Interprofessional Team-based Opioid Education

Introduction and Background

**Student instructions:** The goal of these background materials is to provide you, no matter your health profession, with pertinent information on providing team-based care to patients taking opioids. This information will allow you to actively participate in your team’s discussion. The required reading will take approximately 30 minutes. Review of the optional resource guide is strongly encouraged. The required reading and optional resources will be referenced throughout the interprofessional class session, so please bring an electronic copy with you.

- **Required reading:** Prior to the interprofessional opioid education session, **please read this Introduction and Background AND review the required documents noted below which are available on the website.**
  - Your profession’s specific toolkit about the WA State Opioid Prescribing Requirements
    - Advanced registered nurse practitioner
    - Pharmacist
    - Medical
  - Review the following screening tools including how to interpret results. These three tools will be used during the interprofessional session when you will be provided with specific results for your patient(s). The resource guide below contains information on other available screening tools.
    - Pain: PEG (Pain, Enjoyment, General Activity) scale
    - Opioid use: DAST-10 (Drug Abuse Screening Test)
    - Depression: PHQ-9 (Patient Health Questionnaire)
  - Meet your patient
    - Sam Jones Patient Case

**LEARNING OBJECTIVES:**

By the end of the in-class session, students should be able to:

1. **Describe the roles and responsibilities of the healthcare team and how they work together to provide team-based care to patients using opioids.**
2. **Utilize appropriate non-stigmatizing language when caring for patients taking or potentially misusing opioids.**
3. **Express one’s knowledge and opinions to healthcare team members with confidence, clarity, and respect, working to ensure common understanding of information, treatment, and care decisions.**
4. **As a member of the healthcare team, evaluate a patient for potential opioid misuse or opioid use disorder.**
5. **Differentiate between treatment options for a patient with an opioid use disorder and/or pain management.**
6. **Work collaboratively with the healthcare team and the patient to develop a patient care plan.**
Section I: Washington State Opioid Prescribing Requirements

“In response to the opioid crisis in Washington State and across the country, the legislature directed five prescribing boards and commissions to develop and adopt new opioid prescribing requirements. The Department of Health, in collaboration with the boards and commissions, is providing education and outreach on Washington’s new opioid prescribing requirements.”


The following link provides current profession-specific toolkits for opioid prescribing including mandatory continuing education requirements:


Implementation of the opioid prescribing rules will be highlighted throughout this interprofessional training. Prior to the educational session, review your professions toolkit handout.

The toolkits contain handouts for:

- The public/patient
- Dental
- Nursing
- Osteopathic
- Podiatry
- Pharmacy
- Medical

Section II: Using appropriate language

To provide care to a patient using opioids, all members of the healthcare team must be familiar with the following definitions.

**Opioid misuse:** Opioid use contrary to the directed or prescribed pattern of use, regardless of the presence or absence of harm or adverse effects. One might “misuse” opioids to manage pain symptoms or “misuse” by using medications prescribed to someone else.

**Opioid abuse:** Intentional use of the opioid for a nonmedical purpose, such as euphoria or altering one’s state of consciousness.

**Addiction:** Pattern of continued use with experience of, or demonstrated potential for, harm (e.g., “impaired control over drug use, compulsive use, continued use despite harm, and craving”).

**Opioid tolerance:** Defined as a “decrease in pharmacologic response following repeated or prolonged response” to an opioid. This is normal and expected.
Dependence: \textit{Physical dependence} is “a state of adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.” \textit{Psychological dependence} is “a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence.” From ASAM National Practice Guideline

Substance use disorder: “Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.” From https://www.samhsa.gov/disorders/substance-use

Opioid use disorder: “A substance use disorder involving opioids.” From ASAM National Practice Guideline

Opioid treatment program: “A program certified by the United States, Substance Abuse and Mental Health Services Administration (SAMHSA)… that engages in supervised assessment and treatment... of individuals who are addicted to opioids.” From ASAM National Practice Guideline

Additionally, healthcare team members should be aware of and avoid the use of stigmatizing language. Examples of stigmatizing language and more appropriate word choices are noted below.

