Mindful
Continuing Education

Treating Opioid Use Disorder

Introduction

Opioid Use Disorder (OUD) has emerged as a compelling and urgent health crisis with far-reaching individual, societal, and economic implications. The opioid epidemic, which is characterized by the widespread misuse of prescription opioids and the increase in the use of illicit opioid substances, has touched all facets of society. The misuse of opioids has shattered countless lives, devastated communities, and strained and overburdened healthcare systems. In order to respond to the crisis, health professionals, government entities, and community stakeholders must come together and truly understand the landscape of opioid use disorder and develop practical strategies that will help alleviate the suffering wrought by opioid addiction. With the implementation of comprehensive prevention, treatment, and recovery interventions, people with opioid use disorder can receive compassionate person-centered services, and communities and healthcare systems can recover from the demands that have been placed on them.

Definition, Prevalence, and Impact of Opioid Use Disorder

Opioid use disorder (OUD) is a mental health disorder in which the person has a pattern of misuse of opioid(s) that causes them distress and/or impairs their functioning in their daily life. OUD may be mild to severe. It usually consists of an overpowering desire to use opioids despite consequences, increased tolerance, and withdrawal symptoms when discontinuing use. OUD is usually a lifelong disorder that has the possibility of serious results, including overdose, relapse, disability, and death (Cleveland Clinic, 2022).

Opioid use disorder affects more than 3 million people in the United States and more than 20 million people worldwide. There are over 120,000 deaths per year worldwide due to opioids. Only one in four people with OUD receive professional treatment (Cleveland Clinic, 2022).

- Overdose deaths are the leading cause of injury-related death in the United States (CDC, 2022).
- For every overdose death, there are multiple nonfatal overdoses (CDC, 2022).
- Three out of every five overdose deaths had at least one potential opportunity to connect the person to care before their fatal overdose or to administer life-saving measures at the time of the fatal overdose (CDC, 2022).
- 75% of the almost 92,000 drug overdose deaths in 2020 involved an opioid (CDC, 2022).
- More than 932,000 people have died from a drug overdose since 1999 (CDC, 2022).

Opioids and opiates are narcotics, which are a class of drugs that interact with nerve cells and reduce pain. Opioids are synthetic or chemically man-made, while opiates are found in nature and are typically derived from the poppy plant (Opium). Despite being natural, opiates can still be extremely dangerous, especially when purified and concentrated. Medicinally, they are used to relax the body and alleviate pain. Recreationally, people use opioids for the high they provide. Opioids are highly addictive, and overdose and death are common side effects (NIDA, 2021; Cleveland Clinic, 2022).

Prescription narcotics are most often prescribed to treat pain, such as one experiences when recovering from surgery or an injury; occasionally, they are

prescribed to treat chronic pain. Opiate examples include Opium, morphine, codeine, and heroin (heroin is not a medically prescribed opiate, and when used, it is done so recreationally). Examples of opioids include

- Dextromethorphan (available in the U.S. without prescription as NyQuil, Robitussin, Theraflu, Vicks)
- Dextropropoxyphene (Darvocet-N, Darvon)
- Loperamide (Imodium)
- Hydrocodone (Vicodin)
- Oxycodone (Oxycontin, Percocet)
- Oxymorphone (Opana)
- Meperidine (Demerol)
- Methadone (Dolophine)
- Fentanyl/fentanil (Ultiva, Sublimaze, Duragesic patch)
- Carfentanyl/carfentanil (Wildnil, veterinary use)

These are just a few of the most well-known, medically used opioids. There are over 500 pharmaceutically created opioid molecules.

Some opioids are partially derived from Opium and partially synthesized from laboratory opioid molecules. Examples include hydrocodone (Vicodin), hydromorphone (Dilaudid), and oxycodone (Oxycontin, Percocet). (Oregon.gov, 2024).

The addictive aspect of opioids is not only do they dull pain, but they also create a sense of euphoria in some people. As people develop a tolerance, they need to

increase the amount they take to have the same euphoric effect, which can then lead to opioid disorder.

Opioid dependence is the result of developing a tolerance or withdrawal. Tolerance is requiring a higher dose to have the same effects or, over time, having fewer benefits from the same dose. Withdrawal is when a person experiences unpleasant symptoms when terminating opioids; this can include a runny nose, diarrhea, and nausea. A person may experience opioid dependence even when taking the medication how it was prescribed.

Opioid use disorder is a pattern of opioid use that causes problems in the person's daily life or distress in other ways. The person also finds it challenging to reduce or eliminate their use despite the problems that are being caused in their life by their opioid use (Cleveland Clinic, 2022).

Opioid use disorder affects all ages, races, sexes, and socioeconomic statuses. It is estimated that 3% to 19% of people prescribed opioid medication go on to have OUD. When people are no longer able to receive a prescription for an opioid medication, or the medication prescription has become too expensive, they switch to heroin. It is estimated that 45% of those who use heroin began with misuse of prescription opioids. However, some people have an OUD and start with heroin use (Cleveland Clinic, 2022).

Stigma and Misconceptions Surrounding Opioid Use Disorder

Stigma is the shame or disapproval resulting from a person being rejected, discriminated against, and excluded from participating in numerous parts of

society. Stigma devalues a group based on a particular group characteristic (Cheetham et al., 2022).

Illegal drug use is one of the most stigmatized conditions throughout the world. When compared to other mental and physical health conditions, it is more likely to be viewed as a personal choice, a sign of weakness, or a person having bad personal character. People with OUD are frequently viewed as being unpredictable or dangerous, causing social isolation, and may experience exclusion from receiving government assistance with food or housing. Stima is a significant barrier to entering and receiving treatment. Seeing how opioid use disorder has risen significantly, acknowledging and addressing stigma is essential to remove barriers for people to access treatment. Reducing stigma must be done at numerous levels to reduce the segregation of people with OUD (Cheetham et al., 2022).

The stigma around opioid use is complex and varies depending on the type of opioid, how it was acquired, and how it is used. There is a division between the legitimate use of opioids (medically prescribed and used for treatment) versus the illegitimate use of opioids (using recreationally or self-medicating for psychological reasons). Those who use opioids through injection face the most stigma, including negative public attitudes and increased barriers to accessing healthcare. Fentanyl use is also highly stigmatized, which has just increased with media coverage of overdose deaths with a narrative of the person being a danger and problem to their community (Cheetham et al., 2022).

Over the last twenty years, there has been a significant increase in prescribing opioids for chronic pain, which has led to substantial harm, including morbidity and mortality due to accidental overdoses. Media coverage of this subset of opioid users tends to be less negative and more sympathetic, with the narrative often being the person became addicted to prescription opioids they were taking

due to a physical disease rather than being held personally responsible for their condition. They do, however, still face social isolation and stigma, often coming in the form of the person being unable to make decisions about their treatment or finances (Cheetham et al., 2022).

There is also a stigma in the healthcare system of “good” and “bad” opioid use and the “good” and “bad” people who consume opioids, which furthers the stigma among opioid users. This is seen among chronic pain opioid users who report levels of prejudice towards people who are dependent on opioids or use them illegally. To distance themselves, there is often a stigmatizing narrative of being the responsible patient taking prescribed medications for legitimate medical reasons versus the people who use opioids for recreation or pleasure (Cheetham et al., 2022).

The stigma surrounding opioid use is not isolated around its use but intersects and is multiplied by the marginalization of race, ethnicity, gender, sexual orientation, age, and socioeconomic status. When looking at the opioid crisis it has disproportionately affected communities with high poverty levels, income inequality, and lack of access to social capital. Stigma in the criminal justice system creates barriers for people with OUD; there is a significant misunderstanding of the purpose and benefits of treatment while incarcerated, leading to programs either not being offered or being implemented poorly (Cheetham et al., 2022).

Understanding Opioids and Their Effects

Types of Opioids

As previously stated, there are hundreds of different opioids that can be found in nature and have been created in laboratories. This section will focus on the most frequently misused opioids, prescription opioids, heroin, and fentanyl.

Prescription Opioids

Prescription opioids are used to treat moderate to severe pain. They are most frequently prescribed post-surgery or injury or for pain-causing health conditions such as cancer, back pain, and osteoarthritis. There are serious risks when prescribing opioids for chronic pain, not only the risk for addiction but there is a lack of evidence that supports their effectiveness in long-term use. In 2022, there were over 131 million opioid prescriptions given out in the United States. There is also a wide variation in the number of opioid prescriptions across states, which seems to be explained by the variation in the health status of the state's population. For example, Alabama was the highest-prescribing state in 2022, with a rate of prescriptions three times higher than that of Hawaii, the lowest-prescribing state. The prescription opioids with the most overdose deaths are methadone, oxycodone, and hydrocodone (CDC, 2023)

Prescription opioid misuse includes taking the medication in a way or dose other than what is prescribed, taking someone else's prescription medication, or taking the medication expressly to get high and not for the prescribed treatment (NIDA, 2021).

Heroin

Heroin is an opioid drug derived from morphine, which is a natural substance taken from the poppy plant seed pod. Heroin is an opiate since it comes from the opium poppy (ADF, 2023). Heroin can be a white or brown powder or a black sticky substance known as black tar heroin. Opium use was documented over five thousand years ago among the Assyrians and Babylonians, and opium pipes have been found at archeological sites in Asia, Egypt, and Europe dating between 1000 - 300 BCE. Use of opium was common in Europe in the Middle Ages and into the 1800s. Opium was a major ingredient in many patent medicines in the 1800s in the United States, and laudanum was taken by many. In 1805, morphine was purified, and with the invention of the hypodermic syringe in 1853, there was a vast increase in the use of injected morphine during the Civil War. In 1898, the Bayer Company modified morphine and created heroin (NIDA, 2022 & Kuhn et al., 2019).

Fentanyl

Fentanyl is a synthetic opioid similar to morphine but with a 50 to 100 times increase in potency (NIDA, 2021). It is a prescription drug that is made and used both legally and illegally. It is legally used to treat patients with severe pain, such as after surgery or with chronic pain, who have a physical tolerance to other opioids. Brand names include Actiq, Duragesic, and Sublimaze. A current concern with fentanyl is that some dealers are mixing it with other drugs, such as heroin, cocaine, methamphetamine, and MDMA, as it takes very little to produce a high, making it a cheap but effective additive. This also makes it dangerous as many people taking the modified drugs are unaware that they contain fentanyl and are, therefore, more potent and more likely to cause an overdose (NIDA, 2021).

Mechanism of Action of Opioids on the Brain and Body

Opioids affect each person differently based on

- The person's size (height and weight) and health(ADF, 2023)
- The person's is used to taking opioids or not (ADF, 2023)
- If the drug is taken around the same time (ADF, 2023)
- The amount of opioids taken (ADF, 2023)
- The strength of the opioid taken (ADF, 2023)

Heroin

People snort, smoke, or inject heroin. Some people mix heroin with crack cocaine, known as speedballing. Heroin rapidly enters the brain, binding to opioid receptors, particularly to cells involving feelings of pain and pleasure and those controlling heart rate, breathing, and sleeping (NIDA, 2022).

Fentanyl

Legally prescribed fentanyl is taken as an injection, patch, or lozenge. Illegal fentanyl is typically sold as a powder, blotter paper, eye droppers, nasal sprays, and pills. Fentanyl binds to the opioid receptors in the brain that control pain and emotions. Regular use of opioids leads to the brain adapting to the drug, lowering the body's sensitivity to it and making it harder for the person to feel pleasure from anything other than the drug (NIDA, 2021).

Opioids bind to and activate opioid receptors on cells in the brain, spinal cord, and organs, particularly those involved in feeling pain and pleasure. When opioids attach to the receptors, they block pain signals sent from the brain to the body and flood the body with large amounts of dopamine. This strong release

throughout the body reinforces taking the drug as users want to repeat the experience (NIDA, 2021).

