



# Opioid Addiction Identification & Medication for Opioid Use Disorder (MOUD)



This continuing education course, offered by DC Health/Government of the District of Columbia in collaboration with Dr. Edwin Chapman and Innovation Horizons LLC, aims to equip healthcare professionals with essential knowledge and practical tools to tackle the opioid crisis effectively. Tailored for prescribers, pharmacists, and allied health workers, this course offers 1.5 credits and empowers participants to adeptly screen, diagnose, and manage opioid use disorder.



Introduction



Understanding Addiction




Screening and Assessment




Introduction to Medication for Opioid Use Disorders (MOUD)



Understanding Methadone Treatment

 **Understanding Buprenorphine Treatment**

 **Patient Engagement and Counseling**

 **Resources and Support Systems**

# Introduction

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**Justin Ortique PharmD, RPh, CPM**

**A Welcome from the Executive Director of the District of Columbia Board of Pharmacy, Program Manager of Pharmaceutical Control Division, Health Regulation and Licensing Administration for the DC Department of Health**



**Edwin C. Chapman, MD, Course Director**



Dr. Chapman is an accomplished internal medicine and addiction medicine practitioner with over 45 years of experience in Washington DC. His extensive expertise encompasses various roles, including serving as a founding member of the Leadership Council for Healthy Communities. Dr. Chapman is dedicated to advancing integrated medical care in underserved communities and faith institutions. He has contributed significantly to the field through published research and congressional testimonies, advocating for improved access to treatment for opioid use disorder

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**Before delving into the course content,  
let's first address some common  
misconceptions about opioid use  
disorder.**

**DISPELLING MYTHS**

In this segment, we aim to address common misconceptions and myths surrounding opioid addiction and treatment to enhance your understanding as a healthcare provider. Despite advancements in medical knowledge, myths and misconceptions about opioid addiction persist, leading to stigma and barriers to effective treatment.

**Please select each of the flip cards below** to reveal the truth regarding some common misconceptions and use the **arrows to advance** to the next card. Thank you.

MYTH OR FACT  
***Addiction is a choice.***

***Addiction is a complex medical condition influenced by genetic, environmental, and social factors. It is not simply a matter of choice.***

MYTH OR FACT

***People who are addicted to opioids are morally weak or lacking willpower.***

***Addiction is a brain disorder that affects decision-making, impulse control, and judgment. It is not a reflection of moral character or willpower.***

MYTH OR FACT

***Opioid addiction only affects certain demographics or socioeconomic groups.***

***Opioid addiction can affect individuals from all walks of life, regardless of age, gender, race, or socioeconomic status.***

MYTH OR FACT

4 of 5

**MOUD is an evidence-based treatment approach that helps**

MYTH OR FACT

**People with opioid addiction cannot recover or lead productive lives.**

**With proper treatment and support, individuals with opioid addiction can achieve and sustain recovery, leading fulfilling and productive lives.**

5 of 5

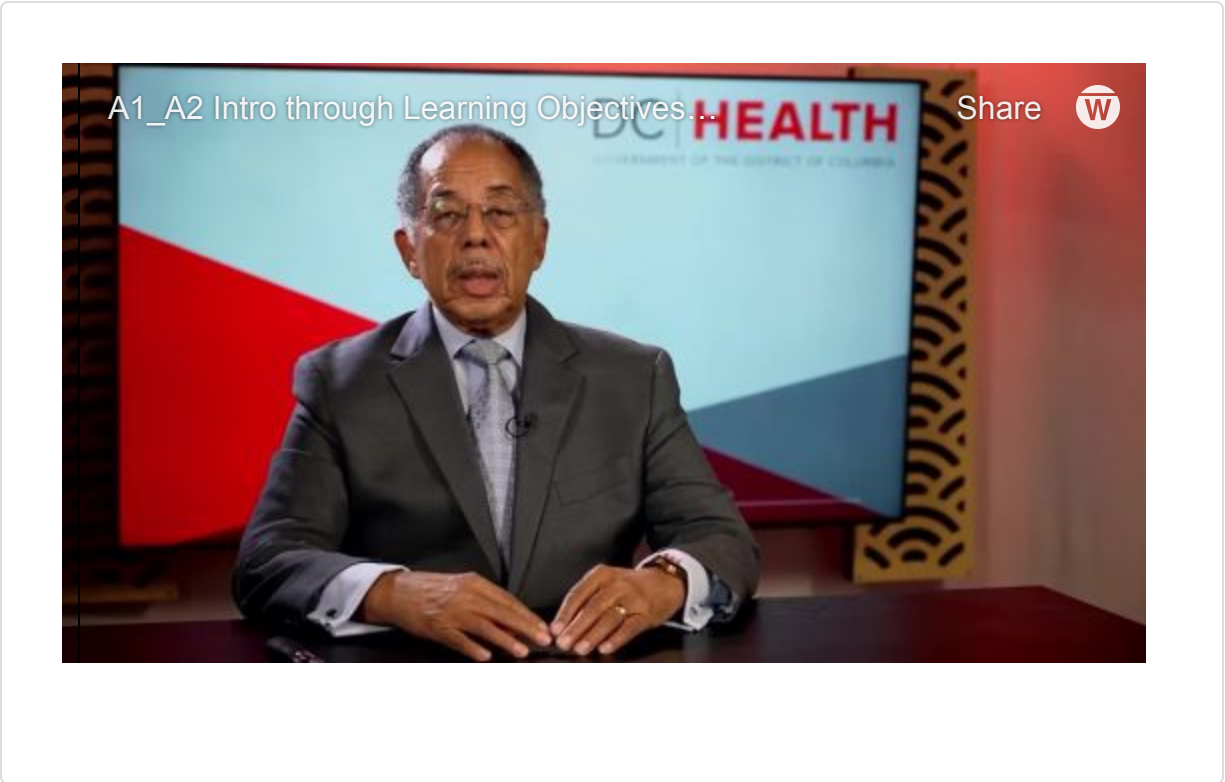
## Introduction

In this section, Dr. Chapman offers a brief overview of the opioid crisis, particularly emphasizing its repercussions within the District of Columbia, while also reviewing the learning objectives for this course. Dr. Chapman's expertise and insights illuminate the multifaceted nature of the crisis, delving into its origins, consequences, and persistent obstacles. This foundational understanding serves as a springboard for a more in-depth examination of opioid use disorder screening, diagnosis, and treatment complexities. Such knowledge empowers learners to discern and implement informed decisions and interventions within their clinical practice.

*While this course was being developed, new policies were introduced from DC Medicaid about a change in the District of Columbia's (DC's) Suboxone and Buprenorphine-containing product's daily dosing limit. Effective May 1, 2024, the daily dosing limit for*



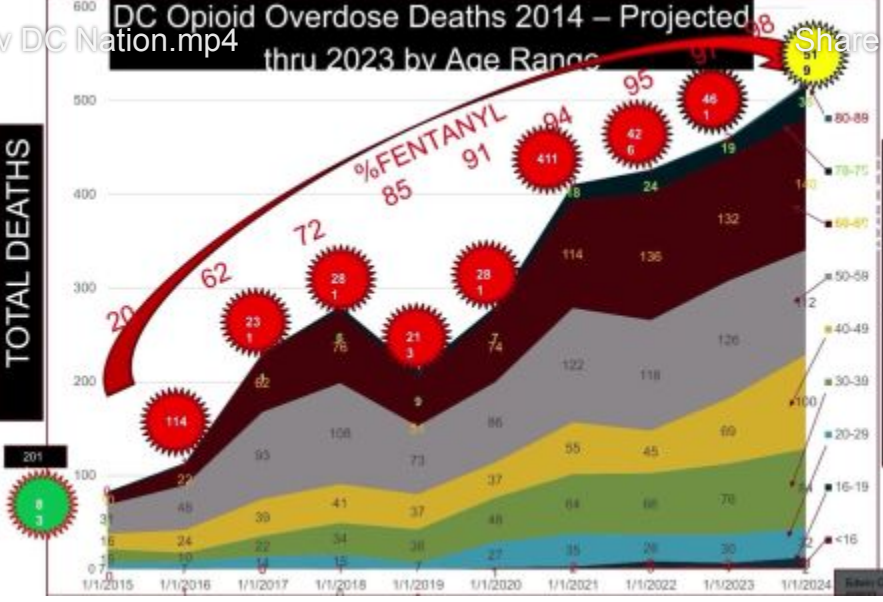
*Suboxone and Buprenorphine-containing products without a prior authorization will increase to 32mg. The previous daily dosing limit was 24mg.*



Prev DC Nation.mp4

# DC Opioid Overdose Deaths 2014 – Projected thru 2023 by Age Range

TOTAL DEATHS



DEATHS BY AGE

Shirley C. Chapman, MD

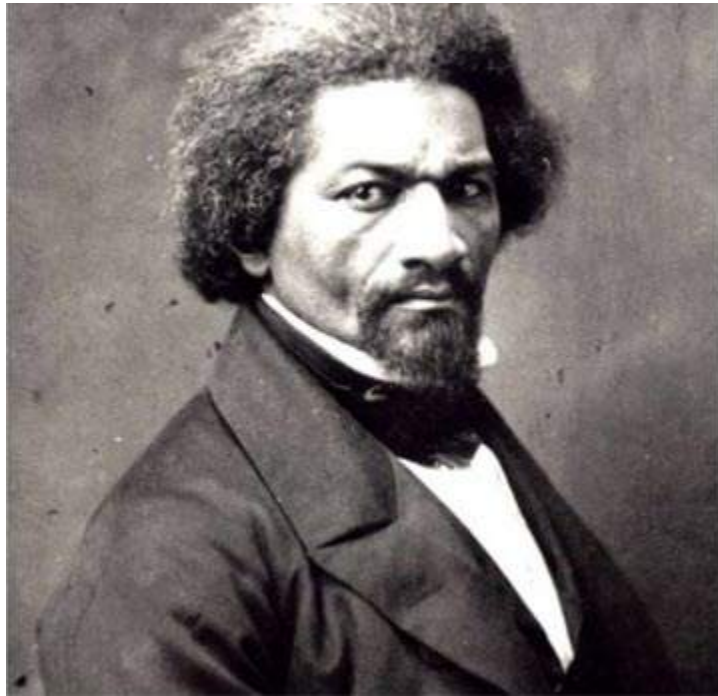
## **A Brief Look At Our History**

It is essential to understand the historical context that has shaped our current understanding of this complex condition. In this brief section, we'll explore key milestones, trends, and societal factors that have influenced the evolution of OUD management, providing valuable insights into the challenges and advancements in addressing this pressing public health issue.

## First Prominent American Recovering Alcoholic



01:16



"We Cannot Stagger to Freedom" Frederick Douglass, Leader of the Black Temperance Movement

## Faces and Voices of Recovery: Innovations in Recovery Award



00:30

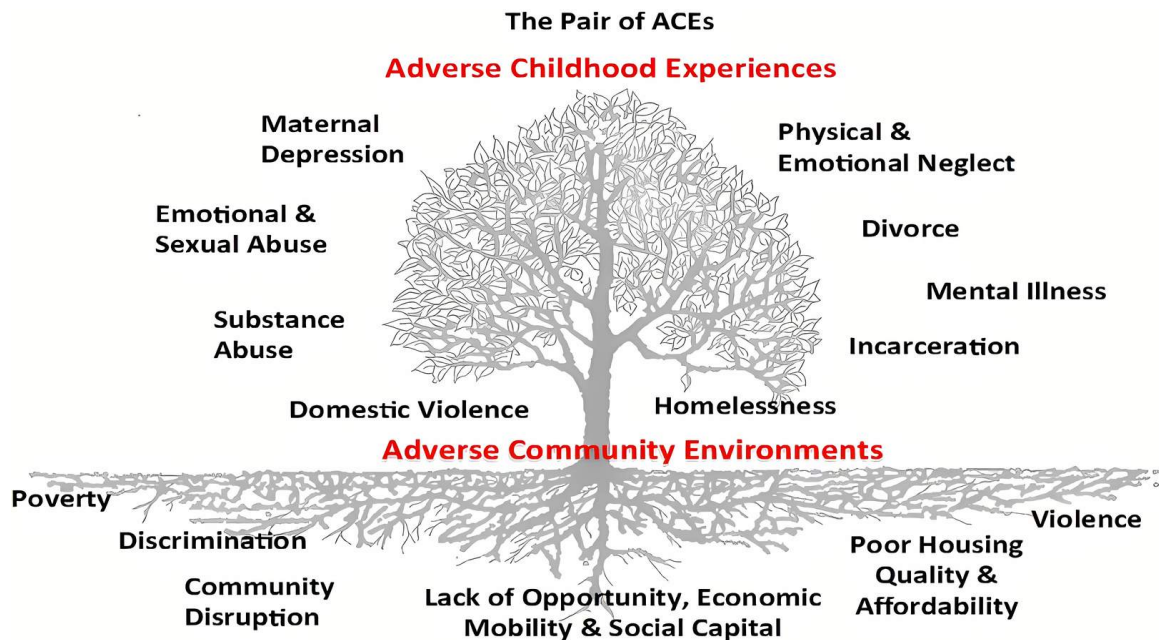
### Winner – 2023 Faces and Voices of Recovery: Innovations in Recovery Award



“Imagine if the government chased sick people with diabetes. Then sent them to jail. If we did that everyone would know we were crazy. Yet we do practically the same thing every day of the week to sick people hooked on drugs.”