<table>
<thead>
<tr>
<th>Words to avoid</th>
<th>Words to use</th>
<th>Reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict, abuser, junkie</td>
<td>Person with a substance use disorder, person experiencing a drug problem</td>
<td>Terms like addict, abuser, and junkie are demeaning. They do not differentiate between the person and his/her disease. It is better to use language that suggests that the person has a problem that can be addressed.</td>
</tr>
<tr>
<td>Abuse</td>
<td>Misuse, inappropriate use, harmful use</td>
<td>“Abuse” suggests there is a choice. In reality, these disorders are medical conditions.</td>
</tr>
<tr>
<td>Clean, dirty</td>
<td>Negative, positive, substance-free</td>
<td>Use of “clean” and “dirty” associates the patient with filth.</td>
</tr>
<tr>
<td>Habit, drug habit</td>
<td>Substance use disorder, opioid use disorder</td>
<td>“Habit” or “drug habit” implies that the problem is related to a lack of willpower to overcome the habitual behavior.</td>
</tr>
<tr>
<td>User</td>
<td>Person who misuses drugs</td>
<td>“User” is stigmatizing as it labels a person by their behavior.</td>
</tr>
</tbody>
</table>

Adapted from The National Alliance of Advocates for Buprenorphine Treatment, “The Words We Use Matter. Reducing Stigma through Language.”
Section III: Using opioids for pain management and Opioid Use Disorder (OUD)

“Opioid use is associated with increased mortality. The leading causes of death in people using opioids for nonmedical purposes are overdose and trauma. The number of unintentional overdose deaths from prescription opioids has more than quadrupled since 1999” (American Society of Addiction Medicine (ASAM) Guidelines). “Monitoring and vigilance are critical to ensure effective and safe use of opioids for the thousands of Washington residents who are on opioids chronically, especially for those on high doses” (Washington State Agency Medical Directors’ Group (AMDG) Guidelines).

Important considerations for the healthcare team who care for patients taking opioids include:

- Pain is divided into three categories: acute (0-6 weeks), subacute (6-12 weeks), and chronic (>12 weeks) (WA State Prescribing Requirements).
- “Acute pain, whether related to disease, injury, or recent surgery, usually diminishes with tissue healing, whereas chronic pain typically lasts >3 months and involves neurological, emotional, and behavioral features that often impact a patient’s quality of life, function, and social roles” (AMDG Guidelines).
- When appropriately prescribed and managed, opioids may be an effective treatment option for acute and subacute pain. For certain patients, opioids may be an option for treating chronic pain. However, a focus should be on preventing the inappropriate transition from acute and subacute opioid use to chronic opioid use especially when other alternatives for treating pain may be equally effective and safer in the long-term (AMDG Guidelines).
- All members of the health care team need to be involved in managing the care of a patient taking opioids. Appropriate prescribing of opioids includes the following:
  - Evaluate patient for risk and benefits
  - Evaluate current opioid use
  - Document patient treatment plan
  - Limit quantity and days of therapy of opioids
  - Provide patient education
  - Monitor for safe opioid use
- Despite best practices, some patients may develop opioid use disorder (OUD). “Opioid use disorder is a chronic, relapsing disease, which has significant economic, personal, and public health consequences.” “Opioid use disorder” is diagnosed by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (ASAM Guidelines).

Two helpful resources when providing care to a patient using opioids with potential opioid use disorder are:


Section IV: Assessment of patient

The following are sources of information that can inform the healthcare team about a patient taking and/or misusing opioids:

- **Histories:** History of present condition, social, family, and past medical history (process for obtaining a complete medical history is not covered in this workshop)
- **Screening tools and interpretation of results**
- **Prescription monitoring program (PMP) report**
- **Morphine equivalent dose (MED) calculation**
- **Aberrant behaviors**
- **DSM 5 diagnostic criteria for opioid use disorder**

### A. Screening tools:
- Many self-report assessment tools are available for health professionals to use when providing care to a patient using opioids.
- During the workshop, you will use the following screening tools:
  - Pain: PEG (Pain, Enjoyment, General Activity) scale
  - Opioid use: DAST-10 (Drug Abuse Screening Test)
  - Depression: PHQ-9 (Patient Health Questionnaire)

*Prior to the educational session, review these three specific tools, knowing how to score and interpret each of them.*

