Supporting Individuals with Opioid Use Disorder in Psychosocial Programs:

A Practice Support Document

CRISM-ICRAS
Canadian Research Initiative in Substance Misuse
Initiative Canadienne de Recherche en Abus de Substance

CIHR IRSC
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Introduction

Objective

This guide is designed to support addiction program managers and service providers in designing, developing, and delivering treatment for individuals with opioid use disorder (OUD) within their psychosocial treatment setting.

This guide provides an overview of OUD, highlights considerations for individuals presenting with OUD, and identifies key principles of practice for the treatment of OUD within psychosocial programs.

Background

In response to the drug poisoning crisis in Canada, treatment programs are integrating opioid agonist treatment (OAT) and addiction treatment and recovery services that provide a variety of non-pharmacological psychosocial interventions.

To better understand the current approach to treating opioid use disorder (OUD) in these settings, The Treatment of Opioid Use Disorder in Psychosocial Programs (TOPP) project, funded by the Canadian Research Initiative in Substance Misuse (CRISM), surveyed psychosocial addiction treatment programs across Canada.

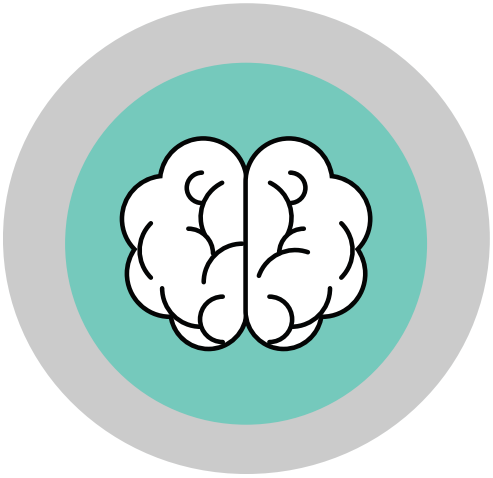
Following completion of an online census survey with Canadian psychosocial addiction treatment programs (N=214), 14 interviews were completed with key stakeholders to identify examples of model programs and key practice principles for providing treatment for individuals with OUD within a variety of psychosocial settings, including outpatient, day programs, and bed-based treatment.

Overview of Opioid Use Disorder

Opioid use disorder (OUD) is defined as a chronic condition with significant personal and public health consequences.

OUD may involve the use of prescription opioid medications (e.g., hydromorphone, morphine) or street manufactured opioids, such as heroin or fentanyl analogs.

In Canada, the landscape of opioid use has increasingly involved the non-medical use of prescription opioids and the use of highly potent street manufactured fentanyl and fentanyl analogues.



Opioids have the potential to be highly addictive and change the way the brain operates.

Opioid use disorder can develop in anyone, even when opioids are prescribed and taken as directed.

Opioid Withdrawal

Opioid withdrawal is the mental and physical discomfort that is experienced when the intake of an opioid is reduced or stopped completely.

Opioid withdrawal symptoms can be very extreme and painful, lasting for days to weeks. Symptoms may include*:

- Sweating and trembling
- Anxiety
- Depression
- Insomnia
- Muscle aches
- Stomach pain
- Vomiting
- Feeling jittery

Many people may continue using opioids because the symptoms of withdrawal are unmanageable

*withdrawal symptoms can differ depending on the type of opioid used and/or other adjunct substances or materials added in the unregulated supply (e.g., benzodiazepines)

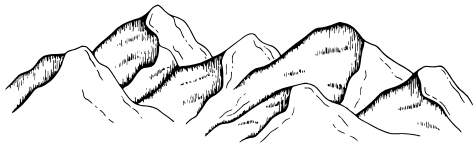
Screening and Diagnosis of OUD

Screening for OUD allows for identification of individuals who may be at risk of OUD and who may benefit from psychosocial interventions and supports. There are various screening tools available and the best one may be defined by what works best for your team.

In addition to opioid-specific screening tools, additional screening tools may be used to assess polysubstance use, mental health, and physical health concerns (e.g., sexually transmitted and blood-borne infections).

Screening and Diagnosis of OUD

Rapid Opioid Dependence Screen



RODS assesses multiple types of general opioid dependence. It is a valid and reliable measure that can be administered quickly. If there is opioid dependency present, further assessment may be conducted using DSM-5©.

