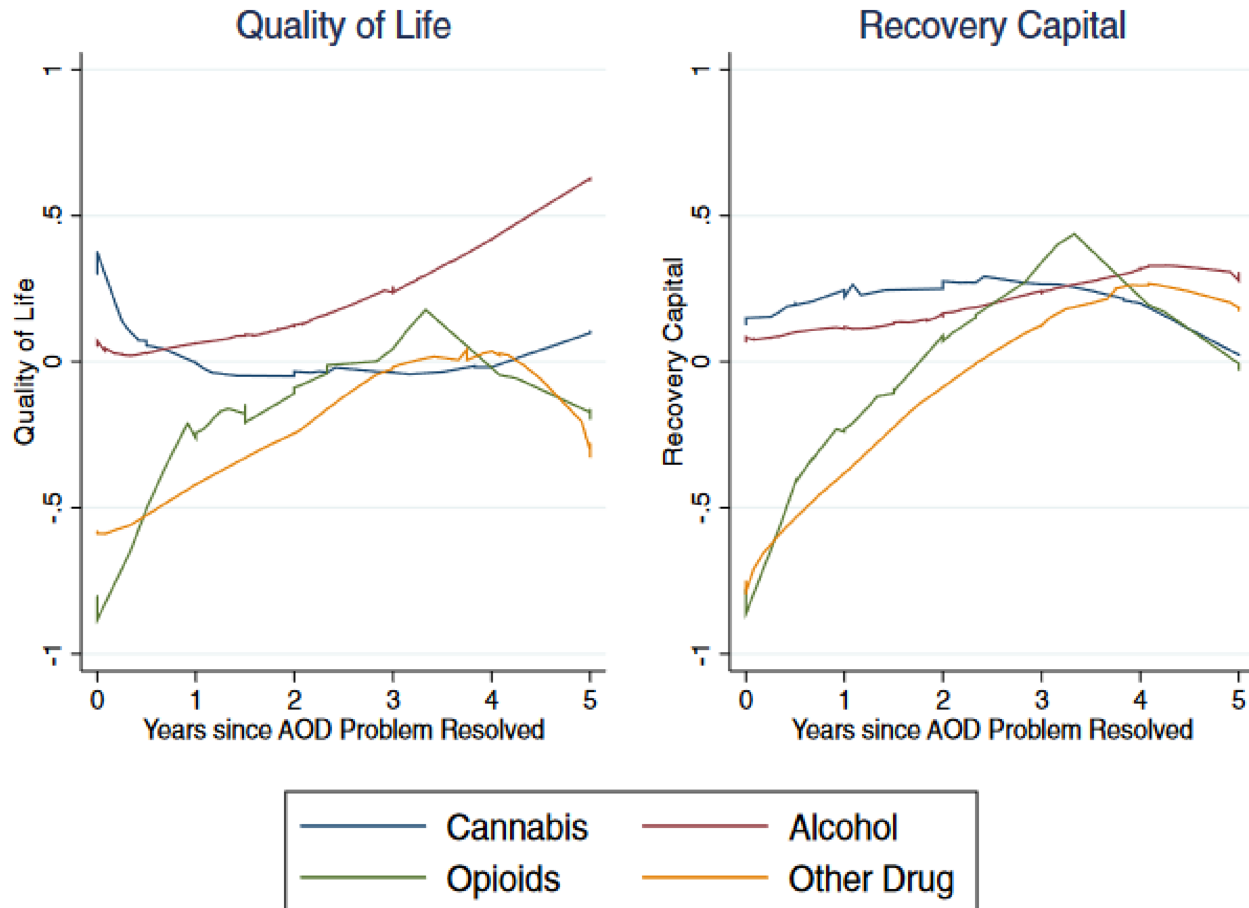

Fig. 5. Locally Weighted Scatterplot Smoothing (LOWESS) analysis of recovery indices by years since problem resolution stratified by primary substance.

- Recovery from opioid and stimulant use disorders takes significantly longer than for alcohol and cannabis (3 years vs 1 year)
- Many in recovery continue to use substances

Beyond Abstinence: Changes in Indices of Quality of Life with Time in Recovery in a Nationally Representative Sample of U.S. Adults
John F Kelly;M Claire Greene;Brandon G Bergman
DOI: 10.1111/acer.13604 Alcoholism: clinical and experimental research. , 2018, Vol.42(4), p.770-780

Catalysts for a new way

- People DO want to reduce chaos and often their use
  - They DO want effective care [1 2]
- Brief interventions in ED often have modest, short term impact [3 4]
- People who use drugs often do NOT feel welcome in traditional health care or SUD treatment settings [5 6 7]
- Mandated treatment is generally not effective [8]
- Treatment, harm reduction, and recovery ***can*** overlap
- What about a new way that is truly person-centered, community-based care?