- In addition to the above screening tools, many other screening tools are commonly used to assess opioid misuse, substance abuse, and/or mental health disorders. The AMDG Assessment Tool website has links to a numerous tools ([http://www.agencymeddirectors.wa.gov/AssessmentTools.asp](http://www.agencymeddirectors.wa.gov/AssessmentTools.asp)). Some of the more common validated screening tools include the following:
  - Current Opioid Misuse Measure (COMM)
  - Screener and Opioid Assessment for Patients with Pain - Revised (SOAPP-R)
  - Opioid Risk Tool (ORT)
  - CAGE Adapted to Include Drugs (CAGE-AID)
  - DIRE (predicts the efficacy of analgesia and adherence with long-term opioid therapy)
  - GAD-7 (Generalized Anxiety Disorder) Questionnaire
  - AUDIT (Alcohol Use Disorder Identification Test)

### B. Prescription monitoring program (PMP) reports:
- Washington State has an online prescription monitoring program (PMP).
- The primary purpose of the PMP is to centrally track prescription drug use of controlled substances (i.e. schedule II through V).
- Most states have their own individual PMP systems and regulations.
- The Washington State RxSentry Prescription Monitoring Program is “a web-based system that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of prescription drugs.”
• Per the WA State Opioid Prescribing Requirements, all prescribers and pharmacists in Washington state are required to register with the PMP.
  o Once a prescriber has an active PMP account, the prescriber is permitted to delegate performance of a required PMP query to an authorized health care designee.
  o Delegates may include nurse, medical assistant, or others.

• WA State Opioid Prescribing Requirements indicate that the PMP must be queried at specific times during the opioid prescribing process. Each profession may have slight differences to the timing of the required PMP queries. Examples of when a PMP query is usually required includes the following.
  o Prior to prescribing opioids for a new episode of pain.
  o During the transition from subacute to chronic pain management.
  o Routinely for patients prescribed opioids for chronic pain, depending on patient risk level.
  o Regularly for patients who are being treated for addiction disorder.

The following image shows a mock PMP report with tips on interpretation of information.

• Additional information on PMPs including Washington’s PMP may be found in the Resource Guide.

C. Morphine Equivalent Dose (MED) Calculation (may also be referred to as Morphine Milligram equivalents or MME):
• Morphine equivalent dosing (MED) determines a patient’s cumulative intake of any drugs in the opioid class over 24 hours in an effort to help reduce the likelihood of overdose.
• Purpose: “Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.” [https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf]

• The Washington State Opioid Prescribing Requirements require mandatory consultation with a pain management specialist when prescribing over 120 MED unless exempt. Note that exemptions may vary by profession and are specified in Washington administrative code.

• According to AMDG Interagency Guideline on Prescribing Opioids for Pain:
  o Patients taking >120 morphine equivalents per day are at increased risk for developing an opioid use disorder (122-fold increase for chronic high dose opioids >120 mg/day MED)
  o Overdose risk approximately doubles at doses between 20 and 49 mg/day MED, and increases nine-fold at doses of 100 mg/day MED or more.

• Washington State AMDG has an online calculator
  o Prior to the educational session, navigate to the calculator [http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm]
  o Please note: The calculator should **NOT** be used to determine doses for opioid conversions*

• Links to other resources are available in the Resource Guide for pertinent information on calculating total daily doses of opioids.

D. **Aberrant behaviors:**

• Aberrant behaviors are those that are suggestive of potential substance misuse and/or addiction.

• Some behaviors may appear aberrant but may be the result of unresolved pain or a mental health disorder

• The table below indicates behaviors associated with medication abuse or addiction.

<table>
<thead>
<tr>
<th>Behaviors more likely to be associated with medication abuse/addiction:</th>
<th>Behaviors that look aberrant that could be associated with addiction but may be more a part of stabilizing a patient’s pain condition, and less predictive of medication abuse/addiction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Selling medications or obtaining them from non-medical sources</td>
<td>• Asking for, or even demanding, more medication</td>
</tr>
<tr>
<td>• Falsification of prescription—forgery or alteration</td>
<td>• Asking for specific medications</td>
</tr>
<tr>
<td>• Injecting medications meant for oral use; oral or IV use of transdermal patches</td>
<td>• Stockpiling medications during times when pain is less severe</td>
</tr>
<tr>
<td>• Resistance to changing medications despite deterioration in function or significant negative effects</td>
<td>• Use of the pain medications during times when pain is less severe</td>
</tr>
<tr>
<td>• Loss of control over alcohol use</td>
<td>• Use of the pain medication to treat other symptoms</td>
</tr>
<tr>
<td>• Use of illegal drugs or controlled substances that are not prescribed for the patient</td>
<td>• Reluctance to decrease opioid dosing once stable</td>
</tr>
<tr>
<td>• Recurrent episodes of:</td>
<td>• And, in the earlier stages of treatment:</td>
</tr>
</tbody>
</table>
o Prescription loss or theft
o Obtaining opioids from other providers in violation of treatment agreement
o Increases in dosing without provider’s instruction
o Running short with medication supply, and requests for early refills