1. Have you ever taken any of the following drugs?

- Heroin
- Methadone
- Buprenorphine
- Morphine
- MS Contin
- Oxycodone

If any drug from Question 1 is chosen, move on to Question 2

2. Did you ever need to use more opioids to get the same high as when you first started using opioids?

Yes No

3. Did the idea of missing a fix (or dose) ever make you anxious or worried?

Yes No

4. In the morning, did you ever use opioids to keep from feeling “dope sick”, or did you ever feel “dope sick”?

Yes No

5. Did you worry about your use of opioids?

Yes No

6. Did you find it difficult to stop or not use opioids?

Yes No

7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high?

Yes No

8. Did you ever miss important things like doctor’s appointments, family/ friend activities, or other things because of opioids?

Yes No

Add number of “yes” responses from questions 2 to 8.
If total is 3 or more, there is opioid dependency present and additional screening may be completed with the DSM-5.

Wickersham, J. A., Azar, M. M., Cannon, C. M., Altice, F. L., & Springer, S. A. (2015). Validation of a Brief Measure of Opioid Dependence: The Rapid Opioid Dependence Screen (RODS). Journal of correctional health care : the official journal of the National Commission on Correctional Health Care, 21(1), 12–26. https://doi.org/10.1177/1078345814557513

Screening and Diagnosis of OUD

DSM-5 Opioid Use Disorder Criteria

The DSM-5 defines OUD as a problematic pattern of opioid use leading to clinically significant impairment or distress.

Check all that apply

- ☐ Opioids are often taken in larger amounts or over a longer period of time than intended
- ☐ There is a persistent desire or unsuccessful efforts to cut down or control opioid use
- ☐ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects
- ☐ Craving or a strong desire to use opioids
- ☐ Recurrent opioid use resulting in failure to fulfill major role obligations at work, school, or home
- ☐ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
- ☐ Important social, occupational, or recreational activities are given up or reduced because of opioid use
- ☐ Recurrent opioid use in situations in which it is physically hazardous
- ☐ Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids
- ☐ Tolerance, as defined by **either of the following:**
  (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect
  (b) markedly diminished effect with continued use of the same amount of an opioid
- ☐ Withdrawal, as manifested by **either of the following:**
  (a) the characteristic opioid withdrawal syndrome
  (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Severity:
Mild: 2-3 symptoms. **Moderate:** 4-5 symptoms. **Severe:** 6 or more symptoms.

Considerations for Individuals with OUD

When admitting individuals with OUD into your program, there are unique considerations to be aware of:

Substance Use History

It is important to assess the individual's use of substances, including all types of substances used, age and amount of first use, periods of abstinence, any previous overdose(s) from opioid use, as well as treatment history and current treatment goals.

Opioid Agonist Treatment

Opioid agonist treatment (OAT) can support individuals in achieving their recovery goals. OAT involves taking medication to prevent withdrawal symptoms and reduce cravings for opioids. Assessing whether the individual has been offered OAT or is interested in OAT, in addition to supporting individuals currently taking OAT is recommended.

Naloxone

Naloxone, a medication used to reverse an opioid overdose, is recommended to be made available to **all individuals** with OUD and/or a history of using opioids. Having naloxone on site to respond to opioid overdose, as well as having naloxone kits and accompanying education available for individuals and their support system, is recommended.

Overview of OAT

- Using OAT for treatment of OUD has been demonstrated to increase treatment retention, reduce use of unregulated or unprescribed substances, and lower risk of morbidity and mortality compared to medically assisted withdrawal management alone. Treatment may be more effective when partnered with counselling/psychosocial care.
- OAT strikes a balance between the principles of abstinence and harm reduction. Its goals include to eradicate or minimize drug use carrying substantial risks and to prevent the progression of opioid tolerance, overdose, intoxication, and withdrawal, resulting from the use of potent opioids.
- Individuals on a stable dose of an OAT can expect to experience increased withdrawal management, which may support participation in group activities.
- Bed-based treatment programs that provide OAT do not report that these medications are triggering to other individuals who are trying to be "drug-free". If an individual is feeling triggered, this can be further explored during their treatment program.
- It is recommended that OAT be accessible to individuals and that tapering from OAT is not required for admission or throughout treatment.

