AMERSA

Interdisciplinary Leaders in Substance Use Education, Research, Care and Policy

# Medication for Opioid Use Disorder (MOUD) Tool Kit for Peer Recovery Specialists

AMERSA (The Association for Multidisciplinary Education and Research in Substance use and Addiction), founded in 1976, is a non-profit professional organization whose mission is to improve health and well-being through interdisciplinary leadership and advocacy in substance use education, research, clinical care, and policy.



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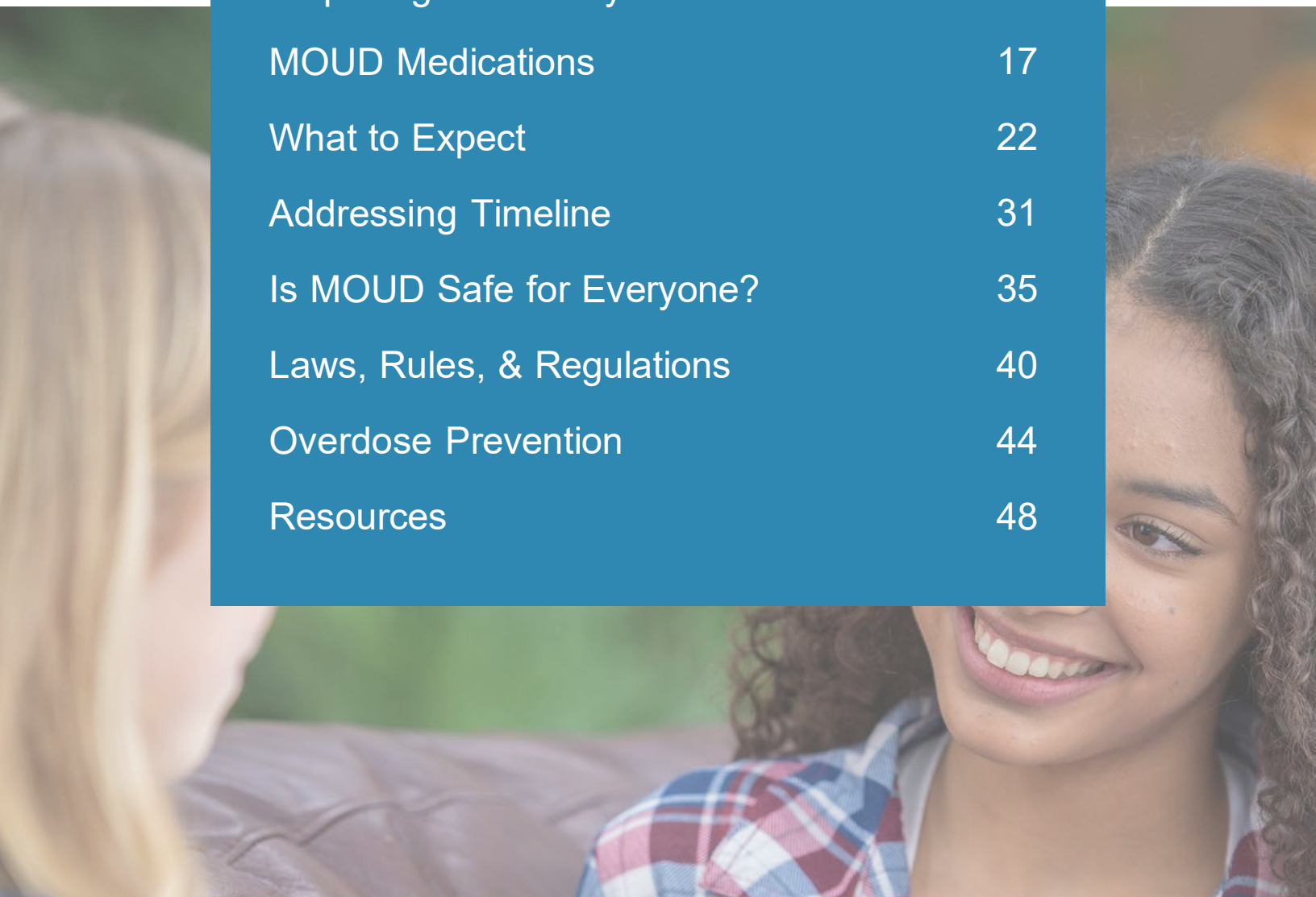

# Background & Introduction

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In the United States in 2020, over 2 million people reported having an opioid use disorder (OUD).[1] This number can be scary, but there is hope. OUD is a treatable, chronic disease that can affect anyone regardless of age, gender, race, and social class. Multiple pathways to OUD recovery exist, and one pathway includes medications for opioid use disorder, or MOUD. MOUD is an evidence-based OUD treatment intervention and has been found to reduce opioid use, other symptoms related to OUD, and chances for overdose. MOUD treatment is versatile. It can be successful on its own, and can also work well with other interventions, such as counseling therapy and mutual aid support groups.

This toolkit is a resource for Peer Recovery Specialists (PRSs) to feel equipped to discuss MOUD with providers, people seeking recovery, and others with questions about this treatment option.