1 Frost et al. 2018 doi: 10.1097/ADM.0000000000000426
2 McMahan et al. 2020 doi: 10.1016/j.drugalcdep.2020.108243
3 D'Onofrio et al. 2017 doi: 10.1007/s11606-017-3993-2
4 Banta-Green et al. 2019 doi: 10.1136/injuryprev-2017-042676
5 Wakeman et al. 2018 doi: 10.1080/10826084.2017.1363238
6 Biancarelli et al. 2019 doi.org/10.1016/j.drugalcdep.2019.01.037
7 http://adai.uw.edu/pubs/pdf/2017syringeexchangehealthsurvey.pdf
8 https://adai.uw.edu/ask-an-expert-mandated-tx/

Pilot program- *Buprenorphine Pathways*

Substance Abuse

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Engaging an unstably housed population with low-barrier buprenorphine treatment at a syringe services program: Lessons learned from Seattle, Washington

Julia E. Hood, Caleb J. Banta-Green, Jeffrey S. Duchin, Joseph Breuner, Wendy Dell, Brad Finegood, Sara N. Glick, Malin Hamblin, Shayla Holcomb, Darla Mosse, Thea Oliphant-Wells & Mi-Hyun Mia Shim

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I relapsed last week. Every other time I've relapsed while in a program I kept using because I knew I'd get kicked out. But, I knew you wouldn't kick me out, so I didn't keep using.

Number of Conversations

70
60
50
40
30
20
10
0

At Capacity

Week 0
Week 1
Week 2
Week 3
Week 4
Week 5
Week 6
Week 7
Week 8
Week 9
Week 10
Week 11
Week 12
Week 13
Week 14
Week 15
Week 16
Week 17
Week 18
Week 19
Week 20

Conversation Initiated by Client
Conversation Initiated by Exchange Staff

Bupe Pathways Takeaways

- High client demand
- High needs population-82% homeless/unstably housed
- Most use multiple substances initially and ongoing
- Buprenorphine was almost always documented in urine drug screen- (increasing from 33% to 96%, $P < .0001$)
- Significant decrease in illicit opioid use (90% to 41%, $P < .0001$)

Community Based Meds First Study

- Adapted buprenorphine pathways
  - added care navigators to the nurse care manager role
- 6 sites across WA State (3 each in Eastern and Western WA)
- Syringe services programs and/or services for unhoused people
- Extensive implementation support from UW clinician-researchers with site staff and administrators

Substance Abuse and Rehabilitation

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Open Access Full Text Article

ORIGINAL RESEARCH

Community-Based Medications First for Opioid Use Disorder - Care Utilization and Mortality Outcomes

Caleb J Banta-Green[1–3], Mandy D Owens[1,4], Jason R Williams[1], Anthony S Floyd[1], Wendy Williams-Gilbert[1], Susan Kingston[1]

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Correspondence: Caleb J Banta-Green, Addictions, Drug & Alcohol Institute, Department of Psychiatry and Behavioral Sciences, School of Medicine, University of Washington, NE Pacific St Box 356560, Seattle, WA, 98195, USA, Email calebbg@uw.edu

Video Abstract

Point your SmartPhone at the code above. If you have a QR code reader the video abstract will appear. Or use: https://youtu.be/lleYt0x-85QE

Purpose: A large treatment gap exists for people who could benefit from medications for opioid use disorder (MOUD). People OUD accessing services in harm reduction and community-based organizations often have difficulty engaging in MOUD at opioid treatment programs and traditional health care settings. We conducted a study to test the impacts of a community-based medications first model of care in six Washington (WA) State communities that provided drop-in MOUD access.

Participants and Methods: Participants included people newly prescribed MOUD. Settings included harm reduction and homeless services programs. A prospective cohort analysis tested the impacts of the intervention on MOUD and care utilization. Intervention impacts on mortality were tested via a synthetic comparison group analysis matching on demographics, MOUD history, and geography using WA State agency administrative data.