The type of OAT will depend on factors such as:

- Priorities of the patient (e.g., preferences, motivation)
- Comorbidities
- Potential drug-drug interactions
- Severity of OUD
- Previous experience with OAT
- Coverage/access to medications
- Most recent published guidelines regarding OAT

Buprenorphine Formulations	Methadone	Slow-release Oral Morphine (SROM) or Hydromorphone	Injectable Opioid Agonist Treatment (iOAT)
Buprenorphine-Naloxone • Partial opioid agonist • Taken sublingually • Contains naloxone to prevent diversion of medication • Individuals must be in withdrawal in order to start medication **Buprenorphine Extended Release (XR)** • Can be given via subcutaneous injection or transdermal as a patch • Requires stabilization with burprenorphine-naloxone prior to initiation	• Recommended second line of treatment • Full opioid agonist • Can be taken orally as a liquid or tablets • Lower safety profile • Can take longer to stabilize (e.g., requires a longer titration period)	• May be recommended if the individual does not respond to first or second line treatments or if preferred by individual • May be used in conjunction with other OAT • SROM taken as pellets sprinkled into cup/soft food; hydromorphone may be liquid, tablet, or injectable • SROM is a long-acting medication • Hydromorphone can be long or short-acting	• Recommended for individuals who have used injectable opioids and do not respond well to other forms of OAT • Often used in conjunction with another long-acting OAT • Injectable hydromorphone or diacetylmorphine

*Other medications for OAT such as fentanyl patches may also be available, depending on region, availability, and preference

Supporting individuals on OAT

If an individual is new to OAT:

Conversations with an individual who is new to OAT should be initiated upon entry into a program.

It is recommended that the individual be introduced to OAT while in treatment rather than deferring initiation until after discharge. Additionally, if OAT was offered on site there should be a transition to an outpatient OAT program set up prior to discharge with a prescription filled (e.g., bridging prescription).

1

To initiate OAT, the individual and/or treatment centre speaks to a medical professional who is approved to prescribe OAT. Together, they determine which medication is most appropriate to initiate.

2

Depending on resources and what is most appropriate for the individual (e.g., location, comfort, accessibility), dispensing of OAT may be done at a treatment centre, clinic, pharmacy, and/or in-home.

3

Most OAT treatment begins as daily witnessed doses (i.e., to monitor reactions and adherence) with the potential of transitioning to take-home doses (e.g., carries) in communication with the prescriber and individual on treatment.

- Individuals who may be pregnant should be started on OAT as soon as possible.
- Youth should not be treated differently in terms of OAT initiation (e.g., not requiring youth to complete a psychosocial treatment trial before offering OAT and/or parental consent).

If an individual enters a program already on OAT:

It is recommended that if an individual enters a treatment program on OAT, they remain on a stable dose of OAT, or continue to titrate as needed, for the duration of the program.

- Rapid tapering may distract the individual from the program in addition to increasing the risk of return to use and adverse events (e.g., overdose)
- In consultation with the prescriber and individual on treatment, titration of the dose may occur if the individual and/or treatment provider express concerns about ability to engage in program due to OAT side effects (e.g., drowsiness)

If an individual expresses desire to taper while in the program, consultation with the prescriber is needed to explore their motivation to taper and the risks associated with same.

Key Practice Principles

The following key practice principles were created in partnership with various bed-based and outpatient programs across Canada. **These are not listed in order of importance.** These are principles to consider if an individual with OUD presents to your program.

1. Opioid Agonist Treatment (OAT)
2. Individually-centred & Recovery-oriented
3. Anti-Racism & Cultural Safety
4. Indigenous Cultural Safety
5. Gender-affirming Care & Informed Approach
6. Trauma-informed Care (TIC)
7. Peer-Support
8. Continuity of Care
9. Network of Services
10. Telehealth/Virtual Services
11. Case Management
12. Naloxone & Harm Reduction Services
13. Quality Improvement & Evaluation

1. Opioid Agonist Treatment

OAT may be prescribed on-site at any treatment location by a regulated prescriber.

If there is no prescriber/provider on-site:

- Explore possibility of prescriber coming to facility once a week
- Arrange transportation for individuals to have access to prescriber
- Utilize virtual programs and/or prescribers (e.g., Virtual Opioid Dependency Program in Alberta)

Opioid Use Disorder training may be helpful and increase the capacity for those treating OUD

It is often not sufficient to defer initiation of OAT to a community OAT clinic after the individual has been discharged. Discharged individuals often have cravings and subacute withdrawal symptoms that could cause them to return to use. Individuals who return to use after a period of abstinence are at a higher risk for overdose due to decreased tolerance and changes in the unregulated supply. It is safer to introduce OAT while the individual is completing the treatment program.