- Billie Holiday, Singer

# The Pair of ACEs

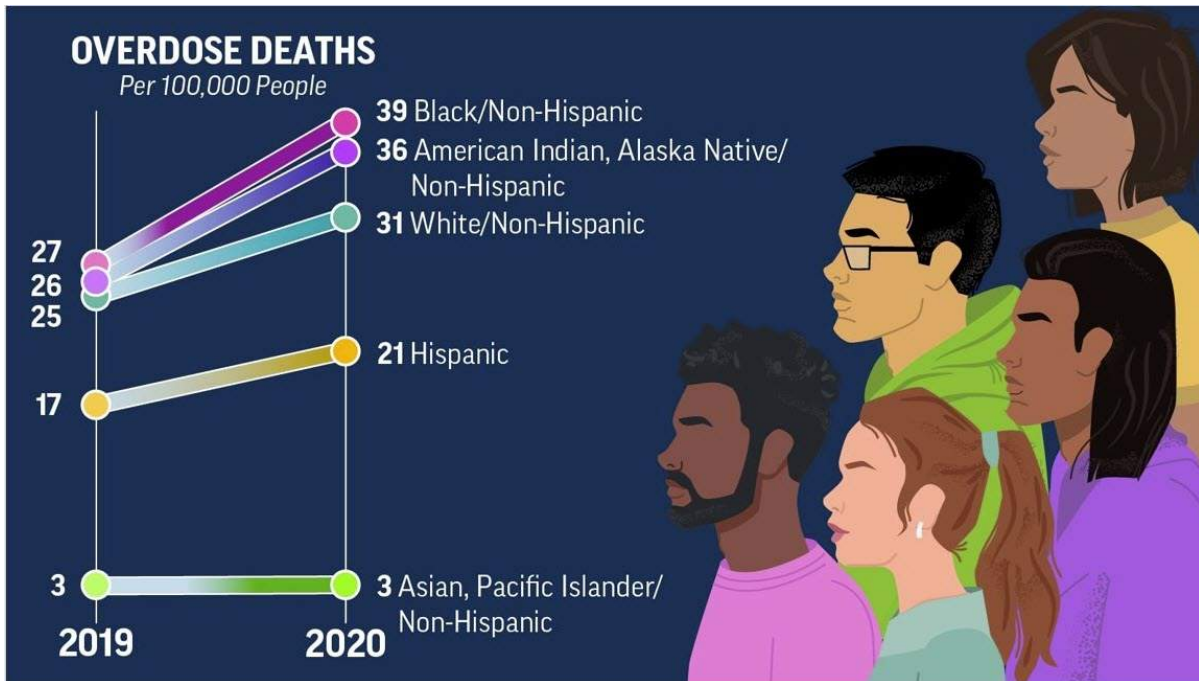


Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

# Overdose Deaths 2019 - 2020



00:18



CONTINUE

# Understanding Addiction

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## Chronic Disease Model of Addiction

*Ideally, patient and provider establish goals of treatment or failure to achieve all goals is likely.*



- A cure is unlikely
- Lifetime management
- Therapeutic alliance

## Distinguishing Abuse From Dependency or Substance Use Disorder



### Chronic Disease Characteristics

- Genetic susceptibility
- Chronic Pathophysiologic/functional changes
- Risk factors influenced by choices
- Similar treatment goals & strategies



- Similar clinical outcomes

*Opioid treatment with methadone or buprenorphine decreases overdose deaths by more than 50%*

## Treating Chronic Medical Illness: Clinical Outcomes

	<i>DM-II</i>	<i>HTN</i>	<i>Asthma</i>
Meds &/or behavioral changes	25-50%	50%	
Hospitalized			10%
ER			35%
↓ Activity prior month			35%

(Turner et al, JAMA 1999; Yurk et al, Am J Man Care 2004; Godley et al, Am J Hlth Syst Pharm 2001)

### Abuse vs. Dependence or Substance Use Disorder



00:46

#### Abuse

- Maladaptive use leading to impairment
- $\geq 2$  diagnostic factors present with 12 months
  - impaired roles
  - use in hazardous situations

#### Dependence or Substance Use Disorder

- Maladaptive use leading to impairment
- $\geq 2$  within a year:
  - tolerance

- legal problems
- continued use despite problems
- **Dependence criteria not met**
  - withdrawal
  - larger amounts or period than intended
  - unable to decrease use
  - excessive time spent
  - decrease in important activities
  - use despite problems

## ENHANCE YOUR UNDERSTANDING

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**Please watch the following video which features real-life insights and experiences from three patients. After viewing the video, take a moment to answer the following questions.**

### **Patient Perspectives**

## Their Own Words: Experiencing Opioid Withdrawal

Which of the following statements about withdrawal symptoms among opioid users is FALSE?

- Withdrawal symptoms are often mistaken for other health issues by opioid abusers.
- Opioid abusers can easily identify withdrawal symptoms without professional assistance.
- Recognizing withdrawal symptoms is typically challenging for opioid abusers.

SUBMIT

The peak of withdrawal symptoms is typically 72 hours after the last dose.

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TRUE

FALSE

SUBMIT

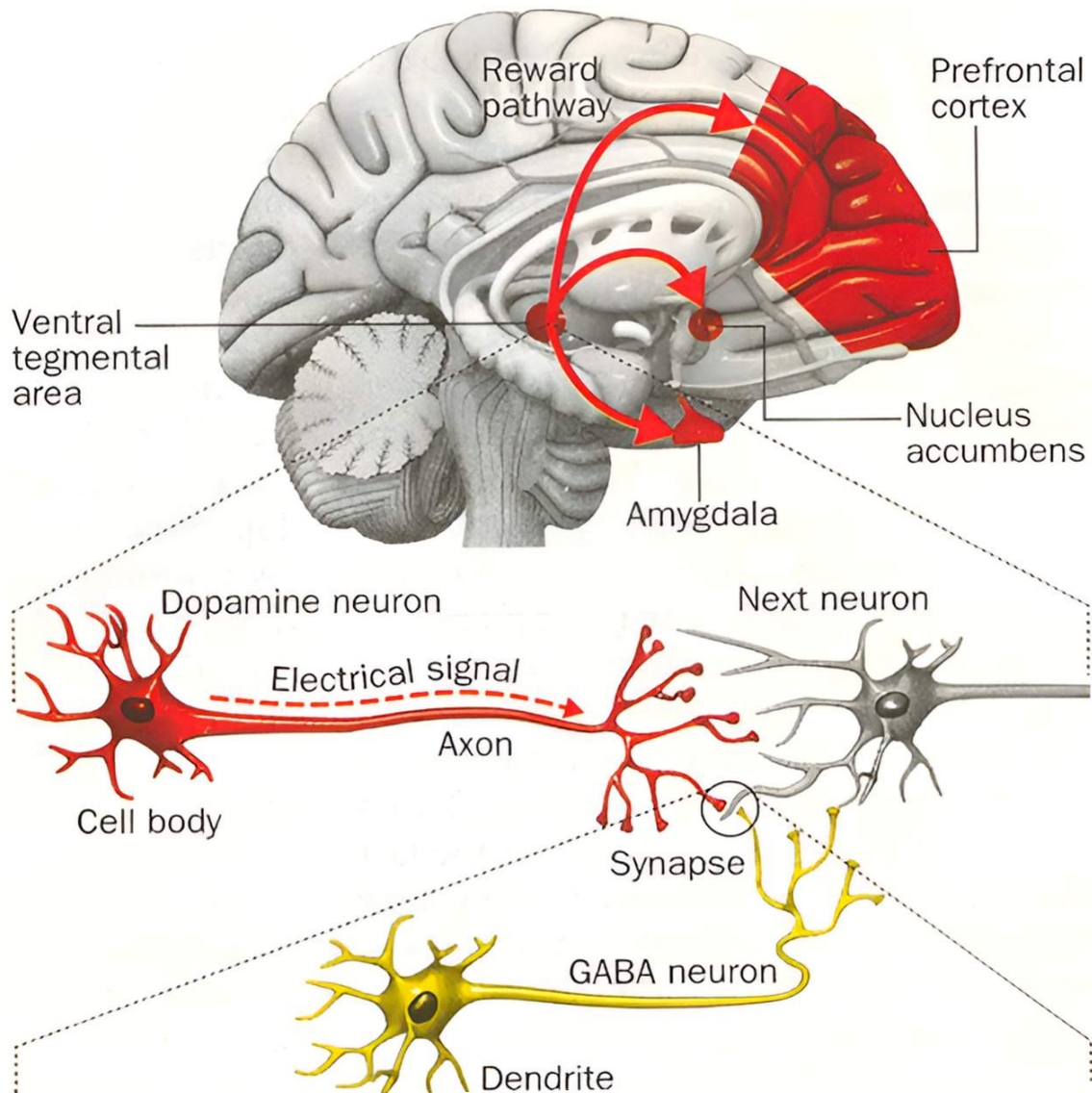
CONTINUE

**Neurobiology of Addiction**

Understanding the neurobiology of addiction is essential for developing effective prevention and treatment strategies that target underlying brain mechanisms involved in addictive behaviors. Select the audio clip below for an explanation of what happens in the brain.



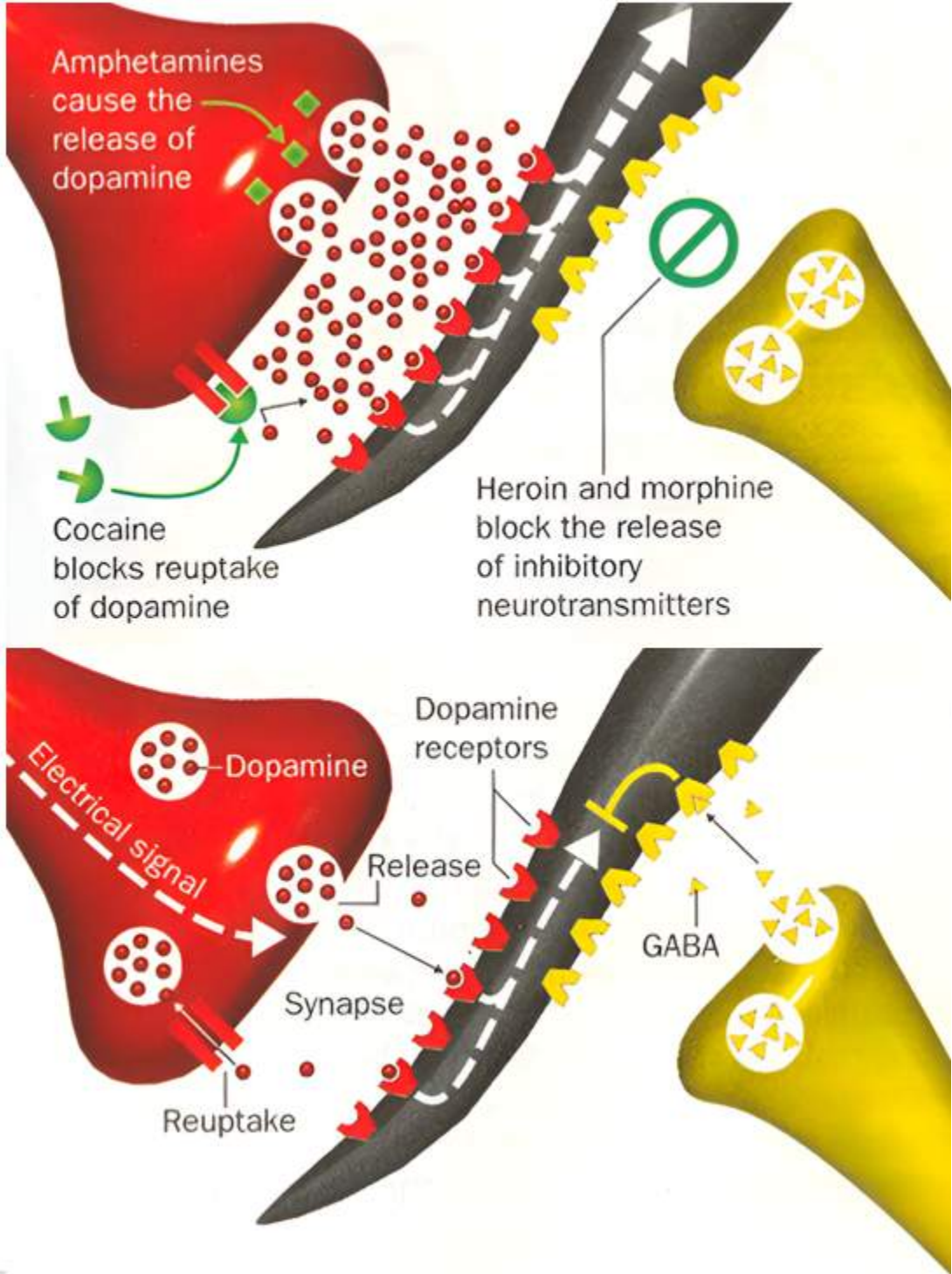
00:13



1. We feel good when neurons in the reward pathway release a neurotransmitter called dopamine into the nucleus accumbens and other brain areas
2. Neurons in the reward pathway communicate by sending electrical signals down their axons. The signal is passed to the next neuron across the synapse.
3. Dopamine is released into the synapse, crosses to the next neuron and binds to receptors, providing a jolt of pleasure. Excess dopamine is taken back up by the sending

cell. Other nerve cells release GABA, an inhibitory neurotransmitter that works to prevent the receptor nerve from being overstimulate.

4. Addictive substances increase the amount of dopamine in the synapse, heightening the feeling of pleasure. Addiction occurs when repeated drug use disrupts the normal balance of brain circuits that control rewards, memory and cognition



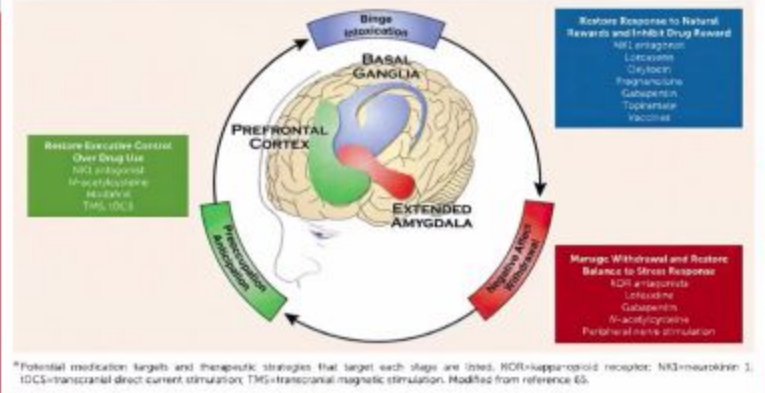
## INTOXICATION - WITHDRAWAL - ANTICIPATION

Slide 22 Figure 1 Three Stages of Addict...