As a PRS, you likely work with people in active use and those seeking recovery. You have most certainly encountered questions and experiences around MOUD. We recognize that facts around MOUD can be complicated with disputed opinions among experts, providers, and people in recovery. MOUD discussions should not be neglected nor bypassed, as it is clinically effective, reduces the need for inpatient detoxification services, provides a more comprehensive program of medication and behavioral therapy, and reduces rates of fatal overdose. Conversations about MOUD are not always easy. Barriers exist around MOUD such as provider and community stigma, frequently changing best practices, and lack of access to treatment and recovery support resources, to name a few. PRSs, with their lived experience, expertise in recovery support and management, and their knowledge of existing resources, are ideally positioned to have meaningful conversations about MOUD. Such conversations can help the participant in their journey to find a pathway to recovery that is best suited for them.

PRSs are professionals who use lived experiences in recovery from mental illness and/or substance use disorder, in addition to skills learned in a formal training, to deliver services promoting recovery and resiliency.[2] This toolkit was developed to best support PRSs as they navigate MOUD treatment alongside their participant and as an active member of the treatment team. The treatment team may consist of several other professionals who are sorting through these decisions with you, such as patient navigators, counselors, and medical providers.

This toolkit provides simple, relevant, and up to date information to help the person in recovery start to explore their options. Additionally, tips and suggestions will be shared on how to enhance motivation while working with clients either interested in MOUD treatment or already receiving it. This toolkit provides you with suggestions on how to empower your participants as they navigate treatment decisions and how to help them explore MOUD treatment mindfully and adequately informed.

## Terminology

In this toolkit you will see the terms “person in recovery” and “participant” used interchangeably to describe the people who a Peer Recovery Specialist works alongside and supports. These terms are meant to encompass people in all stages of recovery from substance use disorder, including active use. They are also meant to communicate a choice by the participant and a collaborative relationship, as opposed to an unequal relationship between the PRS and the person they are serving. Also note not every participant will find the language of “recovery” useful.

We use the term Peer Recovery Specialist (PRS) to describe any kind of peer support worker in this field but recognize different states and working environments may have different terms for this role, such as Peer Recovery Support Specialist or Peer Recovery Worker.

# How to Use This Toolkit

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This toolkit is a guide for you as a Peer Recovery Specialist to help your participants figure out how and what they want to talk to their provider about concerning MOUD. It is *not meant to be used as medical advice*.

There is no specific way of using this toolkit. We suggest you review what information is important to your participant and to look for the suggestions on how to help your participant incorporate this knowledge and consider next steps. As you read this toolkit, keep a look-out for ways to support your participants be successful in reaching their recovery goals.

## Review What is Most Important to You

This guide contains an abundance of information. Decide what is most helpful before meeting with a person in recovery. We understand that like all professions, not all PRSs are the same. Some parts of this toolkit may cover what you already know or may not be applicable to your role. Other parts of this toolkit may be brand new to you or speak to something that happens to you and your participants daily. Participants will vary in how much they know about MOUD as well, and it is important to tailor what you learn from this toolkit to your participant's specific needs and preferences.

**THINGS TO REMEMBER:**
Everyone may use this toolkit differently, so feel empowered to keep it personal to you! If you would say something differently, try putting it in your own words.

## Meeting Participants Where They're At

People in recovery often have their own ideas about MOUD and they have probably heard things prior to meeting with you. It is important to explore such beliefs and acknowledge there may be indecisive feelings about MOUD. Let the participants decide if they want to consider using MOUD as part of their recovery journey. Helping explore questions surrounding MOUD can give clarity not only about using this type of medication but also about how you can support them in whatever path to recovery they choose. Review the ideas for how to talk with your participants about this and think about how to put the examples in your own words, while sharing your own experiences.

## Having the Conversation

Before explaining current MOUD guidance, create a space where participants feel comfortable asking questions and expressing doubts. Here are things to keep in mind, with possible questions you can ask:

- Be clear about explaining your role, how long you plan to talk, and the purpose of your visit. To be most efficient and effective, determine how much time you have before you start. Use open-ended questions to figure out what toolkit sections are most helpful.

  *"You took a huge step by coming in today to learn more about options to treat OUD. I commend you for that, what are some things you have heard about MOUD?"*

- Think about what you share about your own experience with recovery and how it serves your participants, while keeping the focus on them. Determine the message you are trying to share and how it relates to the participant. Consider sharing experiences in a way that leaves room for participants to have different experiences. You may have experiences with MOUD and sharing these can often provide valuable information. Whenever sharing remember to consider what will help participants, and how you can keep the focus on them. Asking permission before sharing a personal experience can create more openness.

  *"I had similar thoughts when I first heard about MOUD; would it be okay if I shared what I was thinking and what I know now?"*

- Discuss confidentiality. Make sure you know mandated reporting laws in your state, as well as what is required by your license, certification, profession, and organization. Be clear on these details before you meet, so you can be as transparent as possible.