Short-term and Long-term Effects

According to the Alcohol and Drug Foundation (2023), Short-term effects of opioids include

- Pain relief
- Euphoria
- Relaxation and sellbeing
- Impaired soncentration
- Reduced sex srive
- Sweating
- Constipation
- Clumsiness
- Drowsiness
- Confusion
- Slurred speech
- Slowed breathing
- Slowed heart rate

The Alcohol and Drug Foundation (2023) lists the following effects of consuming a large dose of opioids include

- Clammy and cold skin
- Slowed breathing
- Blue fingertips and lips
- Falling asleep
- Death due to respiratory depression

According to the Alcohol and Drug Foundation (2023) long-term effects include

- Increased tolerance
- Dependence
- Constipation
- Damage to organs including lungs, heart, and brain.

Physical and Psychological Effects

Heroin

Short-term effects include a rush of pleasure or euphoria, dry mouth, nausea and vomiting, warm flushing skin, heavy feeling in the arms and legs, severe itching, clouded mental functioning, and nodding off (an in and out state of consciousness and semi-consciousness).

Long-term effects include insomnia, collapsed veins (for those who inject the drug), damaged nasal tissues (for those who sniff or snort the drug), heart lining and valve infections, abscesses, constipation, stomach cramping, liver and kidney disease, lung infections, mental health disorders, sexual dysfunction in men, irregular menses for women. Long-term use can also lead to loss of brain white

matter, impacting a person's decision-making capabilities, behavior control, and managing stressful situations (NIDA, 2022).

Fentanyl

Short-term effects include extreme happiness, drowsiness, nausea, constipation, confusion, sedation, difficulty breathing, and unconsciousness. And hypoxia, which is an effect of all opioids.

Prescription Opioids

Short-term effects include pain relief and feeling relaxed and happy. Harmful effects include drowsiness, euphoria, confusion, nausea, constipation, and slowed breathing. Slowed breathing can reach the level of hypoxia, which is when too little oxygen reaches the brain. The psychological and neurological effects of hypoxia include coma, permanent brain damage, and death (NIDA, 2021).

The Center for Disease Control (2022) reports that even when taken as prescribed, prescription opioids can have a number of side effects, including:

- Tolerance (needing a higher dose of the medication to experience the same pain relief)
- Physical dependence (experiencing withdrawal symptoms when the medication is terminated)
- Increased sensitivity to pain
- Constipation
- Nausea & vomiting
- Dry mouth
- Confusion

- Depression
- Low testosterone levels (lowering sex drive and strength)
- Itching
- Sweating

Side Effects and Risks

Older adults are at an increased risk for abuse and accidental misuse as they tend to have multiple prescriptions and health issues. This leads to increased risk for drug-drug interactions and drug-disease interactions. An additional risk factor for older adults is a slowed metabolism that impacts the breakdown of drugs.

There is a high risk of overdose with opioid use. Emergency medical services should be sought immediately through 911 if an opioid overdose is suspected. Naloxone can be administered to treat an opioid overdose. Naloxone works by quickly binding to the opioid receptors, blocking the effects of the opioid, and helping the person to start breathing again. Depending on the drug, the amounts taken, and the person, it may take more than one dose of naloxone to help the person recover from the overdose, which is why it is imperative to seek medical treatment immediately (NIDA, 2021 & NIDA, 2022).

Because fentanyl is being mixed in with other drugs, it is sometimes difficult to know what drug is causing the overdose. Also, because fentanyl is so much stronger than other opioid drugs, it frequently requires multiple doses of naloxone to reverse the overdose. People who are given naloxone should be monitored for at least two hours after the last dose is given to ensure breathing does not slow or stop (NIDA, 2021).

A person experiencing a heroin overdose will have their breathing slow or completely stop. This decreases the oxygen they receive to their brain, resulting in hypoxia. This can have temporary short-term effects to permanent and long-term effects on the nervous system, including coma, permanent brain damage, and death (NIDA, 2022).

Additional risks with heroin use are that it frequently contains additives, including sugar, starch, or powdered milk, which can block blood vessels leading to the lungs, kidneys, liver, or brain, causing permanent damage. Having impaired judgment due to drug use and sharing drug injection equipment are two risk factors for contracting infectious diseases such as HIV and Hepatitis (NIDA, 2022).

Addiction and Withdrawal

Heroin addiction can cause severe withdrawal symptoms within a short time of stopping the drug. Symptoms include restlessness, cold flashes, goosebumps, uncontrollable leg movements, severe muscle and bone pain, and severe drug cravings (NIDA, 2022).

Fentanyl is addictive because of its potency; even those who are legally prescribed fentanyl are warned they may develop a dependency that could lead to an addiction. Severe withdrawal symptoms can be experienced within a few hours after stopping the drug. They include the same symptoms as heroin; see above. The withdrawal symptoms can be extremely uncomfortable, which is why many people find it difficult to stop using. Lofexidine can be prescribed to help diminish withdrawal symptoms.

Prescription opioid withdrawal symptoms can be extremely uncomfortable, including sleep problems, diarrhea, vomiting, cold flashes with goosebumps, muscle and bone pain, uncontrollable leg movements, and severe cravings. There

are some medications that can be given to reduce the withdrawal symptoms (lofexidine) (NIDA, 2021).

Risk Factors

There are a number of risk factors that may cause a person to be more susceptible to opioid misuse and dependency. Some examples of risk factors include

Opioids Effects on Brain Chemistry

Opioids are highly addictive due to activating reward and pleasure areas of the brain. This increases the chances of developing a dependency after using an opioid. Opioids prompt the brain to release endorphins, which are neurotransmitters that reduce the pain perception and increase feelings of euphoria. As the opioid wears off, so do these pleasurable sensations, triggering a strong desire to continue to use and to continue the desirable feelings.

People can develop a physical dependence to opioids in as little as four to eight weeks. Those who use opioids over an extended period of time experience worse chronic pain as the opioids have a toxic effect on the pain signaling in a person's body.

Once a physical dependence to opioids has been established, severe withdrawal symptoms will be experienced, decreasing one's desire and motivation to terminate use significantly (Cleveland Clinic, 2022).

Access and Exposure to Opioids

Access to opioids is an environmental risk factor. Opioids are easily accessed in the United States, both on the availability and volume of prescription opioids.

The most common opportunities for access and exposure to opioids are through

- Being prescribed opioids for pain
- Having a member of one's household use opioids
- Having peers use opioids

Heroin is easier to access than opioid prescriptions, which also contributes to the development of opioid use disorder. Currently, powders and pills that are sold illegally as heroin, cocaine, crystal meth, or prescription opioids often contain fentanyl, which is more dangerous and deadly (Cleveland Clinic, 2022).

Genetics and Biology

Research has shown that genetic factors contribute 40%-60% to one's susceptibility to developing any substance use disorder. Therefore, a person with a first-degree relative with an opioid use disorder is more vulnerable to developing it as well (Cleveland Clinic, 2022).

Mental Health and Medical Conditions

Approximately half the people who experience a mental health disorder will also experience a substance use disorder, and vice versa. Mental illness can play a part in developing a substance use disorder, and substance use disorders can contribute to developing a mental illness. There are many coinciding factors, including genetic vulnerabilities and challenges in similar areas of the brain. Certain health conditions, such as chronic pain, may cause a person to increase their use of opioids and lead to developing OUD (Cleveland Clinic, 2022).

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are a high-risk factor for developing numerous different health conditions, including substance use disorders.

Family-linked ACEs that increase the risk of drug use in adolescence and adulthood include:

- Poor quality in parent-child relationships and interactions
- Parent conflict and domestic violence
- Abuse and neglect in childhood
- Parent incarceration

According to the Cleveland Clinic (2022), child-linked ACEs that increase one's risk of developing OUD include:

- Childhood behavioral disorders
- Untreated ADHD
- Low school performance and lack of commitment to education.

Prognosis for Those with Opioid Use Disorder

People with untreated opioid use disorder have a poor prognosis and are at greater risk for numerous issues, including:

- Injuries (falls, vehicular accidents)
- Blood-borne infections from shared injection equipment (hepatitis B, hepatitis C, and HIV)
- Incarceration
- Overdoses
- Dying from overdoses
- Dying by suicide

Overall, the mortality rate for those with an OUD is ten times higher than the general population. OUD is treatable, and a person can successfully recover and lead a healthy and successful life (Cleveland Clinic, 2022).

Screening and Assessment

Signs and Symptoms

Per the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), signs of opioid use disorder include:

- Taking higher doses of opioids and over a longer time than prescribed
- Having a strong urge or desire to use opioids
- Continuing to take opioids despite repeated interpersonal and social difficulties due to opioid use
- Spending a significant amount of time procuring and/or using opioids, and recovering from the effects of use
- Having difficulties completing responsibilities at home, school, or work due to opioid use
- Reducing or eliminating normal activities due to opioid use
- Using opioids in physically dangerous situations
- Continuing opioid use in spite of physical or psychological problems that are being caused or complicated by opioids
- Developing a tolerance and needing increased amounts of opioids to achieve desired effects

- Experiencing withdrawal or taking opioids or other narcotics to avoid or relieve withdrawal symptoms (APA, 2013)

Having two to three of the above signs is considered mild opioid use disorder.

Having four to five signs is moderate opioid use disorder.

Having six or more signs is severe opioid use disorder.

Symptoms of opioid withdrawal syndrome include

- General pain
- Fever and chills
- Diarrhea
- Dilated pupils
- Agitation
- Restlessness
- Anxiety
- Nausea
- Vomiting
- Intense cravings
- Elevated blood pressure and heart rate
- Sweating
- Insomnia

Assessment Tools and Questionnaires

Opioid use disorder assessment requires a combination of clinical examination, urine drug screening as needed or indicated, and a valid risk assessment tool; together, these improve the possibility of detecting opioid misuse (Ducharme & Moore, 2019).

Due to the epidemic use of opioids and the high rates of overdoses, providers should have a standardized risk assessment approach for their initial evaluation of a client and at follow-up visits. Providers should use universal precautions and assess all new clients. Discussions around opioid use can become emotionally charged, and therefore, assuming all clients may be at risk and using a standardized approach can help lower emotional reactions. Assume all clients may be at risk of opioid use and addiction, and use a screening tool to determine possible opioid risk. Only screening clients who show suspicious symptoms may lead to missing diagnosing clients with OUD and, therefore, not providing the necessary level of care (Ducharme & Moore, 2019).

Screening Tools

Risk assessment tools are often self-reports and rely on the client answering honestly; any misrepresentation of their behaviors, use, and past history does weaken the value of the assessment tool. No risk assessment tool guarantees an accurate risk assessment. Two better-performing assessment tools are the Screener and Opioid Assessment for Patients with Pain - Revised (SOAPP-R) and the Opioid Risk Tool (ORT) (Ducharme & Moore, 2019).

The SOAPP-R is a 24-question screening tool created to predict aberrant drug-related behaviors before starting long-term opioid treatment. The questions are answered on a scale of 0 (never) to 4 (very often), with a maximum total points of

96—a score over 18 points rates a person at a higher risk for misusing their prescription opioids. See Appendix B for SOAPP-R.

The Drug Abuse Screening Test (DAST-10) is a 10 question brief screening tool that can be administered by a therapist or self-administered. The DAST-10 can be completed in less than 8 minutes and requires only yes or no answers. It screens for drug use over the past twelve months. It does not screen for tobacco or alcohol use (USC, 2019). See Appendix C for DAST-10.

Assessment

If a person screens positive for opioid misuse, self-reports misuse, or presents with signs or symptoms of opioid misuse, a more in-depth assessment should be completed. A comprehensive assessment will determine if there is an OUD diagnosis, the severity of the person's OUD, identify any additional medications or drugs they are taking, identify other medical conditions that may need to be addressed, and identify mental health conditions or social issues that need to be addressed. SAMHSA (2021) recommends comprehensive assessmentsl use open-ended, non-judgemental questions to gather information on the person's

- Medical history
- Mental health history
- Substance use history
- Substance use disorder treatment history
- Social history
- Family history

- Depending on the organization, a physical exam and drug test may be completed, or a referral may be provided to complete these with a medical provider.