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

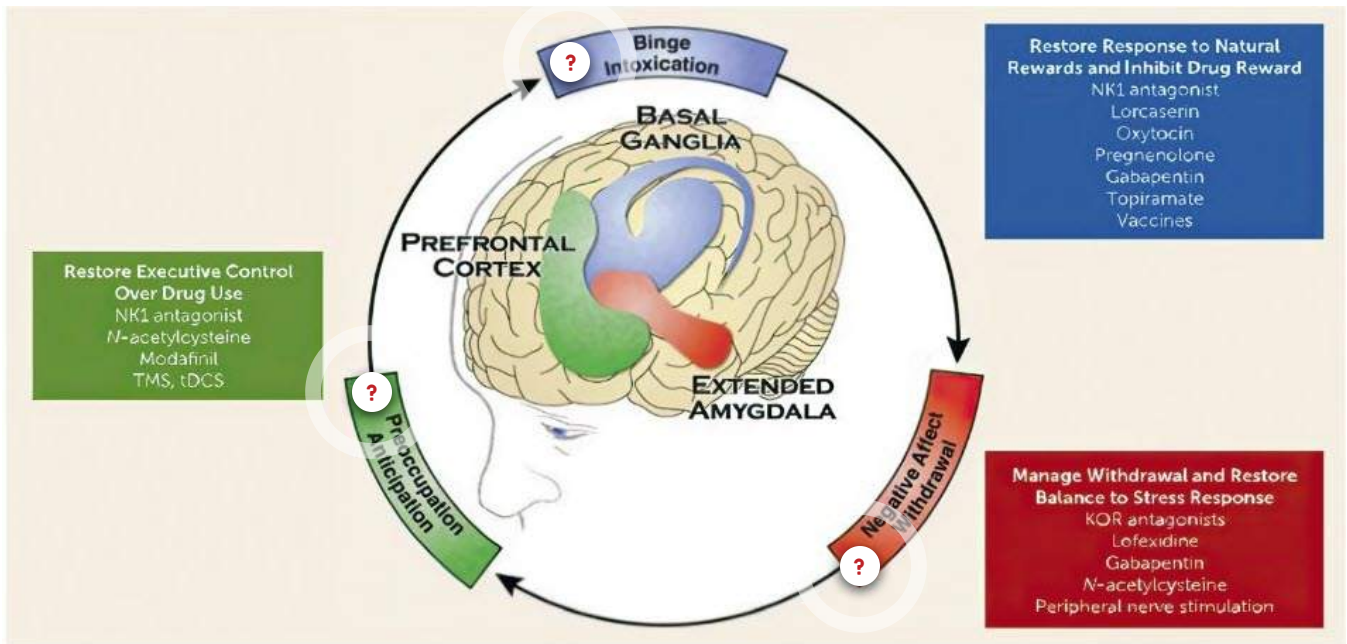
Share 

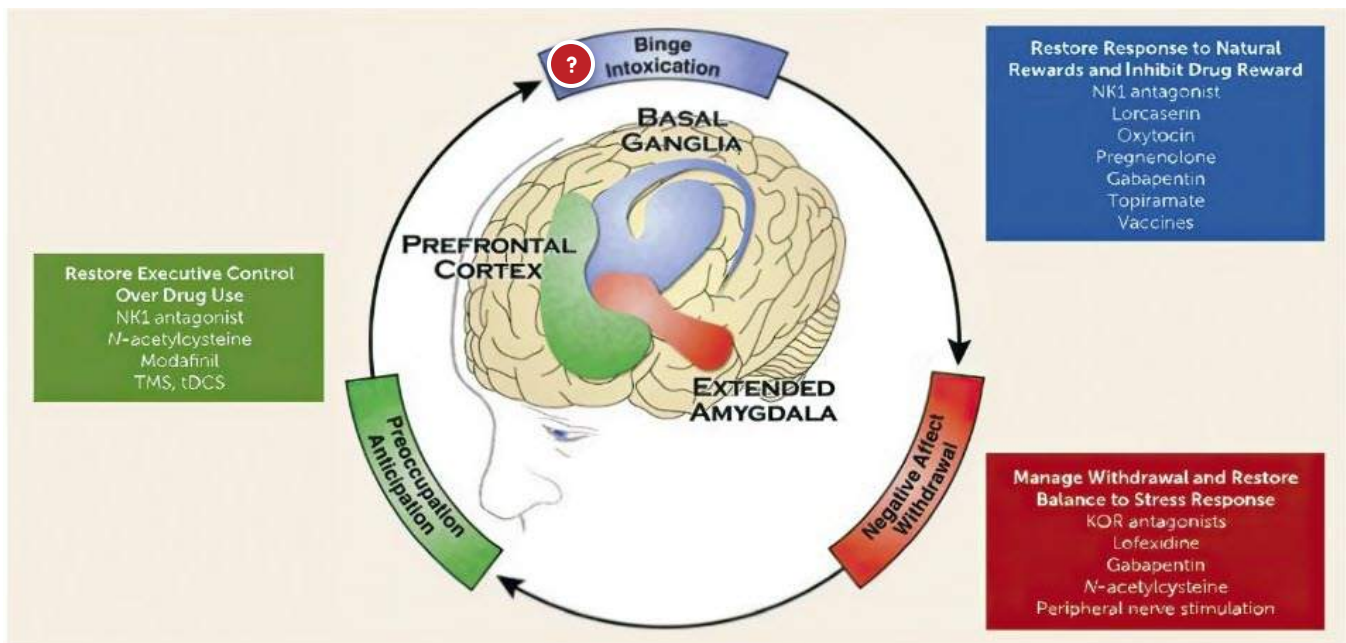
FIGURE 1. The Three Stages of the Addiction Cycle and the Main Brain Regions Implicated\*



Please select the ? icons on the diagram below to access additional information after listening to Dr. Chapman's above recording.

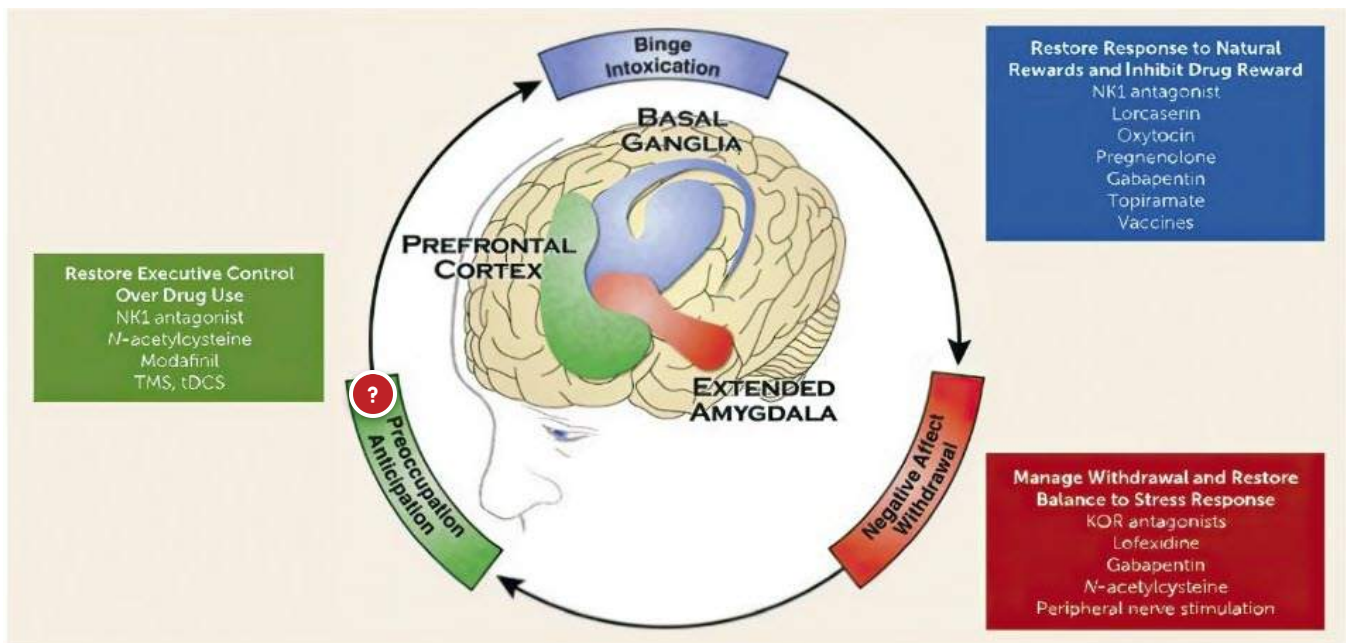






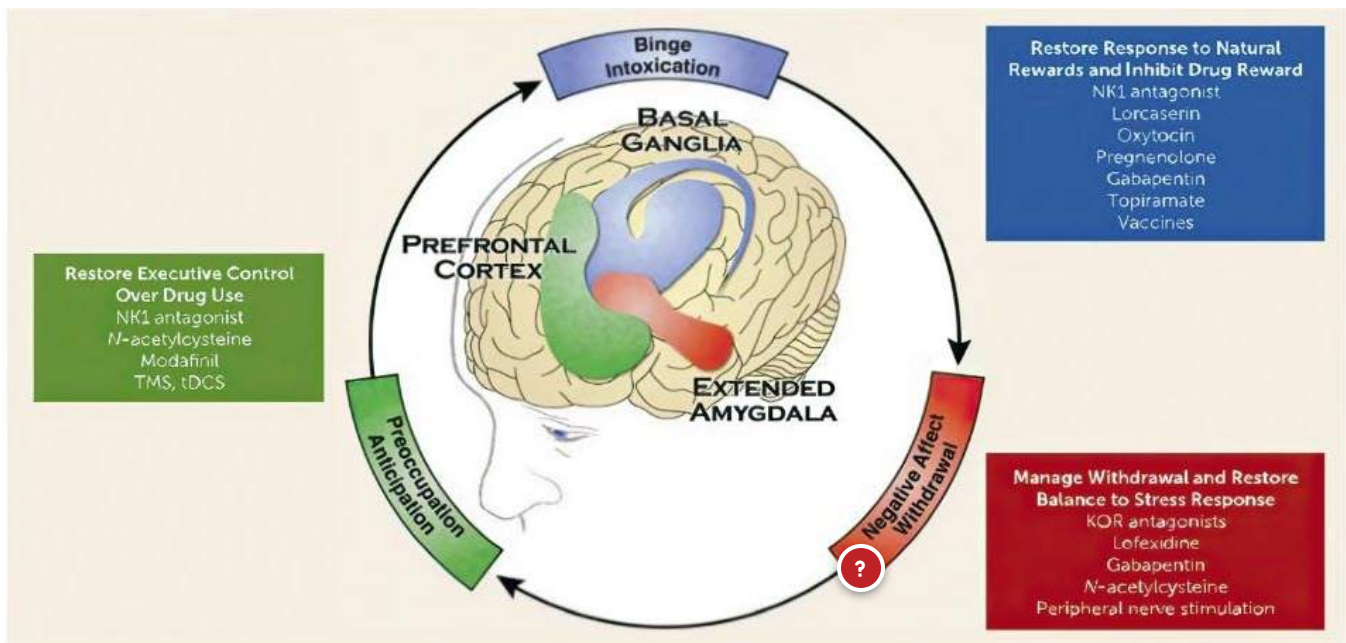
## Binge/Intoxication

During intoxication, the drug stimulates large bursts of dopamine in the mesolimbic reward system (the nucleus accumbens and dorsal striatum) that reinforce drug taking (bingeing) (33) and strengthen conditioned associations, which link stimuli that precede drug consumption with the expectation of reward (34). Counterintuitively, in a person suffering from addiction, the drug-induced dopamine increases are attenuated, an effect that has been observed in both human subjects and animal models (35–37). In humans, the attenuated dopamine response to the drug is associated with reduced subjective experience of reward during intoxication (37). While major emphasis has been placed on the dopaminergic system in explaining the rewarding and reinforcing effects of drugs, it is also clear that other neurotransmitters, including opioids, cannabinoids, GABA, and serotonin—to a greater or lesser extent, depending on the pharmacological characteristics of the drug—contribute to the pleasurable or euphorogenic responses to drugs and to the neuroadaptations that result in addiction (38).



## Preoccupation/Anticipation

During the craving stage, the conditioned stimuli (drug cues) themselves elicit dopamine release in the striatum, triggering the motivation to seek and consume the drug (42). This phase also involves prefrontal circuits, including the orbitofrontal and anterior cingulate cortex, which underlie salience (or value) attribution (43), as well as circuits in the hippocampus and amygdala, which mediate conditioned responses (44). Glutamatergic projections from these regions to the ventral tegmental area and striatum modulate the sensitivity and reactivity to cues and to adverse emotions that trigger the urgent motivation for, and preoccupation with, drug taking (32). In a brain not affected by addiction, the circuits controlling desire for a drug are held in check by prefrontal cortical regions that underlie executive functions, which support making rational, healthy decisions, and that regulate emotions. Thus, the awareness that a drug will provide an immediate reward is balanced by consideration of long-term goals, and the individual is able to make a reasonable choice and carry it through. However, when the prefrontal cortical circuits underlying executive functions are hypofunctional—as a result of repeated drug exposure or from an underlying vulnerability—and the limbic circuits underlying conditioned responses and stress reactivity are hyperactive—as a result of drug withdrawal and long-term neuroadaptations that downregulate sensitivity to nondrug rewards—the addicted individual is at a tremendous disadvantage in opposing the strong motivation to take the drug. This explains the difficulty addicted individuals face when trying to stop taking drugs even when they experience negative consequences and have become tolerant to the drug’s pleasurable effects.



## Negative Affect/Withdrawal

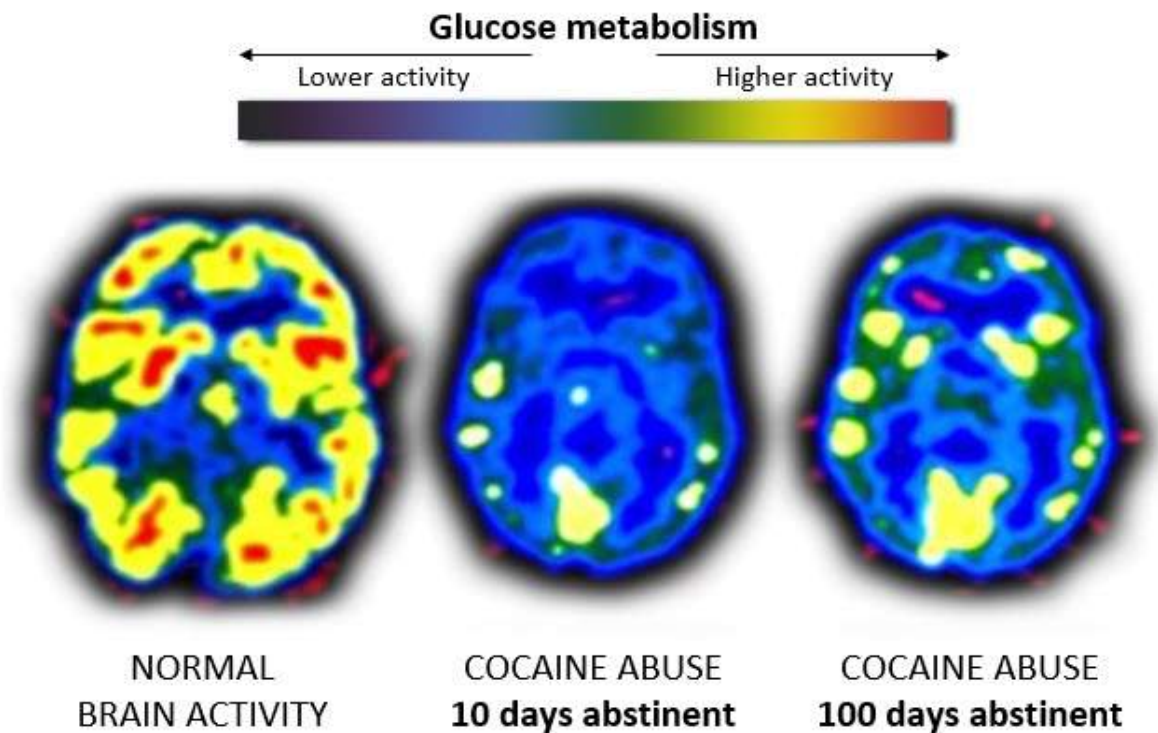
As the intoxicating effects of a drug wear off, an addicted individual enters the withdrawal phase, which is associated with negative mood, including anhedonia, increased sensitivity to stress, and significant dysphoria and anxiety. Such a response is not typically observed in an individual with short drug exposure history, and the duration of exposure needed for a response to emerge varies for the different types of drugs, with opioids producing these effects particularly rapidly. The circuits underlying the withdrawal phase comprise basal forebrain areas, including the extended amygdala as well as the habenula, and implicate neurotransmitters and neuropeptides such as corticotropin-releasing factor (CRF), norepinephrine, and dynorphin (39, 40). Increased signaling in these circuits triggers aversive symptoms that render the individual vulnerable to cravings and preoccupation with taking the drug as means to counteract this aversive state. In parallel, the dopamine reward/motivation system is hypofunctional, contributing to anhedonia and the aversive state during withdrawal (41).