Results: 825 people were enrolled in the study of whom 813 were matched to state records for care utilization and outcomes. Cohort analyses indicated significant increases for days' supply of buprenorphine, months with any MOUD, and months with any buprenorphine for people previously on buprenorphine (all results $p<0.05$). Months with an emergency department overdose did not change. Months with an inpatient hospital stay increased ($p<0.05$). The annual death rate in the first year for the intervention group was 0.45% (3 out of 664) versus 2.2% (222 out of 9893) in the comparison group in the 12 months; a relative risk of 0.323 (95% CI 0.11–0.94).

Conclusion: Findings indicated a significant increase in MOUD for the intervention group and a lower mortality rate relative to the comparison group. The COVID-19 epidemic and rapid increase in non-pharmaceutical-fentanyl may have lessened the intervention impact as measured in the cohort analysis. Study findings support expanding access to a third model of low barrier MOUD care alongside opioid treatment programs and traditional health care settings.

Keywords: opioid use disorder, medications for opioid use disorder, multi-site study, low-barrier care, harm reduction

Background and Aims

A large treatment gap exists between those who have opioid use disorder (OUD) and the proportion receiving medications for OUD (MOUD), which are the most effective and evidence-based treatment for OUD.[1,2] Methadone and buprenorphine also significantly reduce opioid and all-cause mortality providing substantial harm reduction benefit in addition to supporting recovery according to findings from multiple large studies in diverse populations.[3,4] Most people with OUD want to stop or reduce their use and are interested in MOUD.[5] While many people with OUD access an array of services in harm reduction and other community-based organizations, many also have difficulty starting or engaging in care at traditional substance use disorder (SUD) treatment clinics or primary care clinics.[6,7]

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Natural partners- Harm reduction & Treatment

Care Navigation at Harm Reduction Programs: Community-Based "Meds First" Buprenorphine Program Preliminary Data

06/22/2022

ADAI Report by Susan Kingston & Caleb Banta-Green

In 2019, the Addictions, Drug & Alcohol Institute (ADAI) at the University of Washington launched the "Meds First" program to provide onsite, low-barrier access to buprenorphine in partnership with six syringe services programs across WA State.

A key component of the Meds First service model was the addition of care navigation to support client engagement and retention in OUD treatment.

- **Key Findings**
- Care navigation fits flexibly and productively within community-based harm reduction programs.
- Participants of harm reduction programs want—and use—care navigation services, especially in-person support.
- Providing opioid use disorder treatment with a harm reduction orientation supports honest conversations about drug use.
- Care navigation services could be an important feature of a broader, low-barrier, "one-stop" model of health care available at harm reduction programs for people who use drugs and are not adequately served by traditional health care settings.

Health engagement hubs, ORCA, CCC

These models have evolved into:

- WA State supported Health engagement hubs
- ORCA- Overdose Recovery Care Access/ sub-acute stabilization program (UW ADAI NIDA Grant with PHSKC and DESC)
- King County- Crisis Care Centers

- These are a 3rd model of care alongside Specialty SUD care and Primary care
- SAMHSA issued a Dear colleague letter May 2023 in support of Medications First*
- Harm reduction + Treatment + Health care is where substance use services for opioids and stimulants are headed

* www.samhsa.gov/sites/default/files/dear-colleague-letter-fda-samhsa.pdf

Working with patients who use drugs

Harm reduction

- Many drug-related harms—like opioid overdose and HIV infection—are preventable
- Harms can be reduced even if use continues
- Abstinence is not every patient's goal
- Use strategies that work for each patient's situation

Motivational interviewing

- Explore patient's relationship to substances using open-ended questions
- Ask patient to describe perceived risks/benefits of use or stopping
- Assess readiness for change
- Accept ambivalence about change
- Create a plan together

Trauma-informed care

- All patients may have experienced trauma, even if not disclosed
- Challenging behaviors may be related to trauma history
- Avoid coercion and threats; ask for permission before touching patients
- Empower patients in decision-making

Unconditional positive regard

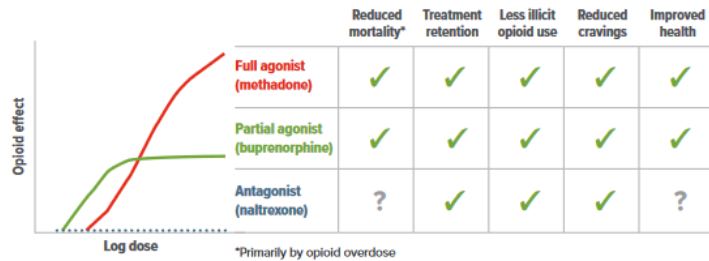
- Assume people are inherently good
- Treat each patient as a whole, unique person
- Respect each patient's own goals, which may not match your goals for them
- Believe that all patients can make positive changes

OPIOIDS

Management of opioid use disorder

Opioid use disorder (OUD) is a chronic, relapsing medical condition that requires treatment.