| o Increasing medication dosing without instruction to do so from the provider
| o Obtaining prescriptions from sources other than the primary pain provider
| o Sharing or borrowing similar medications from friends/family

From National Institute on Drug Abuse

E. **DSM5 criteria for Opioid Use Disorder:**

- The DSM 5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth edition) defines and classifies various mental disorders.
- The DSM 5 includes diagnostic criteria for Opioid Use Disorder.
- To be diagnosed with opioid use disorder, a patient must have at least two of the criteria within a 12-month period.
- The DSM 5 Opioid Use Disorder Diagnostic Criteria is available in the Resource Guide.

**Section IV: Treatment plan options**

Numerous treatment options are available for a patient with unresolved pain and/or suspected opioid use disorder. Brief summaries follow below:

A. **Treatment of pain**
   i. Prescribing opioids for pain
   ii. Co-prescribing of opioids with other high-risk medications
   iii. Complementary/alternative medicine (CAM) options for treatment of pain
   iv. Tapering/discontinuing of opioids
   v. Referral options for treatment of pain

B. **Treatment of opioid use disorder**
   i. Treatment options for opioid use disorder
   ii. Referral options for opioid use disorder

A. **Treatment of pain**

i. **Prescribing opioids for pain:**
   - The Washington State Opioid Prescribing Requirements include requirements for profession-specific opioid prescribing. See prescriber toolkits from Section 1.
   - References/pocket guides are available that summarize when it is appropriate to prescribe opioids, particularly when prescribing opioids for management of chronic pain (i.e. pain ≥3 months). (See Resource Guide).
• Links to resources are available below and in the Resource Guide:

ii. Co-prescribing of opioids with other high-risk medications
• The Washington State Opioid Prescribing Requirements require that opioids **not** be prescribed with the following medications without documentation in patient record, discussion of risks, and consultation with prescribing practitioners of other medications:
  o Benzodiazepines
  o Barbiturates
  o Sedatives
  o Carisoprodol
  o Non-benzodiazepine hypnotics (i.e. zolpidem)

• In addition, the opioid prescribing rules require confirmation or prescription of naloxone when:
  o Opioids are prescribed to a high-risk patient.
  o General opioid prescribing when clinically indicated.

iii. Complementary/Alternative Medicine (CAM) and non-opioid options for treatment of PAIN:
• Definition of CAM: Diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole.
  o Comprises wide range of modalities outside “conventional medicine”
  o Emphasizes holistic approach
• Strongest evidence of non-pharmacological CAM approaches for pain management: *(Evidence-based Chronic Pain Management (2011), Stannard, C., Kalso, E., Ballantyne, J.)*
  o Cognitive Behavioral Therapy (CBT) – address how thoughts influence pain
  o Music therapy
  o Physical exercise/Yoga/ Tai chi
  o Pain self-management/Rehabilitation programs
• Lower evidence CAM options vary with pain type:
  o Massage/Healing touch
  o Mindfulness
  o Meditation/Prayer/Hypnosis/ Guided imagery
  o Distraction/Biofeedback
  o Nutrition/Diet/Supplements
  o Acupuncture
  o Art therapy
  o Gaming/Virtual reality
  o Ice/Heat
  o TENS unit (transcutaneous electrical nerve stimulation)/Spinal cord stimulator
  o Spinal manipulation:
    Osteopathic/Chiropractic
• Nonopioid pain relief options:
  o Adapt pain ladder to meet individual needs
  o Non-opioid analgesics:
    ▪ Acetylsalicylic acid
    ▪ NSAIDs
    ▪ Antidepressants
    ▪ Anxiolytics/Hypnotics
    ▪ Corticosteroids
    ▪ Anticonvulsants
    ▪ Nerve blocks/Anesthetics

• The following resource highlights non-opioid treatment for chronic pain.