**In this section, Dr. Chapman discusses brain development and  
PET Scan images**

## Substance Abuse Disorder Brain Imaging



00:15



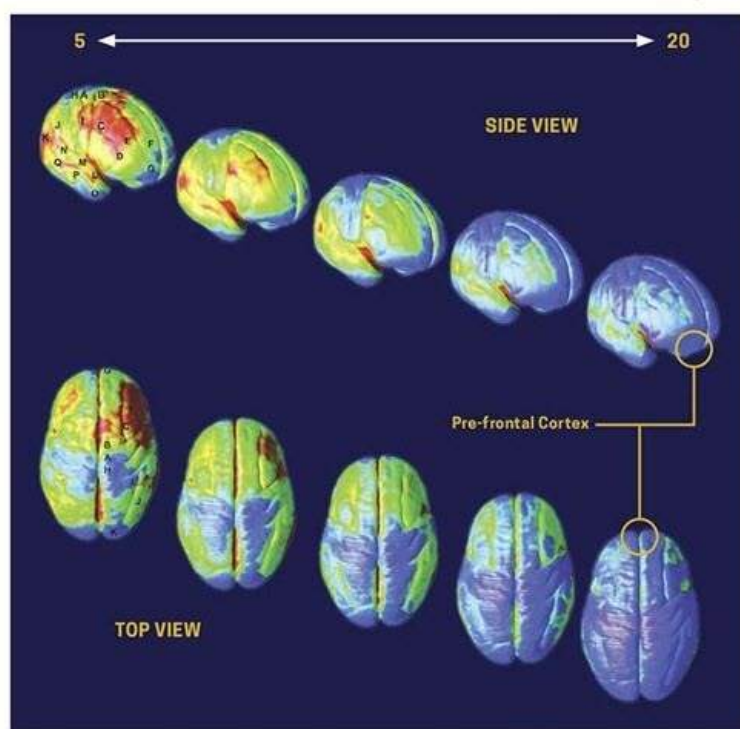
As one example, Cocaine use causes a decrease in glucose metabolism in the brain, especially in the frontal lobes, where planning, abstract thinking and regulation of impulse behavior are governed.

Image 2

# Brain Development in Healthy Children and Teens



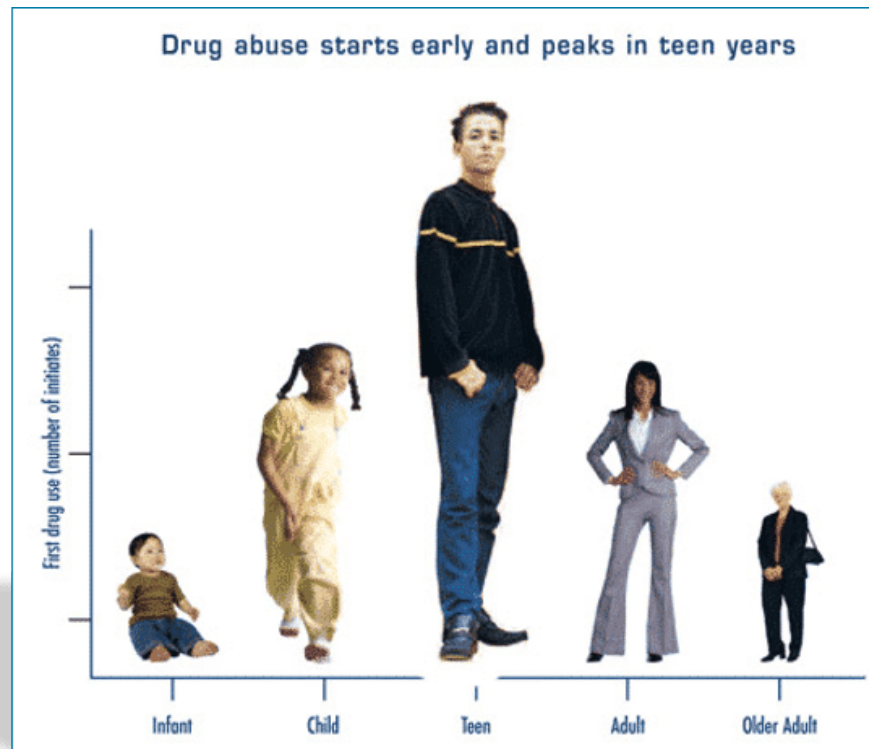
00:17



## Timing of Abuse and Summary



00:20



## Opiates and Opioids



00:12



**Opiates** = naturally present in opium e.g. morphine, codeine, thebaine



*Sap is extracted by splitting the pod.*

**Opioids** = manufactured  
Semisynthetics are derived from an opiate

- heroin from morphine
- buprenorphine from thebaine

Synthetics are completely man-made to work like opiates

- methadone



*Highly refined Southwest Asian heroin or Southeast Asian heroin*

## Opioids: Mu agonists/ Abuse potential

- Diacetylmorphine (heroin)
- Hydromorphone (Dilaudid)
- Oxycodone (OxyContin, Percodan, Percocet, Tylox)
- Hydrocodone (Lortab, Vicodin)
- Methadone
- Morphine (MS Contin, Oramorph)
- Fentanyl (Duragesic, Actiq)
- Propoxyphene (Darvon, Darvocet)
- Meperidine (Demerol)
- Codeine
- Opium

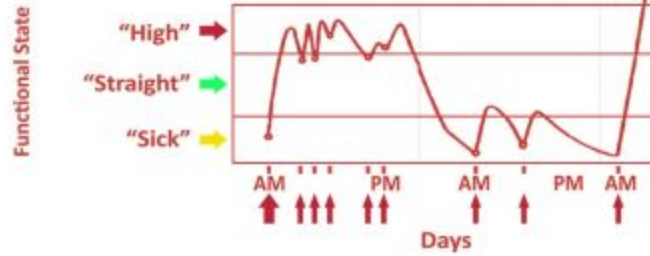
### UNDERSTANDING DEPENDENCE, WITHDRAWAL, OVERDOSE MEDICATIONS

WHAT DOES IT FEEL LIKE TO BE OPIOID DEPENDENT	WITHDRAWAL TIMELINE	KNOW THE SIGNS AND SYMPTOMS OF AN OVERDOSE	CLINICAL OPIOID WITHDRAWAL SCORE	C RES ME
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What does it feel like oia.mp4

Share

## What Does It Feel Like to Be Opioid Dependent?



Diagrammatic summary of functional state of typical "mailline" heroin user. Arrows show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but osmetimes much more. Note that addict is hardly ever in a state of normal function ("straight").

Doris V.E. Spivack MD, PhD, MS, Narcotic Blockade,  
Arch Intern Med. 1998;158(11):1102-1105. PMID: 9532886.

DC HEALTH  
Department of the District of Columbia

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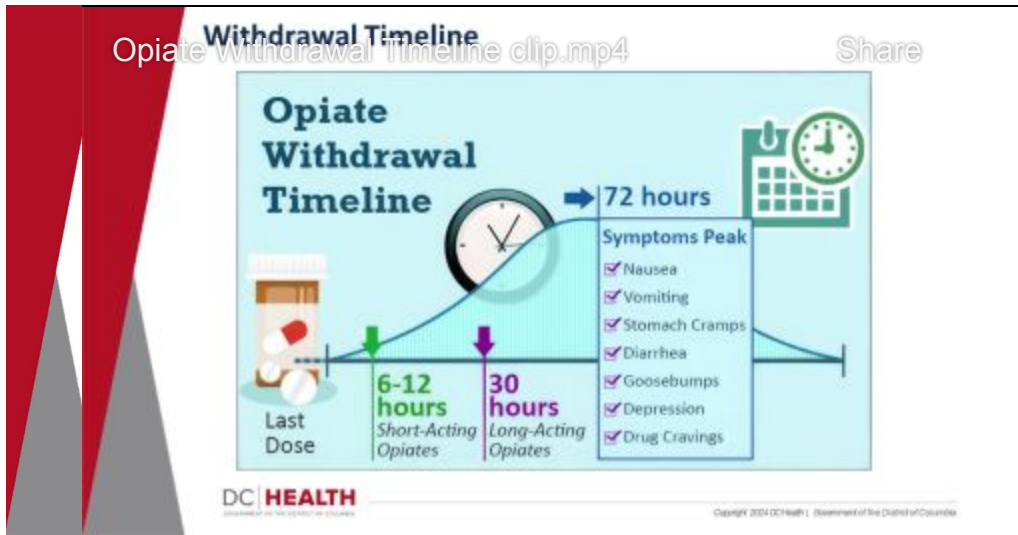
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SCORE

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Description

Overdose symptoms.mp4

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### Know the Signs and Symptoms of an Overdose

Breathing will be slow or gone 	Lips and nails are blue or grey 	Person is not moving 	Person may be choking 
You can hear gurgling sounds or snoring 	Can't be woken up 	Skin feels cold and clammy 	Pupils are tiny 

Anything can be cut with fentanyl or Carfentanyl. (2023, December 4). Ottawa Public Health. <https://www.ottawapublichealth.ca/en/professionals-and-partners/resources/Documents/Anything-can-be-cut-with-Fentanyl-or-Carfentanyl-Foster-DK.pdf>



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CLINICAL OPIOID  
WITHDRAWAL  
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COWS clip.mp4

## Clinical Opioid Withdrawal Score (COWS)

Share



COWS is not required prior to starting buprenorphine, but it can help ensure the patient is ready for the first dose. For each item, write in the number that best describes the patient's signs or symptoms. Rate only the apparent relationship to opiate withdrawal. For example: if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.

**Resting Pulse Rate:** Record beats per minute after patient is sitting or lying down for one minute.

- 0 - pulse rate 90 or below
- 1 - pulse rate 91-100
- 2 - pulse rate 101-120
- 4 - pulse rate greater than 120

**Sweating:** Over past 15 hour not accounted for by room temperature or activity

- 0 - no chills or flushing
- 1 - subjective chills or flushing
- 2 - flushed or observable moistness on face
- 3 - beads of sweat on brow or face
- 4 - sweat streaming off face

**Restlessness:** Observation during assessment.

- 0 - able to sit still
- 1 - reports difficulty sitting still, but is able to do so
- 3 - frequent shifting or evanescent movement of legs/arms
- 5 - unable to sit still for more than a few seconds

**Pupil size:**

- 0 - pupils pinned or normal size for light
- 1 - pupils possibly larger than normal for light
- 2 - pupils moderately dilated
- 5 - pupils dilated that only rim of the iris is visible

**Bone or joint aches:** If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored

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

Time:	Time:	Time:	Time:

**Runny nose or tearing:** Not accounted for by cold symptoms or allergy

- 0 - none present
- 1 - nasal stuffiness or unusually moist eyes
- 2 - nose running or tearing
- 6 - nose constantly running or tears streaming down cheeks

**GI upset:** Over last 15 hour

- 0 - no GI symptoms
- 1 - stomach cramps
- 2 - nausea or loose stool
- 3 - vomiting or diarrhea
- 5 - multiple episodes of diarrhea or vomiting

**Tremor:** Observation of outstretched hands

- 0 - no tremor
- 1 - tremor can be felt, but not observed
- 2 - slight tremor observable
- 6 - gross tremor or muscle twitching

**Yawning:** Observation during assessment

- 0 - no yawning
- 1 - yawning once or twice during assessment
- 2 - yawning three or more times during assessment
- 4 - yawning several times/minute

**Anxiety or irritability:**

- 0 - none
- 1 - patient reports increasing irritability or annoyance
- 2 - patient obviously irritable or anxious
- 4 - patient so irritable or anxious that participation in the assessment is difficult

**Gooseflesh skin:**

- 0 - skin is smooth
- 3 - gooseflesh of skin can be felt or hair standing up on arms
- 5 - prominent gooseflesh

Source: Journal of Addiction Medicine (2012), Vol. 14, No. 3, pp. 205-210. The Clinical Opioid Withdrawal Score (COWS): A Practical Guide. DOI: 10.1093/ajph/14.3.205

10/14

Suggested score to start buprenorphine in the ED is COWS ≥ 8

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OD Meds clip.mp4

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## Naloxone (NARCAN or KLOXXADO) & Nalmefene (OPVEE): Overdose Resuscitation Medication for Opioids

- Reverses Opioid overdose
- Opioid antagonist
- Temporary treatment
- Administered immediately typically, intranasal spray
- Available in intramuscular, subcutaneous, or intravenous injection
- For patients receiving MOUD or at risk for opioid overdose

Narcan:



4 mg



8 mg

Brand Name:  
Kloxxado



DC HEALTH

<https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/release>

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# MEDICATIONS FOR OPIOID OVERDOSE, WITHDRAWAL, & ADDICTION

Medications for opioid **overdose**, **withdrawal**, and **addiction** are safe, effective, and save lives.

The National Institute on Drug Abuse supports research to develop new medicines and delivery systems to treat opioid use disorder and other substance use disorders, as well as other complications of substance use (including withdrawal and overdose), to help people choose treatments that are right for them.

Medications approved by the U.S. Food and Drug Administration for opioid addiction, overdose, and withdrawal work in various ways.

- **Opioid Receptor Agonist**  
Medications attach to opioid receptors in the brain to block withdrawal symptoms and cravings.
- **Opioid Receptor Partial Agonist**  
Medications attach to and partially activate opioid receptors in the brain to ease withdrawal symptoms and cravings.
- **Opioid Receptor Antagonist**  
Medications attach to and block activity of opioid receptors in the brain. Antagonist medications that treat substance use disorders do so by preventing euphoric effects (the high) of opioids and alcohol and by reducing cravings. Antagonist medications used to treat opioid overdoses do so by reversing dangerous drug effects like slowing or stopping breathing.
- **Adrenergic Receptor Agonist**  
A medication that attaches to and activates adrenergic receptors in the brain and helps alleviate withdrawal symptoms.