Drug Testing

Drug testing establishes a baseline of the substance the person is using at the time of testing. It also helps the provider by confirming the patient's reported history of use, facilitates discussion of recent drug use and symptoms, aids in diagnosing and determining the severity of OUD, and helps the patient and provider determine the best course of treatment. A complete drug panel should be utilized, especially if OUD medications will be prescribed, as some drugs and medications may cause risks, complications, or side effects when prescribed with an OUD medication (SAMHSA, 2021).

Co-occurring Mental Health Disorders

Due to the high rate of comorbidity between substance use disorders and mental health disorders, there is a need to integrate assessment, diagnosis, and interventions concurrently. Understanding the overlap of genetics, brain, and environmental influences can help to improve treatment for people with co-occurring disorders and reduce the social stigma that can cause people to be reluctant to seek treatment. Diagnosing co-occurring disorders can be challenging as symptoms often overlap. Comprehensive assessment tools should be used to help disentangle symptoms and reduce the likelihood of misdiagnosis. People with co-occurring disorders often present with symptoms that are more severe, persistent, and resistant to treatment.

People entering mental health treatment should be screened for substance use disorders and vice versa. For those entering substance use treatment, it may be

necessary to observe them once they have been abstinent from substances to be able to distinguish between the effects of their substance use or withdrawal and the symptoms of their mental health disorder. This will allow for a more accurate diagnosis and lead to an appropriate treatment plan for their needs (NIDA, 2021).

Over 18 million people over the age of 12 did not receive needed SUD treatment in the past year (most did not perceive themselves as needing treatment, and only 5% identified that they needed treatment). 48.6% of adults with a COD did not receive any treatment in the past year, 41% received mental health treatment only, 3.3% received SUD treatment only, and 7% received treatment for both. Among adults with SMI and SUD, 30.5% received no treatment, 56% received mental health treatment only, 3% received SUD treatment only, and 11% received treatment for both. There is a high rate of comorbidity and treatment needs for those with a mental health disorder and a substance use disorder (SAMHSA, 2020).

SAMHSA provides six guiding principles for treating clients with co-occurring disorders.

1. Use a recovery perspective.

   The recovery perspective acknowledges that recovery is a long-term, internal change process that proceeds through numerous stages. In practice, this means providers are creating treatment plans that provide a continuity of care over time and various settings the client may progress through. Treatment interventions are specific to the client's stage of recovery.

2. Adopt a multiproblem viewpoint.

   Individuals with CODs typically have multiple needs, including mental, physical, substance use, family, and social problems. Treatment services

must, therefore, be comprehensive to meet the multiproblem needs of each client.

3. Develop a phased approach to treatment.

   By using a phased approach to treatment, providers can ensure comprehensive and appropriate services for the client's needs. Typically, phases are engagement, stabilization/persuasion, active treatment, and continuing care/relapse prevention.

4. Address specific real-life problems early in treatment.

   CODs are greatly impacted by personal and social problems, and treatment should address these issues early on. This may be accomplished through case management support or specialized interventions that address housing or vocational assistance. Supporting clients to solve everyday living issues can be a powerful method of engagement with clients.

5. Plan for the client's cognitive and functional impairments.

   Services must be individualized to each client's needs and level of functioning, especially with those with SMI. Many individuals with CODs have cognitive or functional impairments that impact their ability to understand information and complete tasks. A comprehensive assessment of an individual's abilities and impairments will enable the provider to tailor the treatment plan to meet the client's needs.

6. Use support systems to maintain and extend treatment effectiveness.

   Family, peers, faith community, and other resources within the individual's community can play a valuable role in recovery. This may be especially powerful for clients who have experienced stigma and been ostracised by

their family and community due to their SUD and/or mental health disorder (SAMHSA, 2020).

Individuals with CODs generally are treated in one of the following ways:

Sequential or Serial Treatment: The client is treated for one disorder at a time. This has been the traditional treatment choice, but its effectiveness is limited and can lead to worse outcomes in situations where treating one disorder may worsen the symptoms of another.

Simultaneous or Parallel Treatment: The client is treated for both disorders but by separate providers in separate organizations. This has better results when compared to sequential treatment but is not a collaborative or comprehensive approach to care.

Integrated Treatment: The client is treated for all diagnoses and symptoms in one organization or program with a single team of providers working together. This is the preferred method as it addresses all the client's needs as a whole person. Integrated treatment has superior results in improved substance use and mental illness symptoms, treatment retention, cost-effectiveness, and client satisfaction (SAMHSA, 2020).

Integrated treatment is superior for treating co-occurring substance use and mental health disorders when compared to separate treatment for each diagnosis. Cognitive behavioral therapy is often used as part of integrative treatment to improve interpersonal and coping skills while simultaneously using interventions that motivate and support recovery.

Clients with co-occurring disorders have lower treatment adherence and higher rates of treatment dropout than those with a singular mental health diagnosis.

Integrative treatment often involves collaboration with multiple providers and organizations that provide supportive services to address issues of physical health,

homelessness, vocational skills, and legal issues. Communication among all service providers is critical for the successful implementation of treatment services. Tactics that have been shown to increase communication among service providers include co-location, shared treatment plans and records, and case review meetings (NIDA, 2021).

Integrated treatment is the best practice approach for treating individuals with CODs. It provides positive results in numerous areas, including substance, mental health, functional, and social outcomes. Individuals in integrated treatment programs have decreased substance use and abstinence, improved mental functioning, decreased emergency department visits, inpatient stays, and overall healthcare costs, gains in independent housing and employment, and improved life satisfaction (SAMHSA, 2020).

Medication-Assisted Treatment for Opioid Disorders

Medication-assisted treatment is a pharmacological intervention for alcohol and opioid use disorders. Depending on the medication, it can help alleviate cravings, which helps the person overcome their physical dependence, while others can help minimize withdrawal symptoms. Through stabilization, the person can build healthy psychological, social, and lifestyle changes. Research shows that medication-assisted therapy reduces opioid use, overdoses, criminal activity, and other risky behaviors (SAMHSA, 2018).

Medication for opioid use disorders interacts with the same opioid receptors in the brain as the opioid drug. There are three drugs the Food and Drug Administration (FDA) has approved for treating opioid use disorder: Methadone, Buprenorphine, and Naltrexone. All three treatments are safe and most effective when paired with counseling and psychosocial support. People with OUD seeking treatment should be offered all three options, and providers and clients should

work together to identify what treatment will best meet the person's individual needs. OUD is a chronic condition, and clients may need to continue MAT treatment indefinitely; there is no maximum length of time for maintenance treatment (FDA, 2023).

Methadone

Methadone is a Schedule II controlled medication and can only be dispensed through a certified Opioid Treatment Program. The FDA has approved Methadone for pain management and to treat Opioid Use Disorder. Methadone is an opioid receptor full agonist, which means it attaches to and activates opioid receptors to reduce withdrawal symptoms and cravings. It also blocks opioid effects. When Methadone is prescribed, it should be part of a comprehensive treatment plan that includes counseling and any other additional services the person may need. Under federal law, people receiving treatment in Opioid Treatment Programs must also be given the opportunity to participate in counseling. They must also have access to medical, educational, vocational, and other services that have been determined through assessment or their treatment plan.

Methadone is taken as a daily liquid, powder, or diskette. The brand names are Dolophine and Methadose; generic is available. People using Methadone to treat opioid use disorder must receive their medication under the supervision of a doctor. Once they have established stability based on their progress and compliance with the medication dose, they may be allowed to take Methadone at home between their treatment program visits. The duration of time a person takes Methadone varies but should be a minimum of 12 months. Some people may require long-term methadone treatment. People must work closely with their doctor to gradually wean off their methadone dose to prevent withdrawal (SAMHSA, 2024).

Buprenorphine

Buprenorphine can be prescribed and dispensed by doctor's offices; this increased access to treatment significantly. It provides treatment options for those who are unable to access care at an Opioid Treatment Clinic. When Buprenorphine is prescribed, it should be as part of a comprehensive treatment plan that includes counseling and any additional services the person may be in need of.

Buprenorphine is an opioid receptor partial agonist, which means it attaches to and partly activates opioid receptors to reduce withdrawal symptoms and cravings. Buprenorphine effects of euphoria or slowed respiration are experienced at a decreased level when compared to Methadone or heroin. When taken as prescribed, it is a safe and effective treatment.

Buprenorphine aids in

- Reduces the effects of physical dependency to opioids, including withdrawal symptoms and cravings.
- Improves safety in the event of an overdose.
- Reduces the likelihood of misuse.

It is taken daily as a sublingual tablet or film, monthly as an injection, or every six months as an implant. The brand names include Brixadi, Cassipa, Subutex, Suboxone, Zubsolv, Bunavail, Probuphine, and Sublocade, generic is available.

To begin taking Buprenorphine, the person must refrain from taking opioids for 12 to 24 hours and be in the beginning stages of opioid withdrawal. Those who have higher opioid blood levels or who are not in the beginning stages of withdrawal may experience acute withdrawal. Once a person has significantly reduced or discontinued their opioid use, has no cravings, and experiences no or few side effects, then their dose of Buprenorphine may be adjusted. Buprenorphine is a

long-acting agent; therefore, once a person is stabilized, they may be able to reduce their dosing to every other day. The duration of time a person is prescribed Buprenorphine is customized to meet their needs; some people take Buprenorphine for a short period of time, while others continue indefinitely (SAMHSA, 2024).

Naltrexone

Naltrexone is an opioid receptor antagonist, which means it prevents opioids from attaching to the opioid receptors, blocking their euphoric and sedative effects. It also suppresses cravings. It is not an opioid, it is not addictive, and there are no withdrawal side effects when terminating use. The FDA has approved Naltrexone to treat alcohol use disorder and opioid use disorder. Naltrexone can be prescribed and dispensed by any licensed medical practitioner.

When Naltrexone is prescribed, it should be as part of a comprehensive treatment plan that includes counseling and any additional services the person may be in need of.

It is taken monthly as an extended-release intramuscular injection. The brand name is Vivitrol, and generic is available.

Before starting Naltrexone, the person should wait seven days after using a short-acting opioid or 10 to 14 days after using a long-acting opioid to reduce the risks of withdrawal symptoms. Those taking Naltrexone should not use any opioids, illicit drugs, alcohol, sedatives, tranquilizers, or any other drug. People should discuss with their medical provider all medications they are currently on and any new medications added while on Naltrexone. Those who discontinue their Naltrexone or relapse after a period of abstinence may experience a reduced tolerance to opioids. Taking the same or even a lower dose of opioids than they

may have in the past can potentially lead to life-threatening results (SAMHSA, 2024).

Benefits and Limitations of Medication-Assisted Treatment

The benefits of Medication-Assisted Treatment according to MATClinics (2023), the state of Illinois (2024), and SAMHSA (2021) include:

- Patients receiving MAT have a higher rate of treatment retention and are more likely to stay in programs until completion.
- MAT provides safer withdrawal by reducing symptoms and controlling cravings.
- Participating in MAT reduces positive opioid drug tests by 14.2%.
- MAT reduces opioid-related overdose deaths.
- MAT decreases illicit opioid use, which decreases dangers and legal consequences.
- MAT decreases criminal activity.
- MAT decreases the transmission of infectious diseases.
- MAT improves maternal and fetal outcomes in pregnant and breastfeeding mothers.
- MAT significantly reduces relapse risk, especially when combined with behavioral therapy.
- MAT reduces the need for inpatient detoxification services.
- MAT provides a comprehensive and individually tailored program of medication and behavioral therapy to meet the needs of each person.

- Patients have more flexibility and can go about their daily activities without daily appointments at a treatment center (depending on the medication they are on).
- More insurance companies are recognizing MAT as an evidence-based treatment and providing coverage for it.
- Medication for OUD is cost-effective. There are lower healthcare costs, lower necessary usage of other healthcare services, and lower costs than treatment without medication.