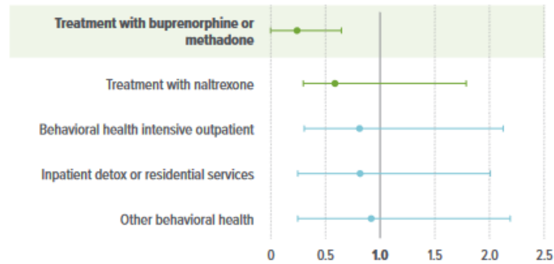
Medications are the most effective treatment for OUD and have multiple benefits.[5-14]



	Reduced mortality*	Treatment retention	Less illicit opioid use	Reduced cravings	Improved health
Full agonist (methadone)	✓	✓	✓	✓	✓
Partial agonist (buprenorphine)	✓	✓	✓	✓	✓
Antagonist (naltrexone)	?	✓	✓	✓	?

*Primarily by opioid overdose

Buprenorphine and methadone are the only interventions associated with reductions in overdose for people with OUD compared to no treatment.[15]



People with OUD are 13x more likely to die from suicide than those who do not have OUD.[16] Treating OUD can reduce the risk of suicide.

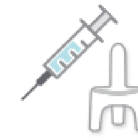
STIMULANTS

Caring for patients who use stimulants

Assessment

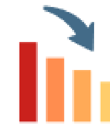
- Be non-judgmental and trauma-informed.
- Learn why the patient uses stimulants and their perception of risks and benefits.
- Use the DSM-5 to diagnose use disorders.

Routine prevention



- Ensure the patient is up-to-date on vaccines and infection screening and has access to overdose prevention and safer drug use supplies.

Use reduction



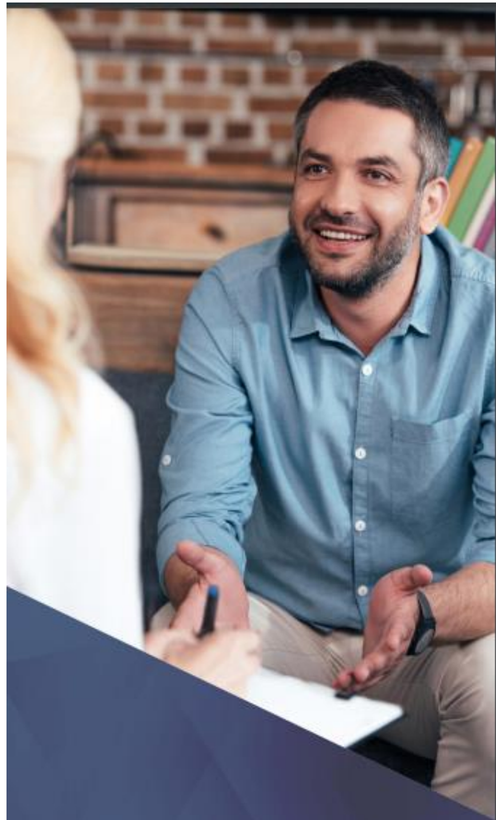
- Offer evidence-based strategies to stop or reduce stimulant use.
- Consider both behavioral and pharmacologic interventions.

Toxicity prevention

- Consider strategies for reducing the cardiovascular and neuropsychiatric harms of continued stimulant use.

https://www.ciaosf.org/_files/ugd/91710f_3b3a1f9daf3b4a99915243d82d8cbfce.pdf

Resources



Format	Location
Brochure	Medications for Opioid Use Disorder. https://stopoverdose.org/wp-content/uploads/2023/02/MOUD-Brochure-2023-1_ENG_Web.pdf
Website	Talking to Clients about OUD. https://www.learnabouttreatment.org/for-professionals/client-engagement/
Web guide	Talking to Someone About Medications for Opioid Use Disorder. https://www.learnabouttreatment.org/guide/#/
Handout	Medications for Opioid Use Disorder: Guide to Using the Brochure. https://www.learnabouttreatment.org/wp-content/uploads/2023/01/MOUD-Brochure-2023-11-web.pdf

More at: LearnAboutTreatment.org