## REDUCES OPIOID USE AND CRAVINGS

### Methadone

Daily liquid or tablet



### Naltrexone

Monthly injection



### Buprenorphine

Daily tablet



### Buprenorphine/ Naloxone

Daily film under the tongue or tablet



## TREATS WITHDRAWAL SYMPTOMS

### Lofexidine

As-needed tablet



## REVERSES OVERDOSE

### Naloxone

Emergency nasal spray or injection



### Nalmefene

Emergency nasal spray or injection



SCREENING AND ASSESSMENT

# Screening and Assessment

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## Comprehensive Assessment of Opioid Use Disorder

### Prescreening Strategy



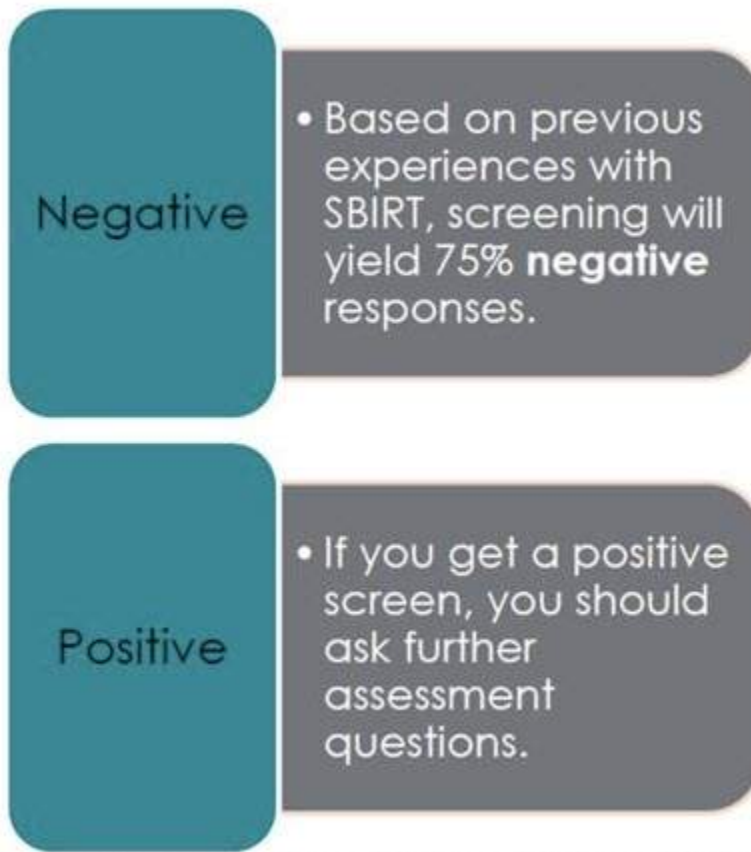
00:15

You may already be using prescreening questions/tools in your practice, such as:

- The NIAAA Single-Question Screen (or the AUDIT C)
- The NIDA Single-Question Drug Screen

<https://cde.nida.nih.gov/instrument>



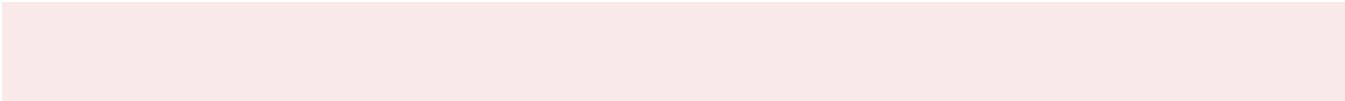


 **NIDA Screening Fact Sheet.pdf**   
1.3 MB

**IMPLEMENTING DRUG AND ALCOHOL SCREENING IN PRIMARY CARE**

This website will guide your team through the process of developing a plan for implementing screening in your practice. This resource was funded in part with federal funds from the National Institute on Drug Abuse, Center for the Clinical Trials Network Dissemination Initiative

**NIDA SCREENING**



# Use of the SBIRT Approach to Screening for Treatment



00:32

Screening, **B**rief **I**ntervention, and **R**eferral to **T**reatment (**SBIRT**) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services. It is used for:

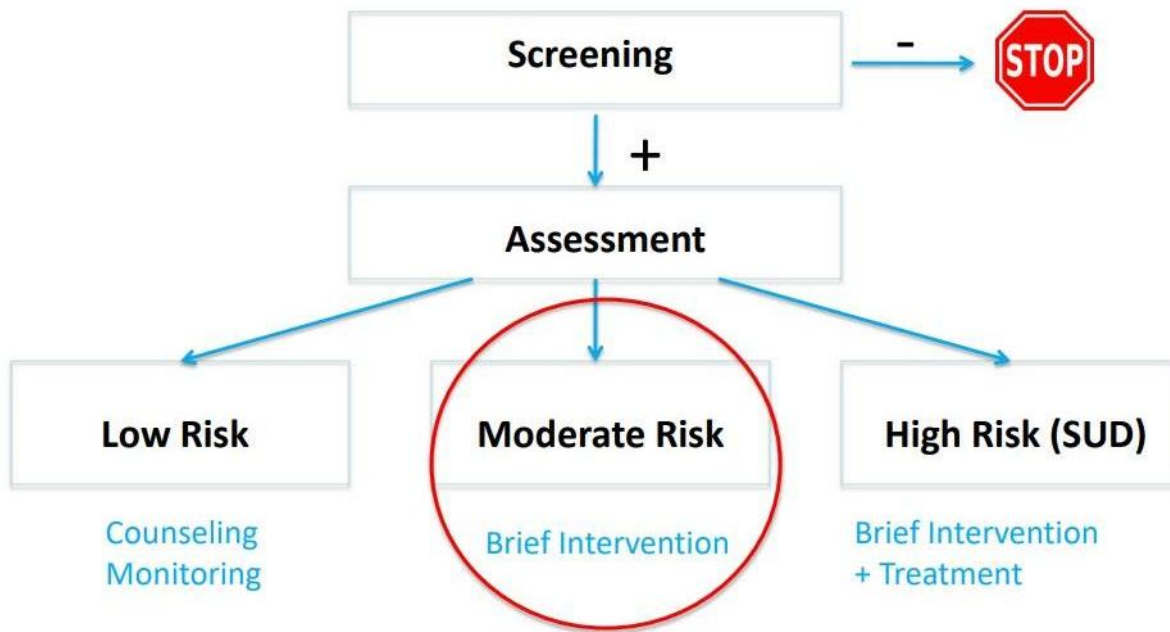
- Persons whose use is at higher levels or risk
- Persons who may already have a substance use disorder
- Effective screening for everyone

## SBIRT Flow Chart and Questions

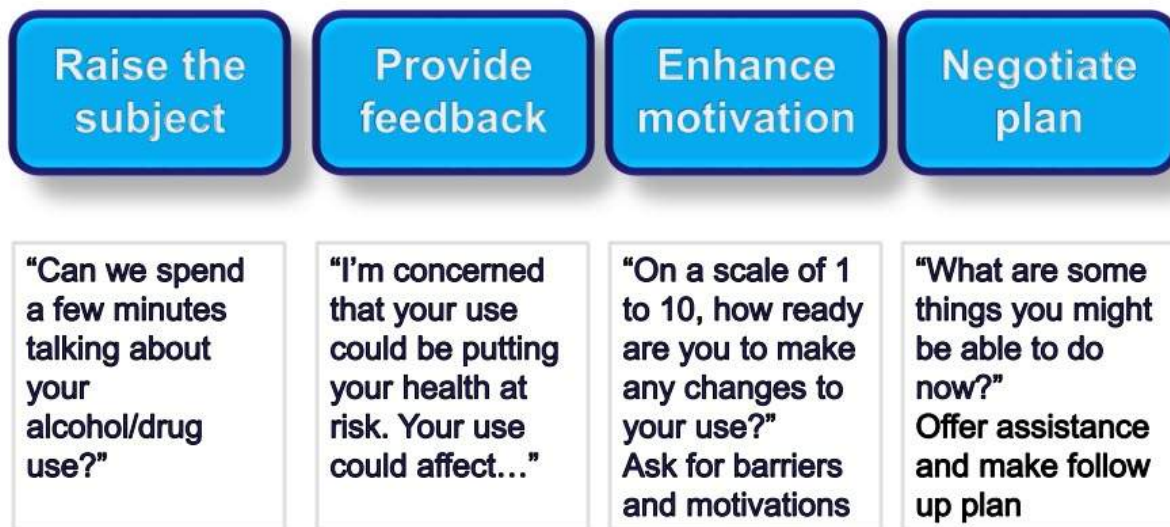
The first slide below is the SBIRT flow chart and the second slide includes some sample questions as described in Dr. Chapman's audio explanation.



00:14



SOURCE: <https://product.simmersion.com/>



## DAST (10) Drug Abuse Screen Test



**DrugAbuseScreeningTest\_2014Mar24.pdf**

50.6 KB



Although many people take medications that are not prescribed to them, we are primarily concerned about prescription misuse of:

- Opioids
- Benzodiazepines
- Stimulants
- Sleep Aids
- Other assorted medications such as clonidine and carisoprodol



Rise image

---

"These questions refer to drug use in the past 12 months. Please answer No or Yes."

**Interpretation of Score:**

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371.

Yudko E, Lozhkina O, Fouts A (2007).

## Clinical Opioid Withdrawal Score (COWS) Assessment



ClinicalOpiateWithdrawalScale.pdf  
606.5 KB



Patient's Name: _____		Date and Time ____/____/____:_____	
Reason for this assessment: _____			
<b>Resting Pulse Rate:</b> _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120		<b>GI Upset: over last 1/2 hour</b> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting	
<b>Sweating: over past 1/2 hour not accounted for by room temperature or patient activity.</b> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face		<b>Tremor observation of outstretched hands</b> 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching	
<b>Restlessness Observation during assessment</b> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds		<b>Yawning Observation during assessment</b> 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute	
<b>Pupil size</b> 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible		<b>Anxiety or Irritability</b> 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult	
<b>Bone or Joint aches</b> <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort		<b>Gooseflesh skin</b> 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection	
<b>Runny nose or tearing</b> <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks		<p style="text-align: right;">Total Score _____</p> <p style="text-align: center;">The total score is the sum of all 11 items</p> Initials of person completing assessment: _____	

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

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

## UNDERSTANDING SOCIAL-EMOTIONAL FACTORS FROM THE PATIENTS' PERSPECTIVE



## ADDITIONAL SCREENING AND ASSESSMENT TOOLS

**National Institute on Drug Abuse Screening and Assessment Tools**



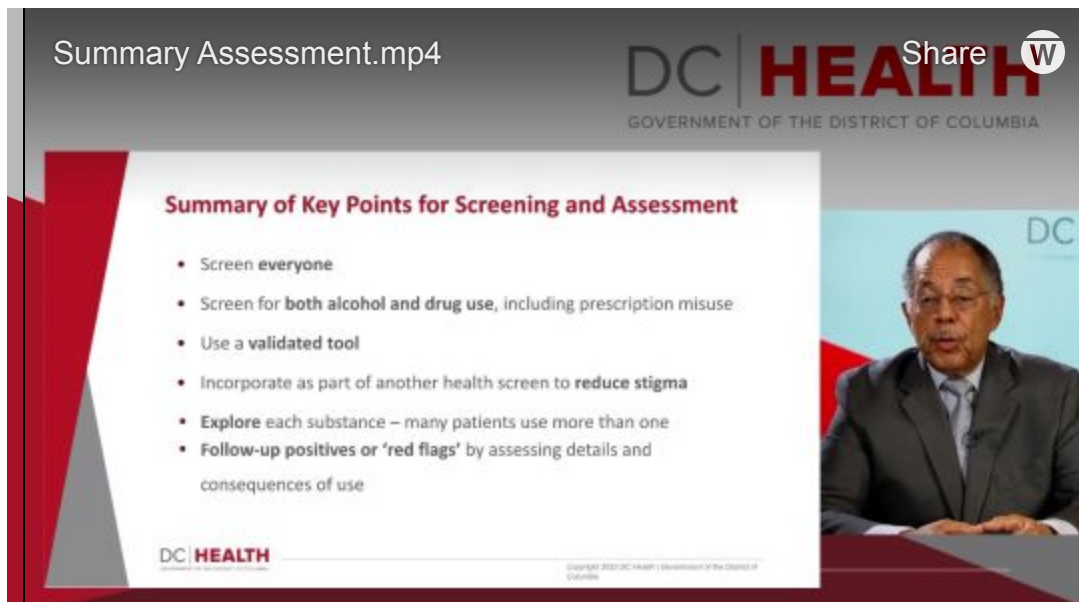
00:05

The following two tables, sourced from the National Institute on Drug Abuse (NIDA), provide information on various screening and assessment tools. Please explore these tables for an overview, and for more detailed information on each tool, we encourage you to visit NIDA's website using the provided link.

Visit the [NIDA Website](#) to access screening and assessment links

[NIDA NIH WEBSITE](#)

## Summary of Screening and Assessment



- Screen everyone
- Screen for both alcohol and drug use, including prescription misuse



- Use a validated tool
- Incorporate as part of another health screen to reduce stigma
- Explore each substance – many patients use more than one
- Follow-up positives or ‘red flags’ by assessing details and consequences of use

## MEDICATION FOR OPIOID USE DISORDERS (MOUD)

# Introduction to Medication for Opioid Use Disorders (MOUD)

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## Overview of FDA-Approved MOUD Medications

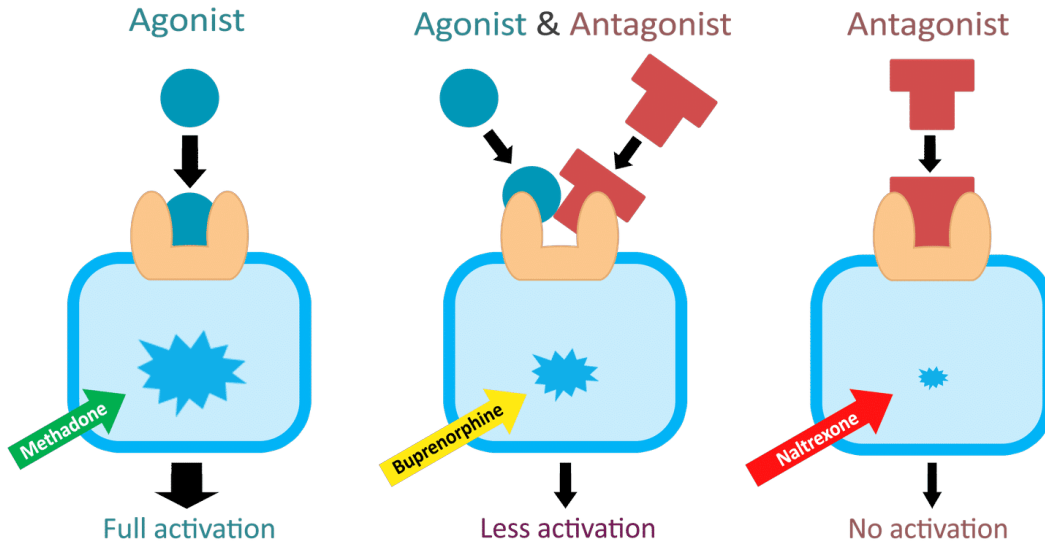
Medications for Opioid Use Disorder (MOUD) represent a cornerstone in the treatment of opioid addiction, offering evidence-based pharmacological interventions to support recovery. This overview explores the diverse range of medications available, their mechanisms of action, and their integral role in comprehensive treatment approaches, providing healthcare providers with essential insights to optimize patient care and outcomes. This section provides an overview of the FDA-approved medications, their mechanisms of action, and their role in MOUD programs, empowering healthcare providers with valuable insights to guide patient care and promote successful recovery journeys. Understanding the mechanism of action and efficacy of MOUD is crucial for optimizing treatment outcomes in individuals struggling with opioid addiction.