According to the New Choices Treatment Center (2020) limitations of Medication Assisted Treatment include:

- MAT requires close medical supervision at a certified opioid treatment program.
- The person may experience side effects from the medications used.
- The medications do have the potential for misuse and abuse.
- There is a risk of trading one addiction for another, and MAT is simply shifting dependence from one drug to another.

Ongoing Monitoring and Management

People with OUD have the best results when they are provided MAT for as long as it is providing them benefits. Once a person is stabilized on OUD medication, many discontinue their use of opioids, while others reduce their use amounts and frequency, reducing their risk for overdose and death. OUD medications give the person time to make life changes for long-term recovery and remission. It allows them to make changes to the people, places, and things linked to their past drug use. Maintenance treatment minimizes withdrawal symptoms and cravings,

making it easier to manage life responsibilities such as school, work, and parenting (SAMSHA, 2021).

Some people decide after a period of time on OUD medication that they would like to stop taking it. They should work with their provider to gradually taper off the medication. However, research shows there is a high rate of relapse after tapering from methadone treatment. One study finding only 13% of people who chose to taper off methadone had successful outcomes after 18 months of discontinuing methadone. Aspects that impact outcomes include length of treatment, illicit drug abstinence, social and financial stability, and the person's motivations to stop medication. Those who wish to go through with terminating methadone treatment should be offered intensive psychosocial treatment, should have ongoing monitoring during and post-taper, be offered extended-release naloxone, and encouraged to quickly resume treatment if they find themselves relapsing with opioid use (SAMHSA, 2021).

Behavioral Interventions and Counseling

Behavioral Therapy

Substance use treatment often consists of a combination of group and individual therapy sessions focused on teaching skills to become sober, maintain abstinence from substance use, and navigate situations and triggers without relapsing to substance use. Individual therapy is guided by a therapist in one-on-one sessions. A therapist usually leads group therapy with a group of peers in a safe and supportive environment. Family therapy is led by a therapist and includes the person in treatment and their significant other, family members, or other significant people in the person's life (SAMHSA, 2021).

Behavioral therapy can help people with OUD improve their problem-solving skills, improve interpersonal relationship skills, identify incentives for abstinence or reduced use, build relapse prevention techniques, and identify rewarding activities to replace drug use (SAMHSA, 2021).

Behavioral therapy is the most often used type of treatment in substance use rehabilitation programs. The following are evidence-based treatment modalities that are effective in treating substance use disorders.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a model of psychotherapy that is structured and goal-oriented. In CBT, the person is encouraged to look at their thoughts and emotions and develop an understanding of how their thoughts affect their actions. With this practice, a person can unlearn negative thoughts and behaviors and replace them with healthier thinking and habits.

Cognitive behavioral therapy encourages people to question and explore their recurring thoughts in order to eliminate those that are negative and unhealthy. CBT teaches people techniques to recognize and change their maladaptive behaviors. CBT helps people learn coping skills, identify risky situations and what to do about them, and relapse prevention. CBT can be used to treat problematic substance use and also treat co-occurring mental or physical health disorders (Cleveland Clinic, 2022; Miller, 2023).

Cognitive behavioral therapy is useful in treating OUD by improving motivation, aiding in decision-making, activating behavioral changes, and developing new beliefs about oneself, drugs, and the future. During active misuse of opioids, people often lose the ability to manage their schedules. One aspect of CBT is helping re-establish routines in areas of what they need to do (work, school, hygiene) and want to do (increasing knowledge in a specific area, learning a new

skill) and identifying areas to experience pleasure outside of opioid use (social activities, recreational skills, hobbies). Often, in addictions, a person creates a negative belief about themselves; CBT works to increase the person's level of competence and improve their belief in themselves, building a positive feedback look instead of a negative self-fulfilling prophesy. Using opioids can lead a person to be numb to life events. CBT works towards renewing emotions, which can be overwhelming if they have been numbed for an extended period of time, and supporting the person in managing those feelings as they arise. Behavioral skills to support emotions may include such things as establishing a healthy sleep routine, practicing mindfulness, and activities such as prayer, meditation, and yoga (Miller, 2022).

Motivational Interviewing

Motivational interviewing (MI) is a treatment method of addressing the ambivalence some people experience in recovery, allowing them to embrace their treatment efforts in a way that works best for them to address their substance use. The goal is to strengthen the person's motivation for and commitment to change in a way that is consistent with their values. Rather than the therapist imposing or enforcing a specific change, the person is met where they are, and they are helped to move towards their goals by building on their readiness to change. A benefit of MI is that while a therapist facilitates it, the person in recovery develops their own motivation and plan for change in the initial sessions, which gives them more of a sense of control over the course of their treatment (Miller, 2023).

Motivational Interviewing is a patient-centered approach that uses techniques to support the person in exploring and resolving their ambivalence to changing their unhealthy or maladaptive behaviors. Those with OUD often have mixed thoughts and feelings about their opioid use. They are most likely aware of the negative

consequences associated with their use; they also derive pleasure from it. There is often a level of ambivalence about changing their opioid use behavior until they are able to shift their views on the risks and benefits of their use. Developing an understanding and resolving their ambivalence is the key aspect of motivational interviewing. Motivational interviewing has been shown to reduce substance use up to one year post-intervention (Ingersoll, 2024).

Contingency Management

Contingency Management (CM) is an evidence-based psychosocial therapy that is effective in treating several substance use disorders and is used to encourage and reinforce sobriety. This treatment method provides physical rewards (gift cards, vouchers, prizes) to motivate desirable behaviors (maintaining sobriety). A benefit of CM is it reduces two of the biggest treatment barriers: dropping out and relapse.

There are two evidence-based reinforcement methods used in contingency management: voucher-based and prize-based.

In Voucher-based Reinforcement programs, those in treatment receive a voucher for every drug-free urine sample they provide. The monetary value of a voucher increases with each consecutive drug-free urine sample, and the value is reset with a positive urine sample. Depending on the program, vouchers may be cash or cash-value vouchers that can be exchanged for food, movie passes, or other goods and services.

In Prize Incentive programs, there is an element of chance to win cash prizes. During the program (usually lasting at least three months and one or more times a week), those in treatment who provide a drug-free urine sample or breath test drawn from a bowl have the chance to win a prize with a value of $1 to $100. Draws start at one and increase with each consecutive negative drug test. Draws

are reset to one with a positive drug screen or unexcused absence. In addition, participants can earn extra draws for attending counseling sessions and completing individualized goal activities.

While it has over three decades of research that supports its successful use in substance use treatment, it is severely underutilized. One of the biggest barriers to the use of CM is the stigma that people will game or defraud the system. Studies using contingency management in conjunction with medications for opioid use disorders resulted in increased abstinence at the end of treatment (HHS, 2023).

Other Behavioral Therapies for Opioid Use Disorder Treatment

Dialectal Behavioral Therapy

Dialectal Behavioral Therapy (DBT) teaches people how to regulate their emotions to reduce their self-destructive behaviors driven by extreme, intense emotions. DBT focuses on four skill sets: distress tolerance, emotion regulation, mindfulness, and interpersonal effectiveness. DBT works to reduce cravings, help people avoid situations or triggers to relapse, support them in giving up behaviors that reinforce substance use, and help them learn healthy coping skills (Miller, 2023).

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) helps people recover from traumatic experiences that result in ongoing distress. EMDR uses "dual stimulation" exercises to discuss past trauma while at the same time engaging other parts of the brain through bilateral eye movements, tones, or taps. EMDR helps heal the brain's information-processing system and promotes emotional

stability and symptom reduction. It is extremely effective in treating those with Post-=Traumatic Stress Disorder and other trauma disorders.

Rational Emotive Behavior Therapy

Rational Emotive Behavior Therapy (REBT) helps people identify, challenge, and replace their destructive thoughts and convictions with healthier, adaptive thoughts. It helps people understand their own thoughts and then develop better habits, think in more positive and rational ways, and gain healthier emotions. The foundation of REBT treatment is that rational thinking should come internally and that external situations are not what contribute to a person feeling happy or unhappy.

Seeking Safety

Seeking Safety is a present-focused therapy that helps people establish safety from trauma and substance use disorders through coping skills, grounding techniques, and education. Some of the treatment's key principles are helping people attain safety in their thinking, emotions, behaviors, and relationships, integrating treatment of substance use and trauma, and focusing on establishing ideals to counteract the loss of ideals that are often experienced in both trauma and substance misuse (Miller, 2023).

Matrix Model

The Matrix Model helps people through a combination of various therapeutic techniques. These include rewarding good behaviors and teaching people to believe in themselves with a focus on improving self-esteem, dignity, and self-worth. The Matrix Model's main goal is relapse prevention with the use of family and group therapy, drug education, and self-help participation (Miller, 2023).

The Role of Counseling in Recovery

Counseling plays a pivotal role in recovery. As previously seen, research supports that those who are most successful in treatment receive a combination of medication-assisted treatment, therapy, and psychosocial support.

SAMHSA (2021) recognizes the numerous roles counselors have, including

- Helping people change how they think, cope, react, and build skills and confidence for a successful recovery.
- Providing support and education for people taking medications for OUD.
- Referring people to additional mental and physical health resources for treatment needs.
- Providing counseling services such as CBT, CM, or MI to support OUD treatment and mental health needs.
- Provide case management to connect clients with additional services such as food, housing, income support, legal aid, dental services, transportation, and vocational support.
- Advocate for clients who may be experiencing barriers, bias, and discrimination due to their OUD or OUD medications.

Psychosocial Support and Recovery Resources

Types of Treatment Settings

Depending on the severity of a person's addiction, they may require one type of substance abuse treatment program or multiple types that they will progress through.

Detoxification Treatment

Detoxification programs are medically managed treatment that stabilizes and helps the person manage withdrawal symptoms from drugs or alcohol. These programs can last anywhere from a few days to weeks. Once the person is stabilized and no longer experiencing medically significant withdrawal symptoms, they may choose to transition into an inpatient program.

Inpatient Treatment

Inpatient and residential rehabilitation programs are where people live and receive supervised treatment and structured care plans to overcome and manage their addiction. Some programs have 24/7 monitoring by licensed professionals. Inpatient programs can last anywhere from a few weeks to months. Upon completion of inpatient treatment, the person may choose to transition to outpatient treatment.

Outpatient Treatment

Outpatient programs give people the flexibility to receive treatment and attend therapy on their own time as they do not require an on-site or live-in level of care. Treatment appointments happen regularly and may occur at a substance use treatment center, community health clinic, hospital-affiliated clinic, or other facility. Some outpatient programs offer night and weekend programs, making them easier to attend for those with personal, family, and/or professional responsibilities that may prevent them from attending during regular business hours (Miller, 2023).

Therapeutic Communities (TCs)

TCs are a type of long-term residential program for substance use disorders. The treatment focuses on resocializing people through community-based programs.

The goal of TCs is to establish abstinence from alcohol and other substance use and to enact global lifestyle change, especially around attitudes and values. TCs see disorders as a whole person problem, and that treatment must focus on abstinence as well as social and psychological changes. This is accomplished through a multidimensional treatment, including intensive mutual support, usually in a residential setting. Residential treatment usually lasts six to twelve months (SAMHSA, 2020).

Support Groups and Peer Support

Self-help programs, like Narcotics Anonymous, can be a key support in OUD treatment. Self-help and peer support groups provide support through behavior modification and improved emotional regulation. Group therapy programs can help people learn healthier coping skills and support relapse prevention. Peer support groups help people with OUD understand their disorder, share challenges with others facing similar problems, and support personal improvement and skills for recovery (Cleveland Clinic, 2022).

The 12-step facilitation goal is to promote abstinence through involvement with 12-step peer support groups. Meetings are hosted by different fellowships, such as Alcoholics Anonymous and Narcotics Anonymous (Miller, 2023).