2. Individually-centred & Recovery-oriented

Success looks **different** for each individual

It could mean decreasing substance use, being abstinent, remaining stable on OAT, or attending consecutive group sessions

Individually-centred care prioritizes **the needs, preferences, and active involvement** of the individual in decision making. People have different reasons for seeking recovery, and it is important that **their reasons** are explored

Recovery-oriented treatment encompasses other areas of life such as:

- relationships
- physical and mental health
- housing
- employment
- life skills

3. Anti-Racism & Cultural Safety

By integrating an anti-racist framework into substance use treatment, we can improve quality-of-care, engagement in treatment, and enhance health outcomes, particularly for marginalized communities and those experiencing racialization

Examples of anti-racist policies:

- Mandate anti-racism training for staff
- Build partnerships with community organizations that support members of racialized communities
- Tailor treatment plans and approaches to specific cultural/racial groups
- Provide space and other necessities for religious or cultural practices
- Establish a confidential, clearly-defined, and communicated procedure for individuals and employees to safely report racial discrimination

4. Indigenous Cultural Safety

Indigenous cultural safety is an approach that moves beyond the concept of cultural sensitivity to consider how social and historical contexts, institutional discrimination, structural and interpersonal power imbalances, and past, current, and ongoing colonization shape health and health care experiences of Indigenous peoples.

When working with First Nations, Métis, and/or Inuit individuals it is imperative that the individual's desired amount of expression of culture and healing be woven through their recovery journey.

Ways to improve Indigenous Cultural Safety:

- Mandating Indigenous Cultural Safety Courses for staff
- Understanding the importance of local history and the lasting and multigenerational impacts of colonization and the residential school system
- Understanding how power imbalances may impact encounters with health care providers
- Understanding health as encompassing physical, mental, emotional, and spiritual well-being
- Respecting and supporting local traditions, traditional beliefs, and healing practices (e.g., offering a space for smudging)
- Recognizing and respecting differences in communication styles, which may be influenced by power imbalances as well as culturally-specific behaviors
- Challenging personal assumptions, being flexible, and being open to changing how things are commonly done

5. Gender-affirming Care & Informed Approach

Gender-affirming care is a holistic approach that acknowledges and supports the diverse needs of individuals in their journey to affirm their gender identity.

Offering gender-affirming care can include:

- Providing training for staff on gender diversity, sensitivity, and the unique needs of individuals across the gender spectrum
- Fostering an understanding of inclusive language and respectful communication (e.g., using preferred pronouns)
- Ensuring that intake forms are gender-inclusive and allow for self-identification of sex, gender, and preferred pronouns
- Creating a physical environment that is welcome to all genders, including gender neutral washrooms, as well as displaying signage that reflects diverse gender identities
- Engaging with 2SLGBTQIA+ communities and organizations to build partnerships and improve services

Opioid use is a gendered experience. Using a gender-informed approach to expand treatment capacity and reduce barriers to treatment engagement is essential.

Barriers to substance use disorder treatment can vary by sex and gender.

Applying a gender-based lens to treatment services can improve accessibility and treatment outcomes.

6. Trauma-informed Care (TIC)

TIC does not mean that the program has to directly address an individual's trauma and work through it, but rather understand that physical, emotional, and spiritual trauma can be widespread in its causes, impacts, and symptoms.

The aim of TIC is to provide control, safety, and choice for an individual while actively working to prevent re-traumatization.

TIC training should be a requirement for staff and on-going training offered

7. Peer Support

A peer-support position is a designated role, in which the employee is present in the program as general support for individuals.