## Agonists and Antagonists



Agonists - Drugs that occupy receptors and activate them.

Antagonists - Drugs that occupy receptors but do not activate them  
 Antagonists block receptor activation by agonists.



## MOUD Characteristics and Considerations

### MOUD Characteristics and Consideration...

Share



MOUD Agent	FDA Recommended Dosing	Methods of Administration	Mechanisms of Action	Side Effects	Special Considerations
<b>Buprenorphine</b>	8-24 mg/day	Sublingual tablets, film	Partial opioid agonist; binds to opioid receptors	Nausea, constipation, headache, insomnia	Can be prescribed by OTP & private providers (DEA); risk of misuse
<b>Methadone</b> "Gold Standard"	Individualized dosing	Oral liquid, tablet	Full opioid agonist; blocks opioid receptors	Drowsiness, dizziness, respiratory depression	Requires daily administration under OTP clinic supervision; risk of overdose
<b>Naltrexone</b>	380 mg/month	Extended-release injection	Opioid antagonist; blocks opioid receptors	Injection site reactions, nausea, headache	Patients must be opioid-free for 7-10 days before starting. Can be prescribed by OTP & private providers

---

## Rationale for Opioid Replacement Therapy



00:19

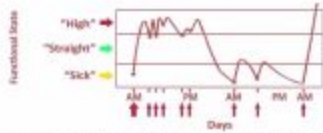
### *Methadone and Buprenorphine Reduce Overdose Deaths*

*Larochelle, M. R., Bernson, D., Land, T., Stopka, T. J.,  
Wang, N., Xuan, Z., ... Walley, A. Y. (2018).*

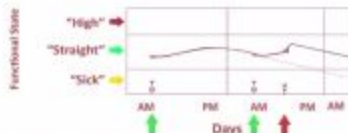
- “Stabilize neuronal circuitry”
  - Cross-tolerant, long-acting, oral
  - $\mu$  occupation/blockade
- Prevent or attenuate euphoric effect
- Prevent withdrawal and craving
- Extinguish compulsive behavior

## Effects of Replacement Therapy

### What Does It Feel Like to Be on Opioid Replacement Therapy?



Diagrammatic summary of functional state of typical "heroin" heroin user. Arrows show the repetitive injection of heroin in uncertain doses, usually 30 to 50 mg but sometimes much more. Note that addict is rarely ever in a state of normal function ("straight").



Stabilization of patient in state of normal function by blockade treatment. A single daily oral dose of methadone prevents him from feeling symptoms of abstinence ("sick") or euphoria ("high"), even if he takes a shot of heroin. Dashed line indicates course if methadone is omitted.



## UNDERSTANDING METHADONE TREATMENT

# Understanding Methadone Treatment

---

## The Dole-Nyswander Treatment of Heroin Addiction



00:14



Ausubel DP. The Dole-Nyswander Treatment of Heroin Addiction. JAMA.  
1966;195(11):949-950.

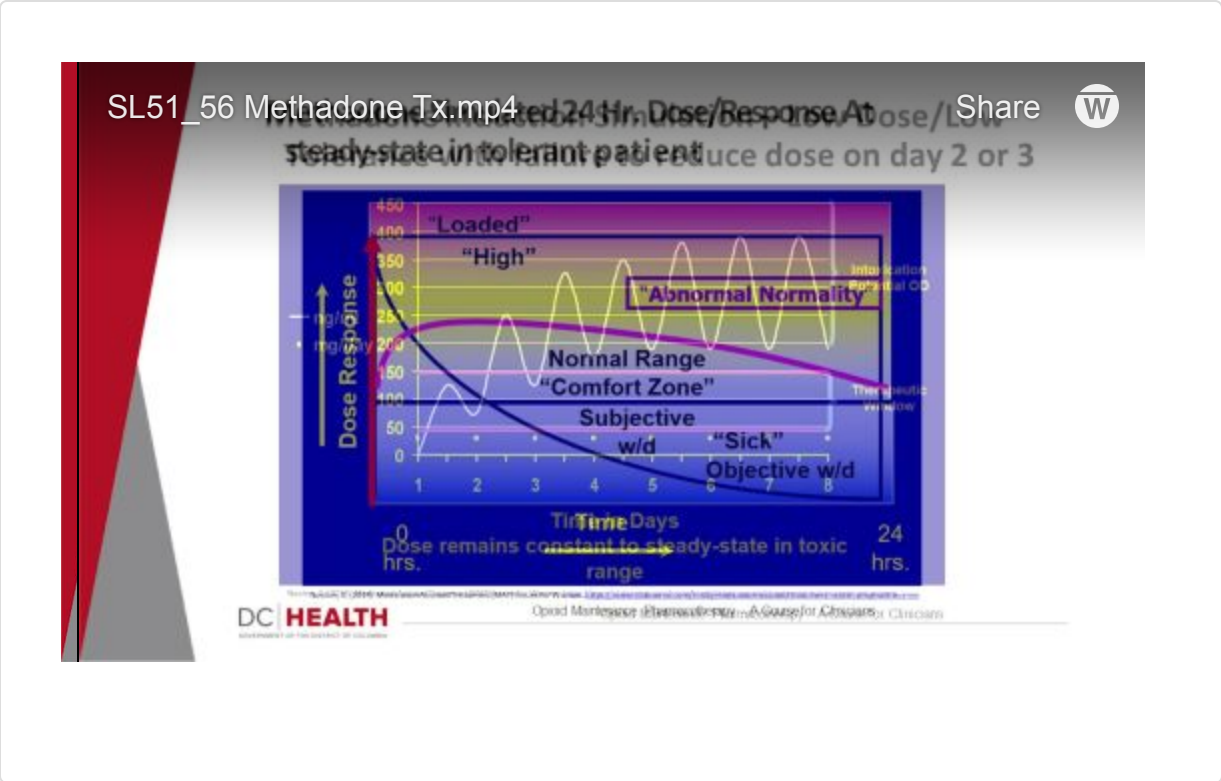
---

Findings published in the August 23, 1965 issue of JAMA,  
by Drs. Dole and Nyswander highlight several crucial

medical and sociological concerns regarding the treatment of drug addiction in the United States.

## Heroin and Methadone Simulated Dose/Response

In this video, Dr. Chapman reviews simulated dose responses for both heroin and methadone and the optimal response from Opioid Agonists in maintenance treatment.



Cytochrome P-450 Enzyme Activity Influences on Methadone  
Drug Interactions - Methadone



**INHIBITION**

- Fluconazole
- Cimetidine
- Erythromycin
- Fluvoxamine (Luvox)
- Ketoconazole
- Nefazodone (Serzone)
- Ritonavir (Norvir)

**INDUCTION**

- Rifampin
- Phenytoin
- Ethyl Alcohol
- Barbiturates
- Carbamazepine
- Nevirapine (Viramune)

## Substance Abuse and Mental Health Services Administration (SAMHSA) New Regulations



- Up to 28 days of take-home methadone after one month of treatment
- Remove counseling as a prerequisite for treatment
- Remove one-year history of OUD requirement
- Add harm reduction and recovery supports

- Add more providers; e.g., nurse practitioners and physician assistants to dispense methadone
- Allow prisons and jails to provide methadone to patients with other health conditions
- Allow for-profit Opioid Treatment Programs to provide interim treatment

## CHECK YOUR UNDERSTANDING

---

**Please watch the following video which features real-life insights and experiences from three patients. After viewing the video, take a moment to answer the following question.**



## Methadone Journeys: Patient Experiences and Insights

Please select the correct answer to complete the following statement:  
Methadone treatment for opioid use disorder

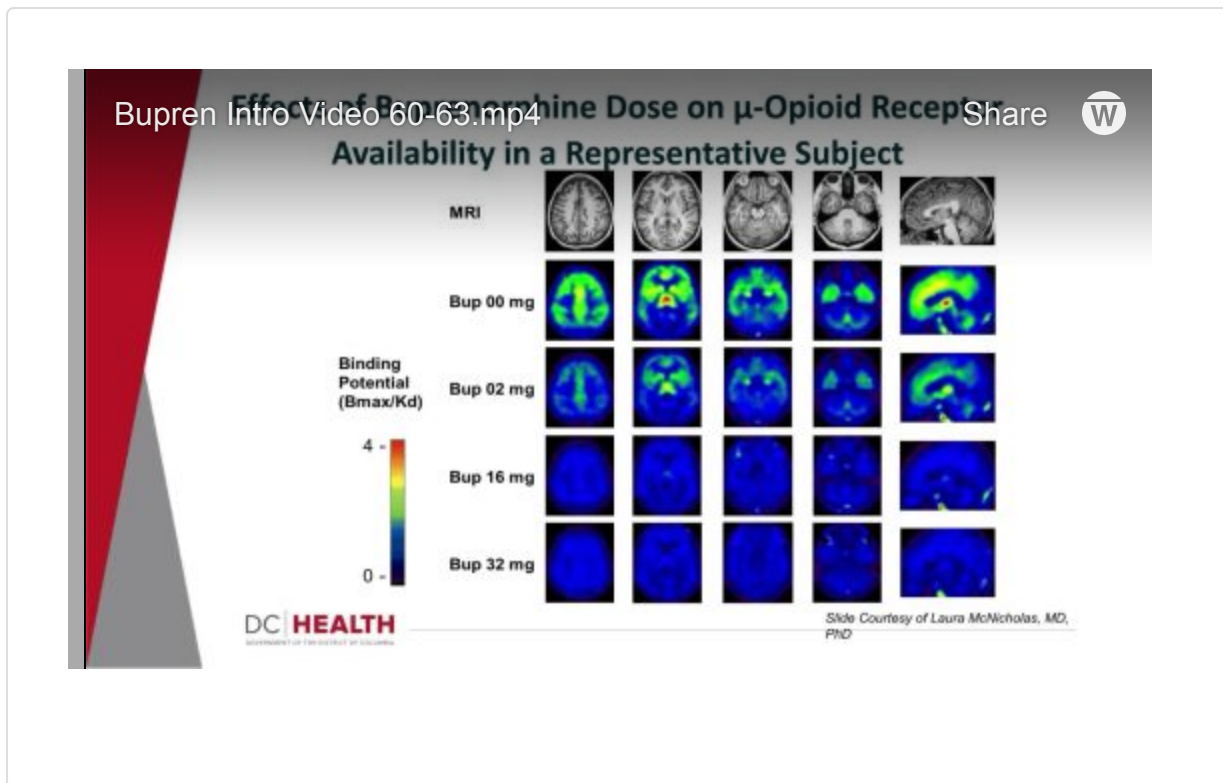
- Is universally effective for all individuals.
- May not be effective for everyone and requires careful monitoring.
- Has no potential for side effects or complications.