Family Involvement

Family is an important consideration from assessment to treatment through relapse prevention. While each family is unique, they can be a significant support during the recovery process, or they may be a trigger to relapse. Family support can play a large role in helping a family member with their substance and mental health disorders. It is also important to acknowledge that when a family member is experiencing a mental or substance use disorder, it impacts more than just that

individual. Family members may benefit from support groups or family therapy to improve treatment effectiveness and provide support to the whole family. Supporting a loved one with mental health and substance use disorders is challenging and can take a toll on the caregivers. They should be encouraged to see their own physical and mental health care (SAMHSA, 2023).

Educating family members on their loved one's mental health and substance use disorders can lead them to be more understanding and offer support when they see mood or behavior changes. They can be a connection to treatment services and support throughout recovery. Family members may be part of the relapse prevention plan and need to be part of treatment so they can understand their role in the plan (SAMHSA, 2023).

Family members can be reminded of the following when wanting to help a loved one with CODs.

- Express your concern and tell them that you're there to help. Create a judgment-free and loving environment to foster conversation and openness. The earlier a person with OUD can receive treatment, the better.
- Practice empathy even when you may disagree with your loved one, and continue to actively listen to them. The more they feel heard, the more they will see you as someone they can trust.
- Discuss your family history of mental illness or drug and alcohol use. It may help your loved one feel less alone.
- Be patient as you help your loved one locate resources and treatment services. One conversation or action is not going to fix their opioid use; there are no quick fixes.
- Being a caregiver can be highly stressful and emotionally draining; take care of yourself, too. Stress, grief, depression, and isolation are all normal

experiences of friends and family members of people with OUD. Seek out your own support group, community, and mental health care.

- Carry naloxone with you at all times so you can be prepared should your loved one experience an overdose. Most communities now provide free training and prescriptions for naloxone. Many states no longer require a prescription for someone to purchase naloxone from their local pharmacy.
- Seek support if your loved one needs help. If your loved one is threatening or has become a danger to themselves or others, call 911.
- Mental and substance use disorders are treatable. People can and do recover (SAMHSA, 2023; Cleveland Clinic, 2022).

Family members also need support for themselves as caregivers and to have support and validation of the impact the family member with COD has had on the family system. There are multiple community-based and online support groups; examples include Al-Anon/Nar-Anon and Adult Children of Alcoholics. NAMI, the National Alliance on Mental Illness, has Family Support Groups that are more structured and provide a safe space for family members to learn about their loved one's mental illness, find strength in shared experiences, learn coping skills for themselves, and reject guilting feelings one may be caring as a caregiver. NAMI has local groups across the United States and also provides programs via Zoom (NAMI.org, 2023).

Family involvement should be tailored to the needs and preferences of the person in treatment. Some people may welcome and benefit from their family's involvement, while others may have more complex family dynamics that require careful navigation and support from the treatment team.

Community Engagement

Community engagement is defined by the World Health Organization as an ongoing process of developing relationships that enable participants to work together to address health-related issues and promote well-being, which ultimately results in positive health outcomes. Genuine community engagement is not a one-time event but rather an ongoing process that brings together the community's skills, knowledge, and experiences to create solutions that work for all its members. It aims to ensure that people most affected by challenges and inequities have a voice in creating and implementing solutions to accelerate change.

For those working to end the opioid overdose crisis, community engagement means working with different members of the community, including people with lived experience, service providers, law enforcement, and emergency medical services personnel. By doing so, we can improve health outcomes, develop more tailored programs to reach a specific audience, decrease stigma and discrimination, help communities maximize scarce resources, and improve a sense of representation within marginalized communities (SAMHSA, 2023).

Harm Reduction Strategies

Harm reduction is an approach to care that meets people where they are and knows that not everyone is able to or desires to stop their substance use. Instead of judging a person's health and behavior who is struggling with addiction, harm reduction focuses on promoting evidence-based methods for reducing use-associated health risks at this moment in time. Harm reduction is not a set of rules or regulations but a generalized approach that meets each individual where they are and their specific need to improve their quality of life. Harm reduction understands that drug use, abuse, and dependence is a multi-faceted and complex

experience with a spectrum of behaviors ranging from severe abuse to complete abstinence and accepts that some ways of using drugs are safer than others. The focus is on the prevention of harm rather than the prevention of substance use.

The defining feature of harm reduction is its focus on the prevention of harm rather than on the prevention of substance use. Harm reduction initiatives have a broad spectrum, from disease prevention and medical care to education and linkage to addiction treatment (Recovery Research Institute, 2023).

Traditional law enforcement approaches and total abstinence programs do not demand use or the negative consequences of substance use. Instead, harm reduction aims to save lives and protect the health of the people who use it and their communities. Secondary harm reduction goals include decreasing the stigma associated with addiction, improving safer substance use education, promoting protected sex, and connecting people who use drugs with health care, social services, or support groups (Coulson & Hartman, 2022).

Harm reduction is part of a continuum of care. Harm reduction approaches have been proven to prevent substance misuse, overdose, injury, disease, and death. Harm reduction effectively addresses the public health epidemic involving substance use, infectious diseases, and other risks associated with substance use.

SAMHSA (2022) lists the following services that harm reduction programs can provide:

- Connect people to overdose education, counseling, and referrals for infectious disease treatment and substance use disorders services.
- Distribute opioid overdose reversal medications (naloxone) to individuals at risk of overdose or those who might respond to an overdose.

- Lessened risks associated with substance use and related behaviors that raise the chances for infectious diseases, such as viral hepatitis, HIV, and fungal and bacterial infections.
- Reduce infectious disease transmission among individuals who use drugs, including those who use injection drugs, by providing them with accurate information and facilitating referral to resources.
- Reduce overdose deaths, promote linkages to care, and facilitate a comprehensive, integrated approach to services through co-location.
- The lower stigma associated with substance use and co-occurring disorders.
- Promote hope and healing by utilizing those with lived experience of recovery in managing harm reduction services and connecting those who have shown interest in treatment, peer support workers, and other recovery support services.

Overdose Prevention Sites

Overdose prevention sites, also known as supervised consumption centers or supervised injection centers, are legally sanctioned spaces where people can use pre-obtained drugs with medical supervision and intervention available in the event of an overdose. The centers do not provide drugs, and medical staff do not inject users. The sale or purchase of drugs is prohibited on the premises, and many programs have admission criteria such as local residency or require identification cards. Models range from peer-run facilities to mobile units to medical models colocated with addiction treatment programs (Samuels et al., 2022 & Recovery Research Institute, 2023).

Safer-use sites frequently offer multiple additional services, including

- In addition to sterile needles, syringes, and other injection equipment, they provide other disease-prevention materials such as condoms and alcohol swabs.
- Referral to substance use disorder treatment or detox programs, including medication-assisted treatment.
- Referral to medical services, including testing and treatment for HIV, tuberculosis, and/or hepatitis B and C, mental health services, and legal or social services. Some programs provide access to these services onsite.
- Information and education on substance use reduction and related harms, overdose prevention, Naloxone training, prevention of HIV and other sexually transmitted diseases, and safer injection practices.
- Safe drug injection equipment disposal (Recovery Research Institute, 2023).

More than 120 Overdose Prevention Centers exist across 10 European countries, Australia, and Canada. The first supervised injection site in North America opened in 2003 in Vancouver, British Columbia. While there have been unsanctioned overdose prevention centers in the United States, it was not until 2021 that the first government-sanctioned center was opened in New York City. In its first two months of operation, there were close to 6000 visits by 600 different individuals, with 75% reporting they would have otherwise used drugs in a public or semi-public location. There were 125 interventions to prevent overdose risk, including administering oxygen or naloxone for individuals using opioids or providing hydration, cooling, or de-escalation for individuals using stimulants. There were three transportations to emergency departments and no overdose fatalities (Samuels et al., 2022).

Earlier attempts at opening overdose prevention centers met with legal, financial, and logistic challenges due to the potential violation of the federal Controlled Substances Act (Samuels et al., 2022).

Benefits of Overdose Prevention Sites

The Drug Policy Alliance (2022) research reviews of over a hundred peer-reviewed, evidence-based studies have consistently shown the positive impacts overdose prevention centers have. These include:

- Providing medical and social services.
- Increasing entry into substance use disorder treatment.
- Preventing overdose deaths and safely managing onsite overdoses (worldwide, there has not been a single overdose fatality reported at an OPS).
- Providing a safe place, without stigma or fear of criminalization, for people who use drugs to find connection and care.
- Reducing the frequency and amount that clients use drugs.
- Reducing public drug use.
- Reducing syringe and other drug paraphernalia litter.
- Reducing HIV and Hepatitis C risk behaviors such as syringe sharing and unsafe sex.
- Saving costs to the community due to a reduction in disease, overdose deaths, and the need for emergency medical services.

Data from Overdose Prevention Sites globally continue to support their safety and effectiveness in preventing fatal overdoses. In 2010, the Medically Supervised

Injecting Centre was opened in Sydney, Australia. It has since experienced 3,426 overdose events with no deaths. Millions of injections have been supervised in European injection sites with no fatal overdoses. The supervised injection center, Insite, in Vancouver, has overseen 766,486 injections between March 2004 and February 2008, which resulted in 1,004 non-fatal overdoses and zero fatal overdoses (NIH, 2021).

In addition to overdose prevention centers lowering overdose mortality rates (approximately 88 fewer overdose deaths per 100,000 person/year), they also result in 67% fewer ambulance calls for treating overdoses and a decrease in HIV infections (NIH, 2021).

Decriminalization of Possession or Use of Drugs

Most people use drugs without criminal penalty and without developing a substance use disorder (SUD). In 2022, 70.3 million people over the age of 12, in the United States used an illicit drug in the past year. Among those who had used an illicit drug in the past year, 27.2 million met the criteria for a drug-use disorder (SAMHSA, 2023).

Meanwhile, there were 1.5 million drug-related arrests in the United States in 2019, and they were disproportionately among black, indigenous, and Latinx people (Bratburg et al., 2023). People who are marginalized, poor, black, indigenous, or people of color are more likely to experience punishment for drug use, develop SUD, and experience health care discrimination, including receiving less treatment. One can argue that the current policies and structures exacerbate drug-related harms and that decriminalization as a harm reduction strategy would improve patient and community health. Drug decriminalization is not legalized because it does not establish a legally regulated market or supply chain for drug cultivation, production, or sale. The benefits of drug decriminalization include

reducing jail and prison populations, better law enforcement resource utilization, decreased drug use stigma, and removal of barriers to evidence-based harm reduction practices (Bratburg et al., 2023).

One misconception is that decriminalizing drugs will lead to higher drug use and crime rates. However, data from the United States and globally shows that treating problematic drug use as a health issue rather than a criminal issue helps keep communities healthy and safe. Numerous countries have eliminated criminal penalties for drug use and possession without increased societal harm (Bratburg et al., 2023).

In 2021, Oregon decriminalized possession of small amounts of drugs, including heroin (less than 1 gram) and cocaine (less than 2 grams), stating that substance misuse should be treated as a disease rather than a crime. In 2019, Oregon saw 6,700 arrests and 4,000 convictions for drug possession. Between February and August of 2021, there were 1,800 arrests of possession crimes, and 364 courts issued convictions. There has not been a rise in crime, and rates of property crime have actually decreased (Quinton, 2021).

Addressing Relapse and Overdose

Recognizing Signs of Relapse

People with opioid use disorder are at the highest risk for death in the first four weeks of OUD treatment and in the four weeks post-treatment if they experience a relapse. The reason for this is that during treatment, their tolerance has been lowered; if they relapse and use previously tolerated doses, they are at greater risk for overdose if they have not calculated for a reduction in tolerance (Cleveland Clinic, 2022).