A peer-support worker might:

- Assist with individual engagement and participation in the program
- Foster connections between individual and community services (e.g., OAT clinic, pharmacy)
- Offer mentorship and support; sharing of their own journey with recovery
- Advocate for individual needs
- Reduce isolation and loneliness
- Model wellness
- Assist individual in attending appointments and/or activities

An example of a peer support role may be sitting in the waiting room with individuals before/after an appointment, or checking-in on an individual in the community and assisting them in attending an appointment

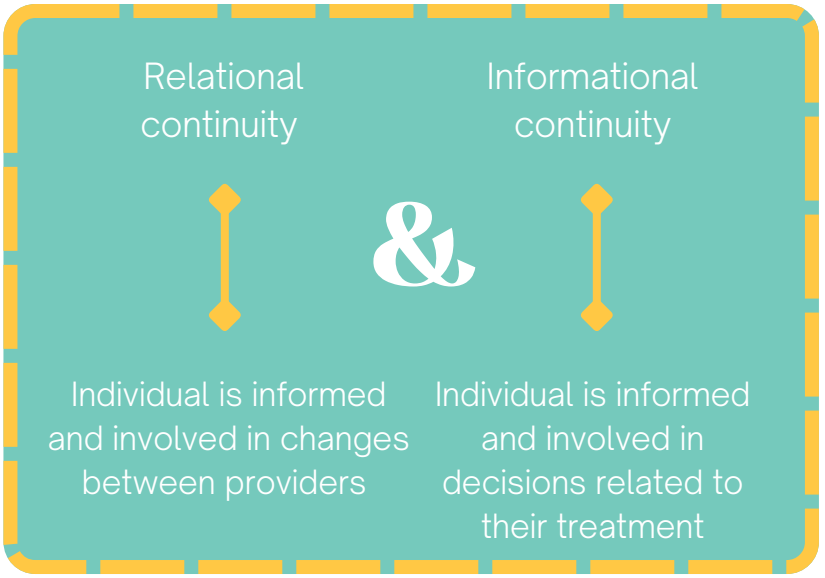
8. Continuity of Care

For many individuals, continuity of care means that their experience of care is connected and well-organized through their entire care journey - between care providers and between facilities.

For example, if an individual initiates OAT while in a program and OAT is offered on-site, transition to outpatient OAT should be initiated and established prior to individual discharge.

It also means that individuals are informed of, and involved in, decisions around:

- Who is involved in their care
- What the plan of care is
- What will happen next



9. Network of Services

Network of services encompasses having strong partnerships and effective communication with services that an individual may need during treatment.

If the services are not available on site, having a partnership with these services so that the individual can have easier access is important.

For example, if OAT is being taken off-site or in an outpatient setting, there should be on-going communication between the pharmacist, prescriber, and individual to address issues such as treatment adherence (e.g., missed dose) or a change in dose (e.g., increase, reduction, titration, or taper).

While recognizing that it may not always be possible to have an OAT provider see an individual during the treatment program, many communities have additional OAT providers such as Rapid Access Addiction Medicine (RAAM) clinics or Centre de Réadaptation en Dépendance, who can facilitate OAT.

Bed-based treatment centers can establish relationships with local OAT providers to support individuals with OUD who are not on OAT. In some regions, a virtual program may be available.

10. Telehealth & Virtual Services

Telehealth or telemedicine became more widely used during the Covid-19 pandemic and has continued to be helpful for individuals and practitioners, particularly those in rural settings.

If possible, it is best to see the individual in person. If in-person is not feasible, telehealth is a useful alternative.

When considering telehealth for OUD, healthcare providers should consider:

- Each individual's needs
- Stability and safety
- Storage and transport of medication
- Overdose risk, diversion risk, lapse or relapse
- The safety of different OAT medications

11. Case Management

Case management focuses on fostering a **coordinated and interdisciplinary** approach to individual needs.

This role may be filled by a variety of providers (e.g., nurses, social workers, addiction counsellors). It is essential that the Case Manager is skilled in advocacy, 'seeing the big picture', sharing, and coordinating perspectives.

Roles may include:

- Assessing individual needs
- Meeting with an interdisciplinary team (e.g., social workers, nurses, psychologists) for updates on individual progress and needs
- Advocating for needs as identified by the individual
- Coordinating care providers and post-treatment planning

12. Naloxone & Harm Reduction Services

In addition to staff training on overdose prevention and response, it is recommended that naloxone be offered to everyone who enters the treatment program, regardless of their risk or usage, including family and/or friends of the individual.

Alongside providing a naloxone kit, its crucial to provide education on safe drug use practices in case of return to use. This may include strategies such as doing a 'test-dose' first as a precaution for decreased tolerance, not using substances alone, and refraining from intentionally combining opioids with substances like benzodiazepines and/or alcohol.