• Resources available in the Resource Guide:
  o

iv. Tapering/discontinuing of opioids:
• Pocket guides and additional reference materials are available to guide when and how to taper opioids prescribed for chronic pain. See Resource Guide.
• Resources available in the Resource Guide:
  o Agency Medical Directors’ Group Interagency Guideline on Prescribing Opioids for Pain, 3rd Edition, 2015, pgs 36 – 38

B. Treatment of opioid use disorder

i. Treatment options for opioid use disorder
• Once patients are diagnosed with opioid use disorder, the following treatment options are commonly considered.
  “Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.” https://www.samhsa.gov/medication-assisted-treatment.
• A brief introduction to the pharmacologic treatment options for opioid use disorder is provided below. For more comprehensive, detailed information about patient management (including for special populations such as pregnant women), see the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. https://www.asam.org/resources/guidelines-and-consensus-documents/npg
- **methadone** (Dolophine® or Methadose®): Methadone is used for opioid use disorder treatment and withdrawal management. Methadone is an opioid mu-agonist that binds to opiate receptors in the brain where it inhibits pain pathways and alters responses and perceptions to pain. It also suppresses withdrawal symptoms in patients who are addicted to heroin or other opioids. Methadone is administered orally. It is a long-acting opioid that requires special consideration during titration and establishment of a maintenance dose. Typical side effects from opioids (excessive sedation, respiratory depression) may be intensified with methadone due to its’ extended action in the body. When used as a treatment option for opioid use disorder, it is only available through an approved Opioid Treatment Program.

  *Treatment goals with methadone follow.*
  1. Suppress opioid withdrawal.
  2. Block effects of illicit opioids.
  3. Reduce opioid craving and stop/reduce the use of illicit opioids.

  *ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 4, pg 29-31)

- **buprenorphine** (Buprenex®, Butrans®) and combination buprenorphine and naloxone* (*Suboxone®): Buprenorphine is used for opioid use disorder treatment and withdrawal management and may be used in the outpatient setting. Buprenorphine is a partial mu-agonist which means the risk of overdose with buprenorphine is lower when used for opioid use disorder therapy because it does not completely “fill” the receptor. Buprenorphine has a high affinity for the mu-opioid receptor which means that it competitively displaces full agonists (such as morphine) from the mu-opioid receptors. Drug cravings are reduced while avoiding dangerous side effects and/or euphoria produced by other opioids.

  *Treatment goals with buprenorphine and/or buprenorphine/naloxone follow:*
  1. To suppress opioid withdrawal.
  2. To block the effects of illicit opioids.
  3. To reduce opioid craving and stop or reduce the use of illicit opioids.
  4. To promote and facilitate patient engagement in recovery oriented activities including psychosocial intervention.

  *ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 5, pg 32-35)

  * Opioid use disorder prescribing of buprenorphine monoprotect or combination buprenorphine/naloxone for requires a waiver under DATA 2000. There are specific criteria that prescribers must be to qualify for a waiver including completion of a training program.

  o **naltrexone** (oral products: ReVia®, Depade®– antagonist; extended release injectable: Vivitrol®):
Naltrexone is used to prevent relapse to opioid use by competitively blocking the effects of exogenously administered opioids and is also approved for the treatment of alcohol use disorder. Naltrexone is a long-acting, pure opioid antagonist that shows the highest affinity for mu-receptors. Non-adherence to oral naltrexone is common with an associated risk of opioid overdose upon relapse. Therefore, it is believed to be best for patients who are highly motivated and closely supervised.

*Treatment goals with naltrexone follow.
1. To prevent relapse to opioids in patients who have already been detoxified and are no longer physically dependent on opioids.
2. To block the effects of illicit opioids.
3. To reduce opioid craving.
4. To promote and facilitate patient engagement in recovery oriented activities including psychosocial intervention.

*ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 6, pg 35)

+Naloxone* (Narcan®):
Naloxone is used for the partial or complete (dose dependent) reversal of opioid effects including respiratory and CNS depression. Naloxone is a pure mu-opioid receptor competitive antagonist that displaces opioids at opioid receptor sites. It is efficacious in reversing opioid overdose and preventing fatalities. Individuals trained and authorized to administer naloxone has expanded beyond in-patient facilities and paramedics to include first responders, police officers, firefighters, correctional officers, individuals at risk for opioid overdose and their families*.

*ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 13, pg 48)

* In August 2019, WA State implemented a Standing Order to Dispense Naloxone which is increasing wide access to naloxone. Detailed information and educational material may be found at https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone

- The Complementary/Alternative Medicine (CAM) and non-opioid options previously noted can also be used to assist in management of opioid use disorder.
- Evidence shows that integration of behavioral health strategies, such as the following, can help to improve treatment outcomes:
  - Cognitive behavioral therapy (CBT)
  - Contingency management (i.e. behavioral-based rewards)
  - Group support
ii. Referral options for opioid use disorder

- Medication assisted treatment (MAT) programs can be located online through the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Opioid treatment programs (OTPs):
  o The SAMSHA Opioid Treatment Program Directory provides information on MAT locations in each state.
  o “Opioid treatment programs (OTPs) provide MAT for individuals diagnosed with an opioid use disorder. OTPs also provide a range of services to reduce, eliminate, or prevent the use of illicit drugs, potential criminal activity, and/or the spread of infectious disease. OTPs focus on improving the quality of life of those receiving treatment. OTPs must be accredited by a SAMHSA-approved accrediting body and certified by SAMHSA.” From https://www.samhsa.gov/medication-assisted-treatment/treatment#otps.
  o OTPs can dispense methadone and buprenorphine.
  o The directory can be found at https://dpt2.samhsa.gov/treatment/directory.aspx.
  o A list of Washington state opioid treatment programs is available at https://www.hca.wa.gov/assets/free-low-cost/opioid-treatment-programs.pdf.
- Buprenorphine treatment practitioners:
  o The SAMSHA Buprenorphine Treatment Practitioner Locator provides information for providers that are authorized to prescribe buprenorphine for opioid use disorder.
  o Nurse practitioners and physician assistants must complete 24 hours of required training to prescribe buprenorphine.
  o The buprenorphine practitioner locator is available at https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator.
- Behavior health treatment services:
  o The SAMSHA Behavioral Health Treatment Services Locator helps patients to find treatment facilities for substance abuse, addiction, and/or mental health problems.
  o It is located at https://findtreatment.samhsa.gov/.

C. Risk Assessment and opioid overdose prevention:

All people taking opioids, whether prescribed or from another source, are at risk for developing an opioid use disorder. Specific risk factors for opioid use disorder include past or present substance abuse, untreated mental health conditions, younger age, and social or family environments that encourage misuse. Death from opioid overdose prevalence is higher in people who are middle aged and have substance abuse and mental health comorbidities. (Webster, L.R. 2017. Anesth Analg. Nov. 125 (5) accessed at https://www.ncbi.nlm.nih.gov/pubmed/29049118)

Opioid overdose prevention: Naloxone is a medication (opioid antagonist) that rapidly reverses the effects of opioids. Patients, a close family member or friend, and first responders may carry a pocket-size device that contains the injectable form of naloxone or Narcan, a nasal spray version of naloxone, that can be administered in the case of a suspected overdose. You are encouraged to learn more about naloxone and its administration by going to the following website: http://stopoverdose.org/
There are several ways to access naloxone in Washington State as noted on the StopOverdose.org website (http://stopoverdose.org/section/find-naloxone-near-you):

- “Any prescriber can write a prescription for naloxone and any pharmacy can fill that prescription.”
- “Many syringe exchange and other community programs distribute naloxone, although some distribute only to clients and not to community members at large.”
- In August 2019, WA State implemented a Standing Order to Dispense Naloxone effective until 9/1/2021 which allows pharmacists to prescribe and dispense “opioid overdose reversal medications to any person at risk of experiencing an opioid-related overdose or any person or entity in a position to assist a person at risk of experiencing an opioid-related overdose” per the authorization of the State Health Officer. Detailed information and educational material may be found at https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone

According to the Washington State Opioid Prescribing Requirements, naloxone must be confirmed or prescribed when opioids are prescribed to a high-risk patient or should be considered when clinically indicated.

D. Washington state requirements for patient education

According to the Washington State Opioid Prescribing Requirements, prescribers must provide patient education on the risks, safe and secure storage, and the proper disposal of opioids.