Risk factors that raise a person's likelihood of relapse include

- Stress: Stress in any form can be a risk factor. It may be small daily stressors that build up until they feel unmanageable. Or it may be a big event such as the death of a loved one, a divorce, or a promotion (stress does not have to be negative; even positive changes can cause stress).
- Lack of support: Lack of positive support is a risk factor for relapse. Finding positive and sober supports, such as friends, family, co-workers, or 12-step programs, can help maintain recovery.
- Relapsing into patterns of negative thoughts, feelings, and behaviors: Identifying old negative patterns can act as a warning sign when they begin to return. These would be signs to seek out therapy or increase the level of frequency in therapy and with support systems (Watkins, 2024).

Strategies for Preventing Relapse

An effective OUD relapse prevention plan consists of

- Recognizing warning signs: Knowing one's triggers to use involves recognizing internal triggers, such as thoughts and feelings that are associated with using opioids, and external triggers, such as people, places, things, sounds, and smells that trigger a desire to use opioids.
- Know what to do when a warning sign is identified: Having a list of coping skills and support systems are key aspects of a relapse plan. Accessing the skills, activities, and people that are strong supports can create safety and maintain recovery.
- Have a follow-up plan: Access individual or group counseling to support and validate recovery.

- Have a recovery action plan: Develop a routine and schedule that includes work/school, hobbies, and healthy activities to replace the time that drug use took. Finding new things to find satisfaction and pleasure in helps support a sober lifestyle (Watkins, 2024).

Naloxone and Overdose Prevention

Naloxone is the drug used to reverse overdoses and is available as a nasal spray for emergencies and as an injection. Brand names are Kloxxado, Narcan, and Simhi; generic is available (NIDA, 2021 & NIDA, 2022).

Naloxone is a medication that quickly reverses an opioid overdose. As an opioid antagonist, it attaches to opioid receptors and quickly and safely reverses possible fatal effects of opioid overdose. The biggest impact Naloxone can have is that it quickly restores normal breathing to a person experiencing an opioid overdose if their breathing has slowed or stopped. Naloxone does not affect a person who does not have opioids in their system. It is not a treatment for opioid use disorder outside of its emergency response to an opioid overdose. Targeted distribution programs train and equip people who are most likely to interact with someone experiencing an overdose with naloxone kits. Effective strategies include community distribution programs, co-prescribing Naloxone, and equipping first responders (NIDA, 2022 & CDC, 2018).

Pre-packaged nasal spray such as Narcan is available for substance users, friends, family, and community members. It is a nasal spray administered in one nostril while the person is lying on their back and does not require any special training to use. 911 should still be immediately called when an overdose is suspected, even if Naloxone is administered successfully. Naloxone is only able to reverse opioid overdose for 30 to 90 minutes. As many opioids can remain in the body for longer than this, the person can experience an overdose again as the Naloxone wears off.

Also, some opioids are stronger or a higher amount was consumed and will require more than one dose of Naloxone to reverse the overdose. People given Naloxone should be monitored for a minimum of two hours after their last dose of Naloxone is given to ensure breathing does not slow or stop (NIDA, 2022).

Naloxone should be given to anyone who shows signs of an opioid overdose or when an overdose is suspected. NIDA (2022) list the following signs of an opioid overdose:

- unconsciousness
- very small pupils
- slow or shallow breathing
- vomiting
- an inability to speak
- faint heartbeat
- limp arms and legs
- pale skin
- purple lips and fingernails

People with physical dependence on opioids may have withdrawal symptoms within minutes after being given Naloxone. NIDA (2022) lists the following withdrawal symptoms

- headaches
- sweating
- blood pressure changes

- rapid heart rate
- nausea
- vomiting
- tremors

While these symptoms are unpleasant, they are not usually life-threatening. The risk of death for someone experiencing an opioid overdose is greater than the risk of having a negative reaction to Naloxone (NIDA, 2022).

Opioid overdose education and community Naloxone distribution are effective in reducing overdose deaths. Overdose education and naloxone training programs teach people the risk factors for opioid overdose, such as mixing opioids with other sedatives, drug potency considerations, high dosage of prescription opioids versus using opioids alone, to recognize the signs of opioid overdose, and how to administer overdose reversal medication during an opioid overdose (Recovery Research Institute, 2023).

Naloxone policies have been implemented by some states to increase access to Naloxone. This increased access is not only for people who misuse substances but also for other professionals and medical providers, and more states are providing training and access to community members (Atkins et al., 2019).

Research shows that co-prescribing Naloxone when prescribing opioids can reduce opioid-related emergency room visits and reduce the number of prescribed opioid overdoses and deaths. Despite this, only one Naloxone prescription is given for every seventy high-dose opioid prescriptions. Furthermore, rural counties are almost three times more likely to be ranked as low dispensing compared to urban counties (CDC, 2022).

In the United States, 80% of overdose reversals using Naloxone were administered by people who used drugs (CDC, 2018).

An Ohio study found training and distributing Naloxone to law enforcement officers reduced opioid overdose deaths and increased survival rates.

The Massachusetts Department of Public Health Overdose Education and Naloxone Distribution Program found that family members of persons at risk of overdose made up close to 30% of the program's enrollees and provided 20% of all recorded rescue attempts. While the person took the training to provide rescue Naloxone to their family member, some of the recorded rescues were performed on someone other than their relative. These results indicate that Naloxone distribution across families and social networks can have lifesaving effects throughout the community (CDC, 2018).

Emergency Response to Overdose

The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified five essential steps for first responders in their Opioid Overdose Prevention Toolkit (2018); they are as follows.

Step 1: Evaluate for Signs of Opioid Overdose

The following overdose signs may lead to imminent death if the overdose is not treated immediately.

The person

- Is unconscious, or is difficult to wake up
- Has shallow or slow breathing or is having difficulties breathing, such as choking sounds or gurgling sounds

- Has blue or purple fingernails or lips

The first responder should stimulate the person by

- Calling the person's name
- Vigorously grind knuckles into the breastbone of the person or rubbing knuckles on the person's upper lip
- If the person responds to stimulation, can they maintain breathing and responsiveness?
- Continue to monitor the person for breathing and alertness; keep them alert and awake.

If the person does not respond to the above

- Call 911
- Provide rescue breathing if they are not breathing on their own
- Administer one dose of naloxone

Step 2: Call 911 for Help

An opioid overdose requires medical attention as soon as possible. If there are no emergency medical services at the scene of the overdose, 911 should be called immediately. The first responder can simply say, "Someone is unresponsive and not breathing," and give the address or description of the location. The 911 dispatcher will then give additional instructions based on the information they are given; for example, they may instruct the first responder to begin CPR.

Step 3: Administer Naloxone

If the person does not respond to the first dose of naloxone in two to three minutes, a second dose of naloxone should be administered.

Naloxone should be administered to anyone who shows signs of or is suspected of an opioid overdose. Naloxone is approved by the FDA and has been used successfully for decades by EMS to reverse and resuscitate people who have an opioid overdose. Naloxone is most likely to be given as an intranasal spray by general public first responders. Medical first responders may administer naloxone by intranasal spray or by injection (it may be given intramuscularly, subcutaneously, and intravenously). Overdoses involving longer-acting, higher quantities or potency drugs may require multiple doses of naloxone to reverse the opioid effects. For example, fentanyl's higher potency often requires multiple doses of naloxone to reverse the overdose, and the person is more likely to need rescue breathing to maintain their oxygen.

The duration of naloxone's effects depends on the dose, the administration route, and the overdose symptoms. The goal of naloxone administration is to restore the person's breathing; this may not result in the person's complete arousal. The withdrawal triggered by administering naloxone can be very unpleasant; the person being treated should be comforted and reassured. Some people may be confused or agitated and need to have someone explain to them what happened.

Naloxone is a safe drug to use, and even if accidentally administered to someone who is not experiencing an overdose, it will not result in any clinical effects. When given to a person who is opioid-tolerant and experiencing an overdose, the withdrawal symptoms, while unpleasant, are not life-threatening.

The FDA has approved multiple ways to administer naloxone. They are:

- Spray: The nasal spray is a needle-free, prefilled device that does not require any assembly and can be administered into one nostril in a single dose. The nasal spray comes in a two-dose package should a follow-up dose of naloxone is needed.
- Auto-injector: The auto-injector is turned on, and the device then provides audio instructions on how to deliver the medication, similar to an AED machine. The naloxone is injected into the outer thigh, either into the muscle (intramuscular) or under the skin (subcutaneous). This also comes in a two-pack for a repeat dose to be given if needed.
- Injectable: This naloxone comes in a vial along with a needle and syringe. People who receive these kids should receive training on how to assemble and administer the naloxone to the person overdosing.

All naloxone products have an expiration date. Dates should be checked regularly and replaced as needed.

Studies have shown that women, older people, and people without obvious signs of opioid use have higher death rates as they are less likely to be treated with naloxone. Any person, including women and the elderly, found unresponsive should be considered as experiencing an opioid overdose and administered naloxone.

Step 4: Support the Person's Breathing

Ventilatory support, such as rescue breathing and chest compressions, are important interventions that, on their own, can be lifesaving, even in the absence of naloxone. Rescue breathing is effective in supporting respiration, and chest compressions provide ventilatory support.

Adult rescue breathing involves the following steps:

- Check that the person's airway is clear and that nothing inside their mouth or throat is blocking their airway.
- Place one hand on the person's chin, tilt their head back, and pinch their nose closed.
- Place your mouth over the person's mouth, creating a seal, and give two slow breaths.
- Watch for the person's chest to rise, not their stomach.
- Follow up with one breath every 5 seconds.

Chest compressions for adults involve the following steps:

- Place the person on their back and on a firm surface if possible.
- Press hard and fast on the center of the chest.
- Keep your arms extended.

Step 5: Monitor the Person's Response

Post-overdose treatment, the person needs to be monitored for at least four hours after their last dose of naloxone for any recurring signs and symptoms of opioid toxicity. People who have overdosed on long-acting opioids should be monitored for a longer time period.

Most people respond by returning to independently breathing for themselves. This response usually happens within 2 to 3 minutes of naloxone administration. Resuscitation should be continued while waiting for the naloxone to take effect.

Naloxone does have a relatively short duration of effect, which may cause overdose symptoms to return. Even if the person revives after a dose of naloxone

and appears to feel better, they should still seek medical care immediately at an emergency department or other medical care services.

The signs and symptoms of opioid withdrawal in a person who is physically dependent on opioids may include body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection (gooseflesh), sweating, nausea or vomiting, yawning, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, tearing, insomnia, opioid craving, dilated pupils, and increased blood pressure. These symptoms are uncomfortable but not life-threatening. After an overdose, a person dependent on opioids should be medically monitored for safety and offered assistance to get into treatment for opioid use disorder.

If a person does not respond to naloxone, other clinical symptoms should be considered, and an alternative explanation should be sought. The person is most likely not overdosing on an opioid but rather some other substance, or they are experiencing a non-overdose medical emergency. In either case, if the response to naloxone does not happen quickly in the two to three-minute timeframe, supporting the person with oxygenation, ventilation, and blood pressure will help prevent complications of opioid overdose and support the person if they are experiencing a medical emergency.

Do's and Don'ts When Responding to an Opioid Overdose

- DO assess and support the person's breathing and cardiovascular needs through oxygen administration or providing rescue breathing and/or chest compressions.
- DO administer naloxone and provide a second dose if the person does not respond to the first dose of naloxone within a short period of time.

- DO place the person in the “recovery position” on their side if they must be left unattended for any reason.
- DO stay with the person and keep them warm.
- DON’T slap or try to stimulate the person forcefully; this will only cause further injury. If the person does not wake up by shouting, rubbing your knuckles on their sternum, or light pinching them, the person may be unconscious.
- DON’T place the person into a cold shower or bath. This will increase their risk of falling, drowning, or going into shock.
- DON’T inject the person with any substance (milk, salt water, or stimulants). The only appropriate and safe treatment is providing naloxone.
- DON’T induce the person to vomit the drugs they may have ingested. Choking or inhaling vomit into the lungs can cause a fatal injury.