SUBMIT

## UNDERSTANDING BUPRENORPHINE TREATMENT

# Understanding Buprenorphine Treatment

## Introduction to Buprenorphine Treatment



## Buprenorphine: Subutex and Suboxone



# BUPRENOPHINE MONO: **SUBUTEX**

**SUBUTEX** ⇒ If crushed, dissolved and injected

- Can cause overdose



Buprenorphine Mono

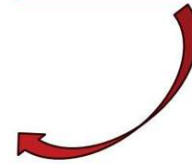
# BUPRENOPHINE + NALOXONE: **SUBOXONE**

**SUBOXONE** ⇒ antagonism of buprenorphine's agonist effect

- Decreases market for diversion
- Therefore, safer if diverted



Buprenorphine / Naloxone Combo

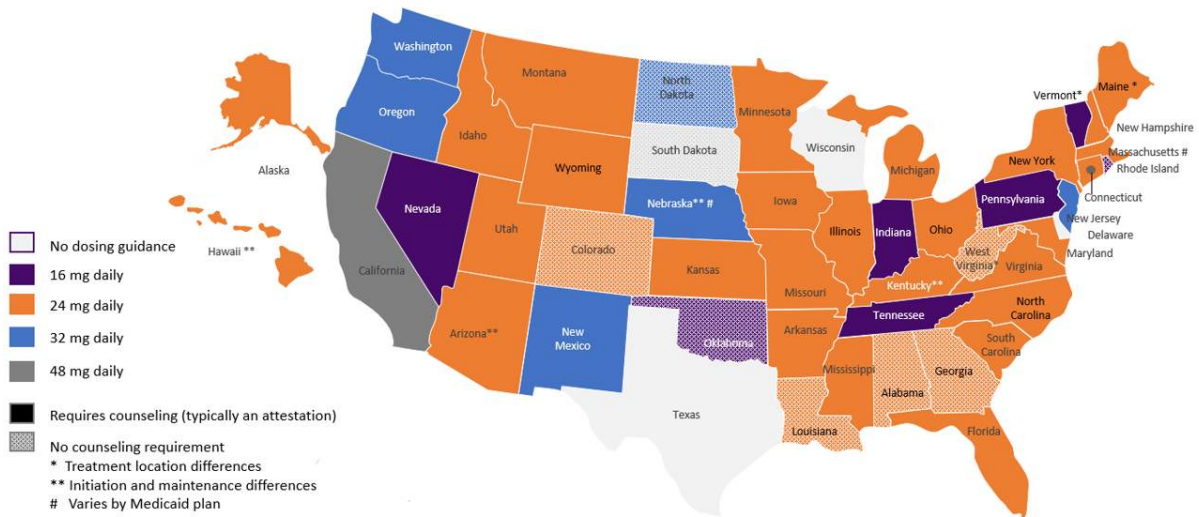


## Buprenorphine Coverage Requirements



00:49

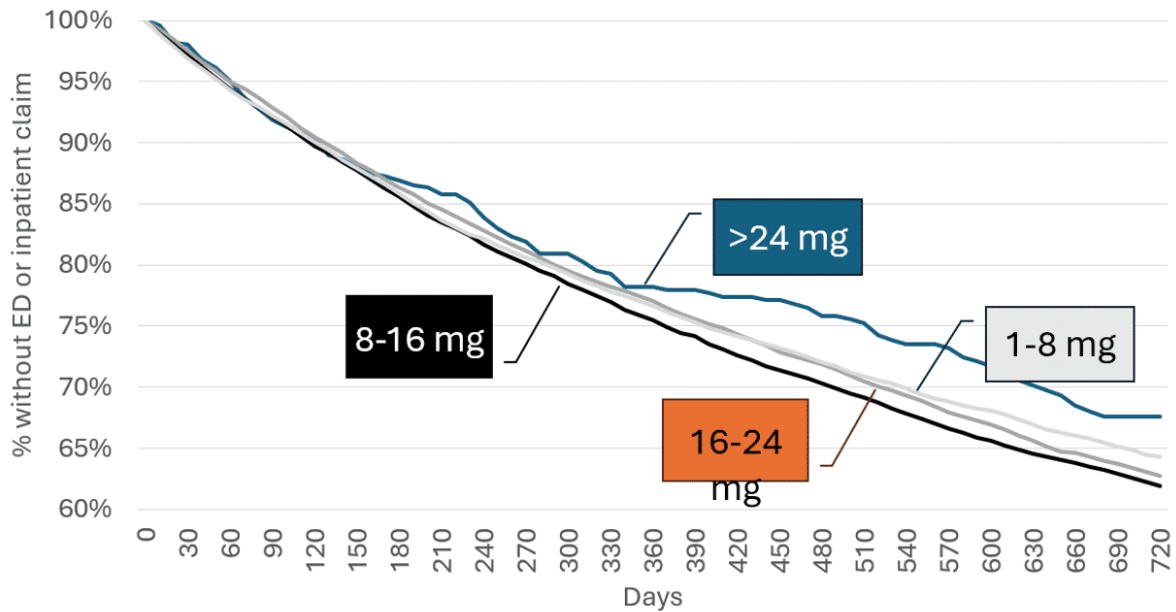
(Dose or Quantity) by State Medicaid



Publicly Available Information from Preferred Drug Lists, 2021 CMS DUR Reporting, and Public Sources.  
Analysis October 2023.

## Individuals in >24mg tier had longer period before having ED/inpatient treatment

00:49



## CA Bridge: Buprenorphine Self-Start

Guidance for Patients starting buprenorphine outside of hospitals or clinics

00:14

# Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

- 1 Plan to take a day off and have a place to rest.
- 2 Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
- 3 Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
- 4 Repeat dose (another 8mg-16mg) in an hour to feel well.
- 5 The next day, take 16-32mg (2-4 tablets or films) at one time.

### If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

### If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.



Place dose under your tongue (sublingual).

## Injectable Buprenorphine



00:25

### Brixadi

- Largest quantity is 0.64mL
- Needle Size: 1/2in 23 gauge needle
- Injection given at 90 degrees
- Latex - based cap

### Sublocade

- Largest quantity is 1.5mL
- Needle Size: 5/8in 19 gauge needle
- Injection given at 45-90 degrees
- Non-latex based cap



- No depot formation!
- Less intense "after burn"
- **Weekly or Monthly dosing option**
- Weekly - can be given +/- 2 days
- Monthly - can be given +/- 7 days
- Breakthrough symptom injection options
- Multiple injection site options
- Steady state in 4 injections
- After weaning- BUP is detectable up to 4 months
- Forms palpable depot in the SC space
- "Burns" during injection
- **Monthly dosing option only**
- Can be given +/- 2 days
- No breakthrough symptom injection option
- Can only be injected in the stomach
- Steady state in 6 injections
- After weaning- BUP is detectable up to 12 months

## Inhibitors, Substrates, and Inducers



# ↑ Buprenorphine levels

## P450 3A4 **Inhibitors**

e.g., fluoxetine (Prozac), azole antifungals (eg ketoconazole), nefazodone (Serzone), protease inhibitors (eg, ritonavir, indinavir, nelfinavir, saquinavir), macrolide antibiotics (erythromycin)

## P450 3A4 **Substrates**

e.g., Trazadone (Desyrel), alprazolam (Xanax), diazepam (Valium), buspirone (Buspar), zolpidem (Ambien), caffeine, haloperidol (Haldol), erythromycin, nifedipine, oral contraceptives

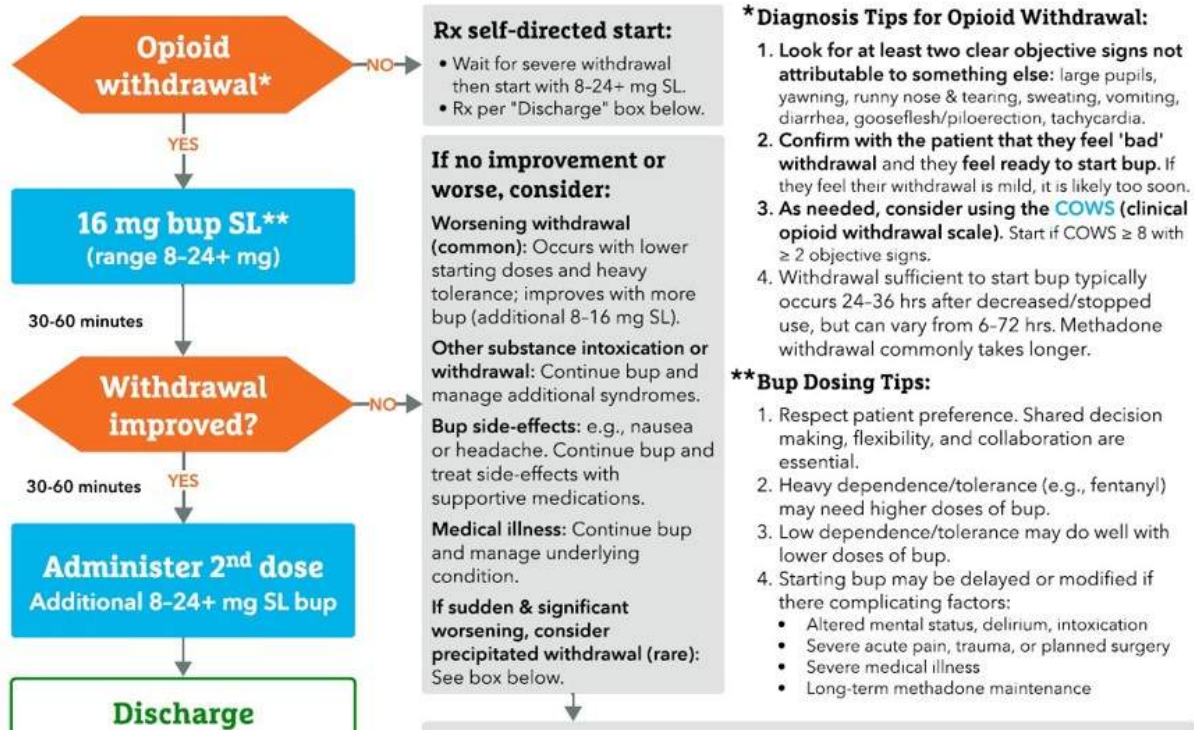
CA Department of Health and Human Services Quick Guides

## CA Bridge: Emergency Department Buprenorphine (Bup) Quick Start

Connect with your patient: Accurate Diagnosis and treatment requires trust, collaboration, and shared decision making



00:44



Bridge to Treatment. (n.d.). Buprenorphine (BUP) Hospital Quick Start. Retrieved from <https://bridgetotreatment.org/resource/buprenorphine-bup-hospital-quick-start/>

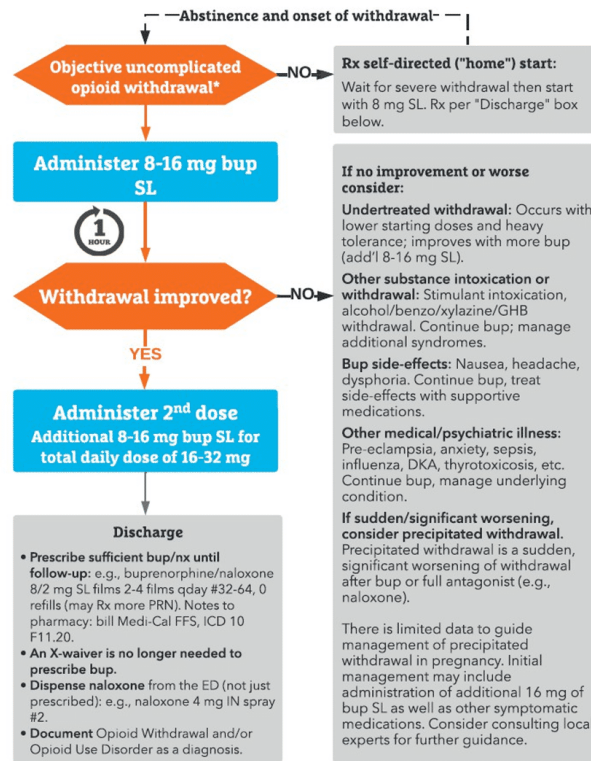
## CA Bridge: Buprenorphine (Bup) Quick Start in Pregnancy

This guidance is for the emergency department (ED). We advocate for continuation & Initiation of bup in inpatient and outpatient settings. Algorithms vary based on clinical scenario.



# Buprenorphine (Bup) Quick Start in Pregnancy

This guidance is for the emergency department (ED). We advocate for continuation & initiation of bup in inpatient and outpatient settings. Algorithms vary based on clinical scenario.



Bridge to Treatment. (n.d.). Buprenorphine Quick Start in Pregnancy. Retrieved from <https://bridgetotreatment.org/resource/buprenorphine-quick-start-in-pregnancy/>

## Risk of Misuse and Diversion of Buprenorphine

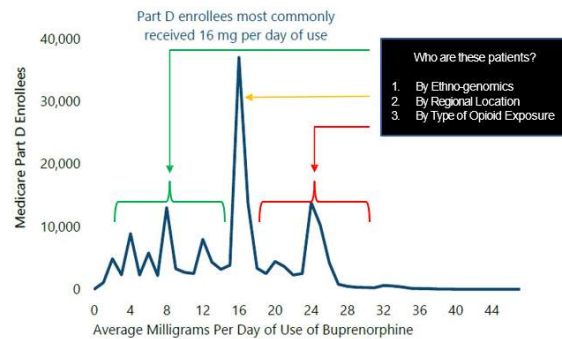




## The Risk of Misuse and Diversion of Buprenorphine for Opioid Use Disorder Appears to Be Low in Medicare Part D



Exhibit 1: Most Part D enrollees received dosages of buprenorphine at or below the recommended range of 4 mg to 24 mg per day



Source: OIG analysis of Prescription Drug Event data, 2023.

On average, enrollees received a total of 7 months of buprenorphine in the year. About a quarter of enrollees received buprenorphine for the entire year.

In addition, the majority of enrollees received buprenorphine from a few prescribers and pharmacies. Over half of enrollees—57 percent—received buprenorphine from one prescriber and almost three quarters—73 percent—filled their prescriptions at one pharmacy.

<https://oig.hhs.gov/reports-and-publications/all-reports-and-publications/the-risk-of-misuse-and-diversion-of-buprenorphine-for-opioid-use-disorder-in-medicare-part-d-continues-to-appear-low-2022/>

### ENHANCE YOUR UNDERSTANDING

Please watch the following video which features real-life insights and experiences from three patients. After viewing the video, take a moment to answer the following question.

### Patient Perspectives



## Navigating Recovery: Buprenorphine Patient Testimonials

How does Buprenorphine work in the treatment of Opioid Use Disorder?

---

- By blocking the effects of opioids and preventing withdrawal symptoms
- By stimulating opioid receptors in the brain, producing a euphoric effect
- By inducing a state of sedation to reduce cravings for opioids



By acting as a partial agonist at opioid receptors, reducing cravings and withdrawal symptoms

SUBMIT

What is one advantage of Buprenorphine over Methadone for MOUD?

---



Buprenorphine has a higher risk of overdose compared to Methadone.



Buprenorphine can be prescribed by qualified healthcare providers in an office-based setting.



Buprenorphine requires daily visits to specialized clinics for administration.



Buprenorphine has a shorter duration of action, necessitating more frequent dosing.

SUBMIT

---

## PATIENT ENGAGEMENT AND COUNSELING



# Patient Engagement and Counseling

---

## Importance of Patient Engagement in MOUD Treatment

Patient engagement plays a pivotal role in the success of Medications for Opioid Use Disorder (MOUD), fostering collaboration between healthcare providers and individuals receiving treatment. This section explores the significance of actively involving patients in their care, promoting adherence to medication regimens, addressing barriers to treatment, and fostering a supportive therapeutic relationship. By prioritizing patient engagement, healthcare providers can enhance treatment outcomes and support individuals on their path to recovery from opioid addiction.

**Patients do better with comprehensive psychosocial, vocational, medical, psychiatric and behavioral therapy**

Dr. Beny J. Primm, left, with Mayor John V. Lindsay of New York, center, and Dr. Bertram S. Brown, director of the National Institute of Mental Health, in an undated photo. As mayor, Mr. Lindsay secured money used by Dr. Primm to open a methadone clinic in Brooklyn in 1969.