Additional harm reduction supplies include safe injection and inhalation supplies, and sex supplies (e.g., condoms)

If your program does not supply these items, ensure that you have a connection with an organization that provides these supplies (network of services)

13. Quality Improvement & Evaluation

Quality Improvement is the **on-going** initiative to improve individual experience at the treatment facility

This might look like:

- Comment cards
- A QI team that meets bi-weekly
- Surveys given to individuals
- Informal conversations with individuals

Quality Improvement can be focused on how the facility runs as a whole, or understanding and adapting to specific individual needs

Evaluation assesses identified indicators for success/recovery on a pre-determined **time-frame** (e.g., quarterly)

Outcomes/Indicators may include:

- Quality of relationships
- Employment
- Housing
- Medical stability regarding OUD

Evaluation indicators may be different depending on the facility, its funders, and how 'success' is defined

Evidence-Based Psychosocial Interventions for OUD

Treatment of OUD may be enhanced when OAT is partnered with psychosocial interventions.

Although research is limited, the treatment approaches described below have been shown to be evidence-based when specifically treating OUD.

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy works with individuals to challenge their outlook on life and self-image. CBT assists people in identifying their values and creating a plan that aligns with their values and what they want their life to look like.

Motivational Interviewing (MI)

Motivational interviewing aims to increase the internal motivation to change by addressing ambivalent feelings related to opioid use. A therapist and individual work together to address any fears or ambivalence the individual has about changing their behavior.

Contingency Management (CM)

Contingency management centers around using incentives to encourage a desired behavior. Incentives may include gift cards, vouchers, or prizes. In the context of opioid use, an incentive may be offered when an individual achieves a treatment related goal (e.g., attending counselling, adhering to OAT medication). Targeted behaviours and incentives may be different for each individual. CM does not need to be carried out by a regulated therapist (unlike CBT and MI).

Resources

Opioid Use Disorder and Opioid Agonist Treatment

Alberta Opioid Dependency Treatment (ODP) Virtual Training Program
http://www.ahs.ca/odt

British Columbia Centre on Substance Use: Guideline for the Clinical Management of OUD
https://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

Opioid Use and Opioid Use Disorder Education Resource
https://ououd.casn.ca/

SafeLink Alberta: Best Practices for Supporting People Who Use Substances
https://safelinkalberta.ca/suap-toolkit/

Indigenous Cultural Safety Courses

The National Indigenous Cultural Safety Collaborative Learning Series
https://www.icscollaborative.com/

The Ontario Indigenous Cultural Safety Program:
http://soahac.on.ca/indigenous-cultural-safety-training-program/

Manitoba Indigenous Cultural Safety Training:
https://wrha.mb.ca/indigenous-health/education-and-training/micst/

San'yas Indigenous Cultural Safety Training Program:
https://sanyas.ca

First Nations Health Authority (FNHA) and BC individual Safety & Quality Council's Cultural Safety and Cultural Humility Webinar Action Series:
https://www.fnha.ca/about/news-and-events/news/cultural-safety-and-cultural-humility-webinar-action-series

Reconciliation Education:
https://www.reconciliationeducation.ca/en-ca/

New Respect Indigenous Cultural Safety by Public Health Training for Equitable Systems Change (PHESC):
http://www.phesc.ca/indigenous

Indigenous Canada course offered by the University of Alberta Faculty of Native Studies:
https://www.ualberta.ca/admissions-programs/online-courses/indigenous-canada/index.html

Resources

Trauma Informed Care

Alberta Health Services Trauma Training Initiative
https://www.albertahealthservices.ca/info/page15526.aspx

The BC Centre of Excellence in Women's Health's New Terrain Toolkit:
https://cewh.ca/wp-content/uploads/2018/06/NewTerrain_FinalOnlinePDF.pdf

The VEGA (Violence, Evidence, Guidance, and Action) Project:
https://vegaproject.mcmaster.ca/

The Manitoba Trauma Information and Education Centre's The Trauma-Informed Toolkit:
https://trauma-informed.ca/

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Trauma-Informed Care in Behavioral Health Services
https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

EQUIP Health Care's Trauma- and Violence-Informed Care Tool:
https://equiphealthcare.ca/resources/toolkit/trauma-and-violence-informed-care/

EQUIP Health Care's Trauma- and Violence-Informed Care Workshop
https://equiphealthcare.ca/tvic-workshop/

EQUIP Health Care's Trauma- and Violence-Informed Care Curriculum
https://equiphealthcare.ca/tvic-foundations/

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