Cultural Competence and Stigma Reduction

Cultural Considerations in Opioid Use Disorder

Disparities in healthcare continue to be widespread and are particularly detrimental in the assessment and treatment of opioid use disorder. Healthcare disparities can come from systems, providers, and patients. The APA (2023) states they can involve:

- Explicit and implicit provider biases, ex. The misconception is that African Americans experience less pain or have a greater tendency to addiction.

- Assuming patients have low health awareness and limited English fluency, those who lack understanding of medication instructions will be less compliant and then label those patients as non-compliant.
- Lower rate of buprenorphine treatment among people of color when compared to higher-income caucasian peers.
- Lack of culturally specific programs and services.
- Patients may be reluctant to seek professional services due to concerns about misdiagnosis, cultural mistrust, and cultural norms that may be counter to medical treatment.
- Greater reluctance among some groups of people to report opioid use due to fear of criminal prosecution or losing parental rights (people of color experience punitive criminal justice outcomes at a higher rate than other groups of people).

Given the above examples and other biases, consideration must be given to integrated approaches to treatment and the interactions between race, ethnicity, cultural context, geography, and socioeconomic status.

Providers should be aware of possible barriers to treatment for racial and ethnic minorities.

Barriers may include

- Lack of adequate medical insurance
- Health system policies (hours of operation, cost, location of services)
- Provider bias toward certain groups or a lack of cultural humility
- Lack of culturally specific services

- Patient hesitation to seek or accept professional intervention due to concerns regarding misdiagnosis, cultural mistrust, and cultural norms that may be inconsistent with treatment (self-reliance, a focus on religion).
- Disparities in the risk of criminal justice involvement for opioid misuse can result in concerns among people of color about confidentiality and the consequences of self-disclosure to a provider (APA, 2023).

Providers should assess patients' beliefs and expectations regarding opioid use disorder treatment.

Providers can

- Enhance the standard intake and assessment with additional questions about treatment preferences and barriers to treatment and adherence, and provide feedback during the initial meeting.
- Knowledge of factors that may influence the care of racial or ethnic minority patients with opioid use disorder contributes to the accurate cultural formulation of cases, proactive addressing of barriers, and satisfactory clinical encounters.
- Assessment items might include: "Describe your experience in health care settings. Overall, have they been positive or negative?" "What would you expect from another medication to help reduce your use of opioids?" Normalizing language intended to assess barriers can also be used, including "Some people may be worried about using a new medication to help them stop using opioids. What do you think?" Such questions can help providers determine whether potential ethnocultural concerns are relevant for individual patients (APA, 2023).

Providers should deliver culturally appropriate care for opioid use disorder. Culturally competent clinicians are aware of their own biases and stereotypes, as

well as cultural factors that may influence patients' opioid use, maintenance, abstinence, and relapse. Culturally competent providers seek to gain the knowledge and skills to address these individual difference variables. Provider–patient communication should follow a shared decision-making model to reduce unmet provider communication needs and increase adherence. Shared decision-making processes should include significant others where appropriate (family members, religious leaders) (APA, 2023).

Reducing Stigma and Discrimination

Stigma is often experienced on three different levels. Institutional stigma exists at a systems level and is experienced through rules, policies, and practices that limit the opportunities and resources for the stigmatized group. Public stigma is stereotypes and negative attitudes that are experienced as prejudice and discrimination. Self-stigma is the negative thoughts and emotions that an individual experiences from being part of a stigmatized group and the negative impact it has on the person's mental health, physical well-being, and behavior. Each level of stigma reinforces the other. It is possible to identify sources at each level of opioid use stigma, how they impact access to treatment, and possible strategies at each level to reduce stigma (Cheetham et al., 2022).

The source of institutional stigma includes inadequate funding, labeling people as less worthy of care, the separation of substance use treatment from mental and physical health treatment, lack of coordination among services, and laws and regulations that limit access to evidence-based treatments. The impact of the stigmas at the institutional level results in underfunded and fragmented care, barriers to evidence-based treatment expansions, restrictive and coercive treatment policies, discriminative responses to chronic pain patients, and stigmatizing language in government and organization policies. Strategies to

address these institutional issues include population-level anti-stigma campaigns, removing regulatory barriers to prescribing medication for OUD, a new model of care for medication for OUD, increasing patient involvement in service planning and delivery, and using person-centered language in policy and procedures (Cheetham et al., 2022).

The sources of public stigma include provider-based stigma, peer support, mutual aid, and the public. The impact of the stigma at the public level includes poor clinical practices in medication for OUD treatment and delivery, narrow perception of who benefits from harm reduction, exclusion of MAT patients from 12-step programs, and lack of support for public health policies vs. punitive policies. Strategies to address public stigma include provider education and training and Opt-out of naloxone (Cheetham et al., 2022).

The source of self-stigma includes interpersonal and intrapersonal relationships. The impact of self-stigma includes delays in help-seeking, disconnection, increased mortality and morbidity, fewer consumer advocates, and fewer stories of home. The main strategy to address this is contact-based interventions (Cheetham et al., 2022).

Stigma and Misconception of Harm Reduction

Enables or Condones Illicit Drug Use

Harm reduction accepts that some people engage in substance use and risky behaviors. There is no judgment for those choices, but this does not mean that those decisions are encouraged. It acknowledges that there are real harms and risks associated with those behaviors, and it does not try to minimize the impact of those choices.

"Opponents sometimes argue that giving people sterile syringes, clean pipes, naloxone, a space to use drugs under supervision, etc., incentivizes drug use or leads to drug use. But people are going to use drugs whether they have these resources or not, and so withholding them doesn't prevent that use; it just makes it more dangerous. Making an activity more dangerous doesn't stop people who are committed to engaging in that activity; it just hurts and kills more of them." Travis Rieder, Ph.D., MA, Associate Research Professor at the Johns Hopkins Berman Institute of Bioethics (Coulson & Hartman, 2022).

Harm reduction does not enable drug use. Instead, it replaces coercion with compassion.

Prevents People from Getting Help

Harm reduction does not prevent or oppose abstinence. The main goal of harm reduction is to keep people alive and as healthy as possible. It often connects people with recovery resources that support sobriety or abstinence. Harm reduction does not exclusively champion treatment or recovery; instead, it gives people information to choose less harmful ways of engaging in a range of risky behaviors. Some individuals with substance use disorders choose to enter treatment, some benefit from medication-assisted treatment, and any of these safer options result in improved health outcomes and, many times, increase the likelihood of long-term recovery (Saleh et al., 2021).

Harm reduction is "both a social movement and a way to provide services, and it includes drug treatment. Harm reduction is not only useful in and of itself, but it also brings people into services who may not otherwise come into services." Susan Sherman, Ph.D., MPH, a professor at John Hopkins Health, Behavior and Society (Coulson & Hartman, 2022).

It Makes Neighborhoods Less Safe

Not In My Backyard attitudes fear harm reduction programs will increase substance use and crime in their communities. Harm reduction programs do not increase crime in their communities. Rather, they often improve community safety and cleanliness. Syringe service programs decrease improper needle disposal, which helps prevent accidental needle sticks. Similarly, supervised consumption centers decrease public space drug use (Saleh et al., 2021).

Harm Reduction is Unnecessary, Eliminate Drugs & Dealers

Attempts to interrupt or terminate the supply chain of illegal drugs have not been successful. Prohibition policies have had harmful effects on individuals and communities. People have engaged in risky behaviors throughout history and will continue to do so in the future. Harm reduction offers realistic and practical solutions that help keep individuals and communities safer by minimizing health harms (Saleh et al., 2021).

Building an Inclusive and Supportive Treatment Environment

Treatment is effective and must be more accessible for those who need it, and the treatment gap must come down. The “Treatment Cascade” concept suggests that the more people are successfully diagnosed, enter treatment, and receive tailored evidence-based treatment, the more people will enter long-term recovery (The White House, 2022).

Low-threshold programs make it easier to get access and participate in treatment; this can include hospital clinics, telemedicine programs, mobile methadone treatment, and other programs that do not require people to “jump through hoops” to begin treatment. Historically, drug use has been grounds for dismissal from a treatment program. Providers are learning that being flexible and

accommodating people who are willing to stop opioid use but not all other drugs improves overall treatment and reduces overdose risks and deaths. Providers can educate people about the risks of using other drugs and the precautions necessary when using benzodiazepines while on buprenorphine and help determine if being on buprenorphine outweighs the risks of co-use (The White House, 2022).

Legal and Ethical Considerations

Regulations Governing Opioid Use Disorder Treatment

In 2001, Part 8 of Title 42 of the Code of Federal Regulations went into effect and included the requirements for opioid treatment programs (OTPs). Only federally accredited and certified OTPs can dispense methadone for OUD treatment. Dispensing buprenorphine does not require OTPs to have a federal waiver. However, individual healthcare providers must have a waiver if they are prescribing buprenorphine. There are no regulations for prescribing naltrexone beyond being an authorized prescribing provider for any drug or medication (SAMHSA, 2021).

In February 2024, the U.S. Department of Health and Human Services (HHS), in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), released the revised regulations to go into effect in October 2024. The main areas of revision focused on increasing access to evidence-based medications for opioid use disorder and addressing treatment retention by promoting compassionate, patient-centered interventions. Revisions also promoted practitioner autonomy, removing stigmatized and outdated language, supporting patient-centered interventions, and reducing barriers to care (SAMHSA, 2024).

During COVID-19, numerous regulations were temporarily revised so people could continue to access care. Some of these temporary revisions removed barriers and increased access to care. For example, the provision of take-home doses of methadone, using telehealth to prescribe buprenorphine, and allowing nurse practitioners and physician assistants the ability to prescribe medications for opioid use disorder. These temporary flexibilities resulted in positive impacts on recovery and are now being made permanent.

Previous OTP admission criteria required the person to have one year of opioid addiction before admission. For those under 18, they must have two unsuccessful treatments before admission to an OTP. The updated regulations allow admission based on a person's problematic pattern of opioid use; there is no longer a timeframe for adults nor a failure number for minors (SAMHSA, 2024).

The final rule can be read in its entirety at: https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-treatment-of-opioid-use-disorder.

Opioid treatment programs are expected to comply with the updated regulations by October 2, 2024. Programs and providers must continue to comply with their state regulations. For example, while the new regulations do allow for nurse practitioners and physician's assistants to prescribe medications for opioid use disorder, some states do not allow this (SAMHSA, 2024).

Ethical Dilemmas in Treatment, Confidentiality, and Privacy

Many of the ethical dilemmas surrounding opioid use disorder are related to barriers to care that prevent or limit access to evidence-based treatment. Some of the ethical considerations follow

Stigma: There are high levels of stigma toward individuals with OUD and toward medications to treat OUD, both among the general public and among professionals. Stigma toward people with OUD is broadly intertwined with persistent stigma (including labeling, stereotyping, status loss, and discrimination) that occurs on the basis of race and social class in the United States. Historically, U.S. drug policies have disproportionately targeted already marginalized groups. Increasing attention has focused on the role of language in reinforcing stigma about OUD. Terms such as “opioid abuser” are being replaced with person-centered terms like “person with an opioid use disorder.”

Medicated-Assisted Treatment: There is a misunderstanding and lack of education about medication for OUD treatment. Some providers continue to believe that MAT is replacing one drug for another and that the person being prescribed a medication for OUD will abuse that drug as well. This has historically led to fewer people being prescribed medications to treat their OUD. Most people report using the medication to manage withdrawal symptoms and cravings and not as a means of intoxication.

Lack of Professional Training: Addiction treatment is typically separate from mainstream health systems, and education about OUD is often neither required nor standardized for health care providers in the United States. Integrating addiction treatment into mainstream physical health & mental health systems could expand treatment capacity and improve providers' education about addiction medicine. For many people with OUD, treatment decisions often occur in the law enforcement and judicial systems rather than in medical settings. Once again, no policies are in place to require that the people making these decisions have received any education about evidence-based OUD treatment.