*Dr. Beny Primm, Pioneer in Addiction and AIDS Prevention*



## Additional Treatment Considerations



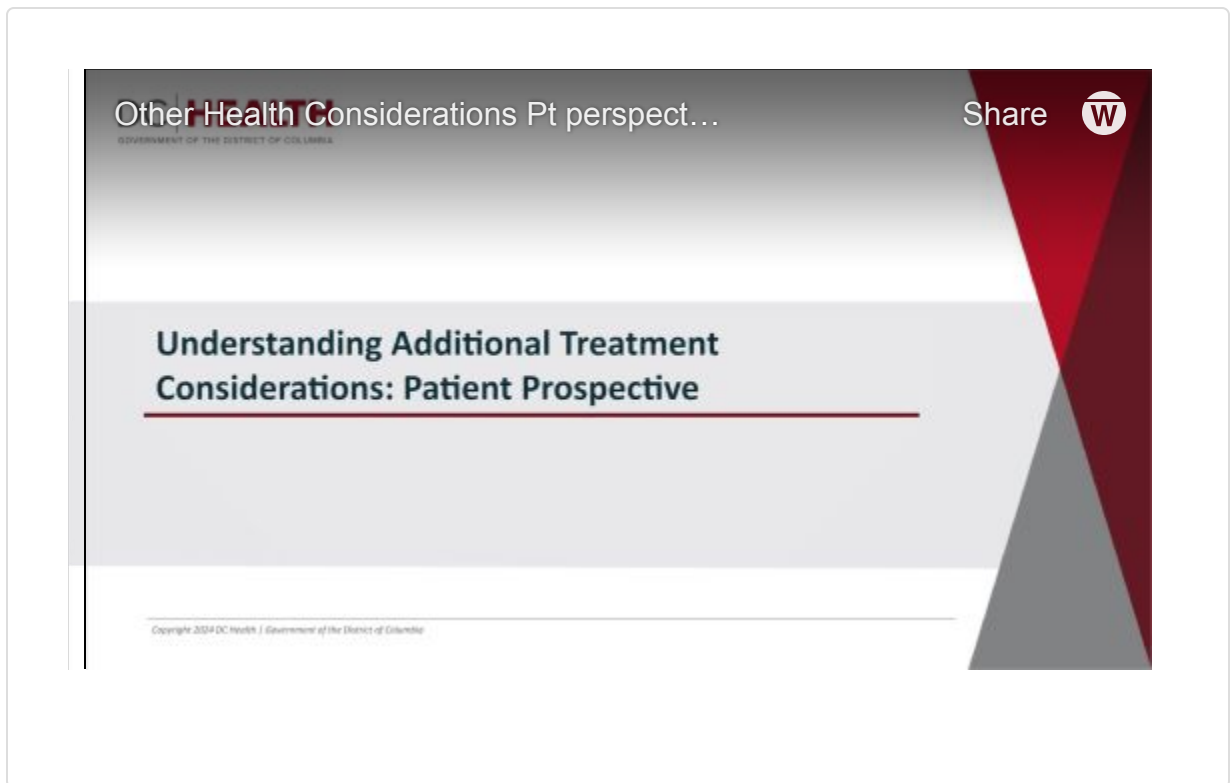
00:21

<https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care>


- Integrative/Collaborative Care
- HIV testing and counseling
- Antiretroviral treatment
- Prevention and treatment of sexually transmitted infections
- Peer-support and education

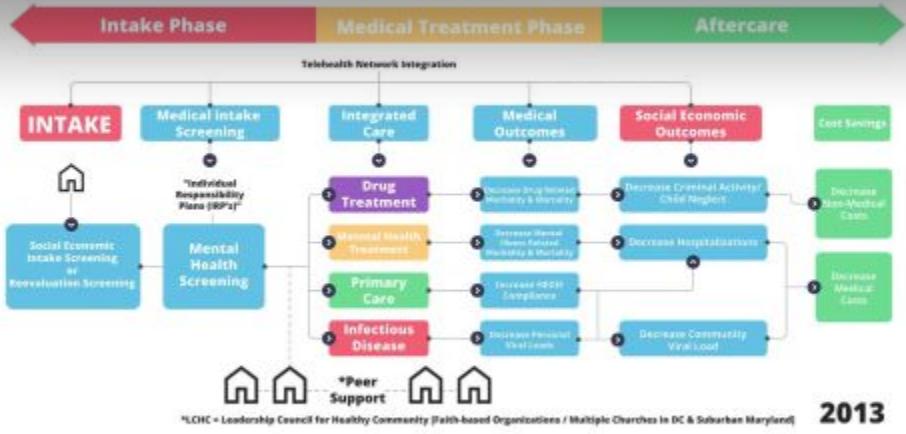
- Group Support-AA and NA
- Individuals with substance abuse were significantly less likely to discontinue HAART in the first and second years of treatment. Treatment of substance use disorders can prevent AIDS

## A Patients' Related Experience



## Integrated Treatment Flow Chart

Integrated Treatment Flow.mp4 **Share** 



Edwin C. Charnin, MD 7/28/2013



**Patient Goal Sheet\_Other drugs.pdf**  
515.8 KB



## Counseling Techniques for Patients on MOUD

Counseling techniques are integral to the comprehensive care of patients receiving Medications for Opioid Use Disorder (MOUD), complementing pharmacological interventions to support holistic recovery. This section provides resources for evidence-based counseling approaches tailored to individuals on MOUD, empowering healthcare providers with effective strategies to address psychosocial factors, enhance treatment adherence, and promote long-term wellness. By integrating counseling into MOUD programs, healthcare providers can offer personalized support to patients, fostering resilience and facilitating sustained recovery from opioid addiction.

### **American Society of Addiction Medicine (ASAM) Guidelines**

ASAM is a professional society representing physicians and other healthcare professionals specializing in addiction medicine. Their Clinical Practice Guideline on Medications for Opioid Use Disorder provides recommendations for the use of medications in the treatment of opioid use disorder, including the importance of involving patients in treatment decisions.

[ASAM LINK](#)

### **Addiction Technology Transfer Center (ATTC) Network**

The ATTC Network offers training, consultation, and resources to support healthcare providers in delivering effective addiction treatment services. They provide webinars, publications, and training events focused on patient engagement and MOUD.

[ATTC NETWORK](#)

### **National Council for Behavioral Health**

The National Council offers resources and training programs to support healthcare providers in delivering integrated behavioral health services, including addiction treatment. They provide webinars, toolkits, and publications on patient engagement and recovery-oriented care.

[NTL COUNCIL BEHAV...](#)

### **National Institute on Drug Abuse (NIDA) Principles of Effective Treatment**

NIDA offers principles of effective treatment for substance use disorders, which emphasize the importance of individualized care and patient involvement in treatment planning. Patient engagement and shared decision-making are key components of these principles

[EFFECTIVE TX](#)

### **Providers Clinical Support System (PCSS)**

PCSS provides evidence-based training and resources for healthcare providers prescribing MOUD. They offer free online courses, webinars, and clinical tools to support patient engagement and treatment adherence.

[PCSS LINK](#)

### **SAMHSA's Treatment Improvement Protocol (TIP) Series**

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a series of Treatment Improvement Protocols (TIPs) that provide evidence-based guidelines for substance use disorder treatment. TIP 63, titled "Medications for Opioid Use Disorder: Treatment Improvement Protocol," emphasizes the importance of patient-centered care and shared decision-making in MOUD treatment.

[TIP SERIES](#)

### **World Health Organization (WHO) Guidelines**

The WHO provides guidelines on the pharmacological treatment of opioid dependence, which emphasize the importance of patient-centered care and involvement in treatment decisions.

[WHO GUIDELINES](#)

**RESOURCES AND SUPPORT SYSTEMS**

# Resources and Support Systems

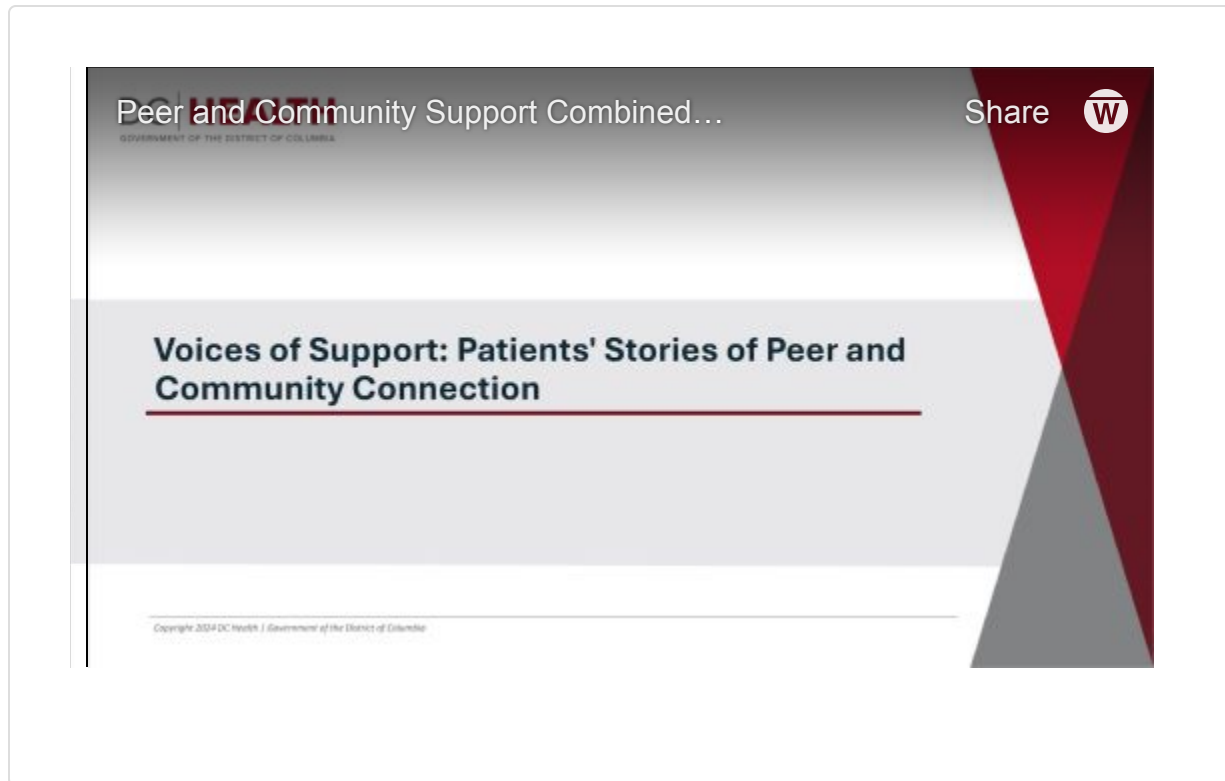
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## Peer and Community Support

Peer and community support play a crucial role in the treatment and recovery of individuals with Opioid Use Disorder (OUD) for several reasons:

- 1. Understanding and Empathy:** Peers who have experienced similar challenges with OUD can offer understanding, empathy, and non-judgmental support, which can help individuals feel less isolated and more accepted.
- 2. Shared Experiences:** Peer support groups provide a safe space for individuals to share their experiences, challenges, and successes in managing OUD. This sharing of experiences can offer valuable insights, coping strategies, and hope for recovery.
- 3. Role Modeling:** Seeing others who have successfully overcome OUD or are in the process of recovery can serve as powerful role models. Peer mentors and community members who have achieved long-term recovery can inspire hope and provide guidance on the journey to recovery.
- 4. Practical Assistance:** Peers and community support networks can offer practical assistance, such as transportation to treatment appointments, childcare, housing support, and access to resources for employment, education, and healthcare.
- 5. Accountability:** Peer support groups often promote accountability by encouraging individuals to set and work towards recovery goals, attend regular meetings, and stay engaged in their treatment plan. Knowing that others are rooting for their success can motivate individuals to stay committed to their recovery journey.

Overall, peer and community support create a sense of belonging, empowerment, and resilience among individuals with OUD, fostering a supportive environment conducive to recovery and well-being. In this brief video, patients discuss how they provide peer-peer support and participate in community support activities.



## Strategies for Facilitating Community Support Systems for Patients with Opioid Use Disorder (OUD)

Physicians, doctors, and nurses can play a crucial role in helping their patients with Opioid Use Disorder (OUD) find and participate in support systems available in their communities through the following strategies:

1. **Education and Awareness:** Healthcare providers can educate their patients about the importance of peer and community support in recovery from OUD. By raising awareness about support groups, mutual aid networks, and community



resources, healthcare providers empower their patients to seek out additional support beyond clinical treatment.






2. **Referrals and Recommendations:** Healthcare providers can provide referrals and recommendations to local support groups, peer-led recovery programs, community-based organizations, and other relevant resources. This may include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), SMART Recovery, Celebrate Recovery, and other peer support groups tailored to individuals with substance use disorders.
3. **Collaboration with Treatment Teams:** Healthcare providers can collaborate with other members of the treatment team, such as counselors, social workers, case managers, and peer support specialists, to facilitate referrals and coordinate care. By working together, healthcare providers can ensure that patients receive comprehensive support that addresses their medical, psychological, social, and recovery needs.
4. **Screening and Assessment:** Healthcare providers can incorporate screening tools and assessments into their practice to identify patients who may benefit from additional support services. Screening for social determinants of health, mental health conditions, trauma history, and substance use severity can help healthcare providers tailor their recommendations and referrals to meet the individual needs of their patients.
5. **Culturally Competent Care:** Healthcare providers should provide culturally competent care that respects the values, beliefs, and preferences of their patients. This includes recognizing the unique cultural factors that may influence help-seeking behaviors, stigma perceptions, and engagement in support systems within diverse communities.
6. **Motivational Interviewing:** Healthcare providers can use motivational interviewing techniques to engage their patients in discussions about the benefits of peer and community support. By exploring patients' readiness for change, addressing ambivalence, and highlighting the positive aspects of participation in support groups, healthcare providers can enhance patient motivation and willingness to seek out support.

**7. Follow-Up and Monitoring:** Healthcare providers should follow up with their patients regularly to assess their progress, address any barriers to participation in support systems, and provide ongoing encouragement and support. By maintaining open communication and offering continued guidance, healthcare providers can reinforce the importance of community involvement in the recovery process.





Overall, healthcare providers play a vital role in connecting their patients with OUD to the support systems and resources available in their communities. By integrating support services into comprehensive treatment plans and adopting a patient-centered approach, healthcare providers can empower their patients to build strong support networks that promote long-term recovery and well-being.

## COURSE DOCUMENTS

For your convenience, in this section, you will find a copy of the presentation slides and several documents gathered from different segments of this course.

	<b>Identification_Treatment of Opioid Use Disorder Presentation</b> .pdf 7.4 MB	
	<b>Clinical Opiate Withdrawal Scale.pdf</b> 606.5 KB	
	<b>Drug Abuse Screening Test_2014Mar24.pdf</b> 50.6 KB	

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	<b>NIDA Screening Fact Sheet.pdf</b> 1.3 MB	
	<b>Patient Goal Sheet_Other drugs.pdf</b> 515.8 KB	

## Acknowledging the Patient Perspectives

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Throughout this course, you heard from patients about their experiences with MOUD. We extend our gratitude to the patients who generously shared their experiences and insights with us. Thank you for your openness, courage, and commitment to improving the lives of others.

Course Outro.mp4


Share



**DC | HEALTH**  
GOVERNMENT OF THE DISTRICT OF COLUMBIA

899 North Capitol Street NE, 5th Fl, Washington, DC 20002

 [dchealth.dc.gov](https://dchealth.dc.gov)

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 [dchealth](https://www.instagram.com/dchealth)

 [DC Health](https://www.facebook.com/DCHealth)

 [dchealth](https://www.tiktok.com/@dchealth)

For more information on the District's COVID-19 response, visit [coronavirus.dc.gov](https://coronavirus.dc.gov)

**PLEASE BE SURE TO COMPLETE THE KNOWLEDGE CHECKS AND  
EVALUATION TO RECEIVE YOUR CE CREDITS.**