Legal and Regulatory Barriers for Prescribing OUD Medication: There are numerous laws, regulations, accreditations, and waivers prescribers and

organizations must meet to prescribe medications for OUD. While there should be safety requirements in place, providers should also have a streamlined process to prescribe and provide MAT, allowing for a wider range of medical settings or organizations to provide medication services.

Privacy Regulations: Programs that receive federal funding can not legally disclose a patient's substance use disorder diagnosis or that they are in treatment without explicit patient consent or a court order. While this protection may encourage a person to seek treatment knowing it will be private, it further isolates addiction treatment as without patient consent; care coordination can not be made with the person's primary care physician, mental health provider, or other providers who may benefit and provide support to substance use treatment. An additional issue surrounding privacy is if the person is receiving treatment in the provider's office, their medications may be tracked through the Prescription Drug Monitoring Programs (PDMPs) that record prescribed controlled substances, so the vast majority of patients who are maintained on buprenorphine have their treatment status disclosed without their consent.

Insurance Barriers: Often, a person's ability to access medication for OUD is determined by insurance coverage. States and insurance companies can choose to exclude certain services. For example, five states do not allow Medicaid to cover buprenorphine or methadone treatment (Mancher & Leshner, 2019).

Conclusion

Opioid Use Disorder (OUD) is an urgent health crisis that has reached epidemic levels, impacting individuals, families, and their communities. Opioid use disorder affects more than 3 million people in the United States, and yet only one in four access treatment. The stigma around OUD and its treatment results in people not accessing the help they need. Not only individuals but also providers, community

members, and stakeholders need to be educated so that evidence-based treatment can be provided. Addressing systems-level barriers will enable people with opioid use disorder to access compassionate person-centered services.

Communities can support harm reduction services as they show positive results in reducing the frequency of use, preventing overdoses, improving community safety, and even having economic benefits. When providers have a clear understanding of opioid use disorder, they can improve individualized treatment care, which then leads to more effective outcomes. As a result of improved education and reduced stigma, individuals, communities, and the health care system can together address and eliminate the opioid epidemic.

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Appendix A: Glossary of Terms

Center for Disease Control and Prevention: Commonly Used Terms

Retreived February 2024. https://www.cdc.gov/opioids/basics/terms.html

Acute Pain – Pain that usually starts suddenly and has a known cause, like an injury or surgery. It normally gets better as your body heals and lasts less than three months.

Analgesics – Pain relieving medications including over-the-counter medications like acetaminophen (Tylenol®) or ibuprofen (Advil®) and prescription opioids.

Analog – Drugs that are similar in chemical structure or pharmacologic effect to another drug, but are not identical.

Benzodiazepines – Sometimes called "benzos," these are sedatives often used to treat anxiety, insomnia, and other conditions. Combining benzodiazepines with opioids increases a person's risk of overdose and death.

Chronic pain – Pain that lasts 3 months or more and can be caused by a disease or condition, injury, medical treatment, inflammation, or an unknown reason.

Drug misuse – The use of illegal drugs and/or the use of prescription drugs in a manner other than as directed by a doctor, such as use in greater amounts, more often, or longer than told to take a drug or using someone else's prescription.

Drug addiction – The preferred term is substance use disorder. When referring to opioids, see the Opioid Use Disorder (OUD) definition below and text box discussing the difference between "tolerance," "dependence," and "addiction."

Extended-release/long-acting (ER/LA) opioids – Slower-acting medication with a longer duration of pain-relieving action.

Fentanyl – Pharmaceutical fentanyl is a synthetic opioid, approved for treating severe pain, typically advanced cancer pain. It is 50 to 100 times more potent than morphine. However, illegally made fentanyl is sold through illicit drug markets for its heroin-like effect, and it is often mixed with heroin or other drugs, such as cocaine, or pressed in to counterfeit prescription pills.

Heroin – An illegal, highly addictive opioid drug processed from morphine and extracted from certain poppy plants.

Illicit drugs – The nonmedical use of a variety of drugs that are prohibited by law. These drugs can include: amphetamine- type stimulants, marijuana/cannabis, cocaine, heroin, other opioids, and synthetic drugs, such as illicitly manufactured fentanyl (IMF) and ecstasy (MDMA).

Immediate-release opioids – Faster-acting medication with a shorter duration of pain-relieving action.

Medication-assisted treatment (MAT) – Treatment for opioid use disorder combining the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

Methamphetamine – A highly addictive central nervous system stimulant that is also categorized as a psychostimulant. Methamphetamine use has been linked to mental disorders, problems with physical health, violent behavior, and overdose deaths. Methamphetamine is commonly referred to as meth, ice, speed, and crystal, among many other terms.

Morphine milligram equivalents (MME) – The amount of milligrams of morphine an opioid dose is equal to when prescribed. Calculating MME accounts for differences in opioid drug type and strength.

Naloxone – A drug that can reverse the effects of opioid overdose and can be life-saving if administered in time. The drug is sold under the brand name Narcan or Evzio.

Narcotic drugs – Originally referred to any substance that dulled the senses and relieved pain. Some people use the term to refer to all illegal drugs but technically, it refers only to opioids. Opioid is now the preferred term to avoid confusion.

Nonmedical use – Taking prescribed or diverted prescription drugs (drugs not prescribed to the person using them) not in the way, for the reasons, in the amount, or during the time-period prescribed.

Non-opioid therapy – Methods of managing pain that does not involve opioids. These methods can include, but are not limited to, acetaminophen (Tylenol®) or ibuprofen (Advil®), cognitive behavioral therapy, physical therapy, acupuncture, meditation, exercise, medications for depression or for seizures, or interventional therapies (injections).

Non-pharmacologic therapy – Treatments that do not involve medications, including physical treatments (e.g., exercise therapy, weight loss) and behavioral treatments (e.g., cognitive behavioral therapy).

Opioid – Natural, synthetic, or semi-synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain. This class of drugs includes the illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Prescription opioids are generally safe when taken for a short time and as directed by a doctor, but because they produce euphoria in addition to pain relief, they can be misused and have addiction potential.

- Opiates" vs. "opioids" Although these terms are often used interchangeably they are different:
    - Opiates refer to natural opioids such as heroin, morphine and codeine.
    - Opioids refer to all natural, semisynthetic, and synthetic opioids.

Opioid analgesics – Commonly referred to as prescription opioids, medications that have been used to treat moderate to severe pain in some patients. Categories of opioids for mortality data include:

- Natural opioid analgesics, including morphine and codeine;
- Semi-synthetic opioid analgesics, including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
- Methadone, a synthetic opioid that can be prescribed for pain reduction or for use in MAT for opioid use disorder (OUD). For MAT, methadone is used under direct supervision of a healthcare provider;
- Synthetic opioid analgesics other than methadone, including drugs such as tramadol and fentanyl.

Opioid use disorder (OUD) – A problematic pattern of opioid use that causes significant impairment or distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria. Opioid use disorder is preferred over other terms with similar definitions, "opioid abuse or dependence" or "opioid addiction."

Overdose – Injury to the body (poisoning) that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.

Physical dependence – Adaptation to a drug that produces symptoms of withdrawal when the drug is stopped.

Prescription drug monitoring programs (PDMPs) – State or territorial-run electronic databases that track controlled substance prescriptions. PDMPs help providers identify patients at risk of opioid misuse, opioid use disorder, and/or overdose due to overlapping prescriptions, high dosages, or co-prescribing of opioids with benzodiazepines.

Tolerance – Reduced response to a drug with repeated use.

Opioid tolerance occurs when a person using opioids begins to experience a reduced response to medication, requiring more opioids to experience the same effect.

Opioid dependence occurs when the body adjusts its normal functioning around regular opioid use. Unpleasant physical symptoms occur when medication is stopped.

Opioid addiction (Opioid use disorder (OUD)) occurs when attempts to cut down or control use are unsuccessful or when use results in social problems and a failure to fulfill obligations at work, school, and home. Opioid addiction often comes after the person has developed opioid tolerance and dependence, making it physically challenging to stop opioid use and increasing the risk of withdrawal.

Appendix B: Screening Tools SOAPP-R

SOAPP-R Retrieved February 2024. https://www.uptodate.com/contents/image?imageKey=ANEST/108384

Revised Screener and Opioid Assessment for Patients with Pain (SOAPP-R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very often
	0	1	2	3	4
1. How often do you have mood swings?	[ ]	[ ]	[ ]	[ ]	[ ]
2. How often have you felt a need for higher doses of medication to treat your pain?	[ ]	[ ]	[ ]	[ ]	[ ]
3. How often have you felt impatient with your doctors?	[ ]	[ ]	[ ]	[ ]	[ ]
4. How often have you felt that things are just too overwhelming that you can't handle them?	[ ]	[ ]	[ ]	[ ]	[ ]
5. How often is there tension in the home?	[ ]	[ ]	[ ]	[ ]	[ ]
6. How often have you counted pain pills to see how many are remaining?	[ ]	[ ]	[ ]	[ ]	[ ]

7. How often have you been concerned that people will judge you for taking pain medication?	[ ]	[ ]	[ ]	[ ]	[ ]
8. How often do you feel bored?	[ ]	[ ]	[ ]	[ ]	[ ]
9. How often have you taken more pain medication than you were supposed to?	[ ]	[ ]	[ ]	[ ]	[ ]
10. How often have you worried about being left alone?	[ ]	[ ]	[ ]	[ ]	[ ]
11. How often have you felt a craving for medication?	[ ]	[ ]	[ ]	[ ]	[ ]
12. How often have others expressed concern over your use of medication?	[ ]	[ ]	[ ]	[ ]	[ ]
13. How often have any of your close friends had a problem with alcohol or drugs?	[ ]	[ ]	[ ]	[ ]	[ ]
14. How often have others told you that you had a bad temper?	[ ]	[ ]	[ ]	[ ]	[ ]
15. How often have you felt consumed by the need to get pain medication?	[ ]	[ ]	[ ]	[ ]	[ ]
16. How often have you run out of pain medication early?	[ ]	[ ]	[ ]	[ ]	[ ]
17. How often have others kept you from getting what you deserve?	[ ]	[ ]	[ ]	[ ]	[ ]

18. How often, in your lifetime, have you had legal problems or been arrested?	[ ]	[ ]	[ ]	[ ]	[ ]
19. How often have you attended an AA or NA meeting?	[ ]	[ ]	[ ]	[ ]	[ ]
20. How often have you been in an argument that was so out of control that someone got hurt?	[ ]	[ ]	[ ]	[ ]	[ ]
21. How often have you been sexually abused?	[ ]	[ ]	[ ]	[ ]	[ ]
22. How often have others suggested that you have a drug or alcohol problem?	[ ]	[ ]	[ ]	[ ]	[ ]
23. How often have you had to borrow pain medications from your family or friends?	[ ]	[ ]	[ ]	[ ]	[ ]
24. How often have you been treated for an alcohol or drug problem?	[ ]	[ ]	[ ]	[ ]	[ ]

Please include any additional information you wish about the above answers.

Thank you.

* As of 2019, Inflexxion, Inc. is part of Integrative Behavioral Health, Inc.

Appendix C: Screening Tools: DAST-10

DAST-10 Retrieved April 2024

https://gwep.usc.edu/wp-content/uploads/2019/11/DAST-10-drug-abuse-screening-test.pdf

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	**No**	**Yes**
1. Have you used drugs other than those required for medical reasons?		
2. Do you abuse more than one drug at a time?		
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."		
4. Have you had "blackouts" or "flashbacks" as a result of drug use?		

5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose “No.”		
6. Does your spouse (or parents) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?		

Interpreting the DAST 10

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point. DAST-10 Score Degree of Problems Related to Drug Abuse Suggested Action.

DAST-10 Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation

6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Skinner, H. A. (1982). The Drug Abuse Screening Test. Addictive Behavior, 7(4),363–371.

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