**RESOURCE CHECKLIST:**
Have you looked into the mandated reporting laws in your state?
http://www.childwelfare.gov/pubpdfs/manda.pdf

- The people in recovery that you work with are the experts in their own lives. Your role is to use current best practices, share relevant personal experiences, and to provide support. Clients must ultimately decide next steps for themselves. Here are ideas for how to empower participants:

  *"If it is ok, I would like to share some things I know about using medication as part of your recovery. You are the only one who can decide if MOUD is something you would like to consider as part of your treatment. What do you think, is this something you want to hear about?"*

  *"I want to support you, so that you can take away what you need to make the best decision for you and your recovery."*

- If it is within the scope of your role, break the conversation into multiple sittings for participants to absorb knowledge more effectively. Try not to overwhelm people with too much information - deliver knowledge in small chunks: share one idea at a time, leaving space to ask questions. After you share something new, check in:

  "*What do you think about this?"*

  *"What do you think about what I have shared so far?"*

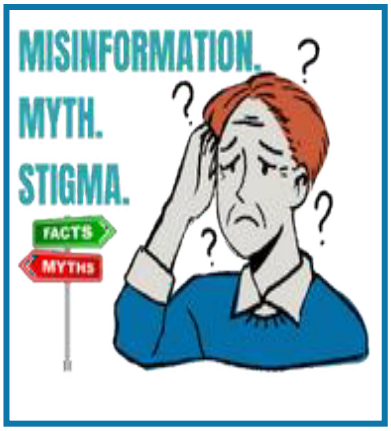
  *"What questions do you have?"*

  *"How do you see this fitting into your recovery?"*

**"My personal experience as a Peer Support Specialist for the last 4 years has led me to believe that my main responsibility is to keep an open dialogue that allows the participant to advocate for themselves, obtain beneficial resources, and to increase their recovery capital."**
**-Jake F.**

# Dispelling MOUD Myths

# Dispelling MOUD Myths




Treating opioid use disorder is not always easy. The many myths about MOUD may keep people in recovery, their families, and even providers from seeing the benefits that come with MOUD. As mentioned, this toolkit does not have to be read or shared in a specific order, however, it is intentional that dispelling myths is discussed first, before other parts of the conversation pertaining to MOUD (e.g., laws/regulations, types of medications, etc.). It is important to address these myths, as false belief in them can increase stigma, which can make it difficult for individuals using MOUD to find jobs, places to live, and medical care.

Much of the time, myths come from misunderstandings about what MOUD is. Learning more about facts behind the myths can help us recognize why this form of treatment can be rewarding for some individuals. Below we address some common myths about MOUD.

**"MOUD JUST REPLACES ONE ADDICTION WITH ANOTHER."**

It is not uncommon for people to group MOUD with opioids used during active addiction, such as heroin and prescription pain medications. However, it is important to know that they are not the same or just a substitute.

Addiction is not the same as dependence. Addiction as defined by the American Society of Addiction Medicine as, "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. *People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences*." When people take opioids over time, our bodies get used to the medication. We could experience negative side effects such as withdrawals and cravings, and a possible return of symptoms if we suddenly stop using our medications. This is what we call dependence. We can be dependent on many types of medications, and dependence on its own is not a negative thing. Using MOUD reduces withdrawal symptoms and cravings, symptoms that when uncontrolled can lead to risky and disruptive behavior we associate with addiction. Separation from these behaviors can create space for people to engage in healthy behaviors, such as connecting with support or finding sustainable housing. Medication is given in a controlled way, under the direction of a prescriber. *When used as prescribed, the intention behind the use is different, and that matters*. Being dependent on MOUD is simply not the same as having an addiction.

OUD treatment medications, such as methadone or buprenorphine, treat many complex symptoms of opioid use disorder, such as stabilizing brain activity, and lessening cravings and withdrawals. Some MOUD, such as naltrexone, act completely different than traditional opioids.

## "PEOPLE SHOULD BE ABLE TO STOP COLD TURKEY. MOUD IS ONLY FOR THE WEAK."

Statistically, those who use medication as part of their treatment for OUD are more likely to remain in treatment, and less likely to die from an opioid related overdose. While it is true that some people have been able to maintain abstinence from opioids without medication, it is important to stress to your participants that MOUD is likely to help them with their goal of cutting down or stopping their use of opioids.

Your participants may come to you sharing what they heard about another individual who was able to abstain from use without the help of MOUD. It is important to relay this information about the effectiveness of MOUD, and that treatment is not one size fits all; just because something worked for one, does not mean it works for all. Opioid use disorder is a chronic medical disorder that involves changes in brain functioning. While some can stop using opioids on their own, others may need assistance in treating these brain changes to find a successful path to recovery – and that can look different for different people. *It is important to remember that there are multiple pathways to recovery.*

## MOUD TAKES TOO LONG, I WANT TO STOP USING OPIOIDS RIGHT NOW."

Addiction disorders are "chronic conditions," like diabetes or heart disease, meaning they can last a long time. MOUD is not a cure for an opioid use disorder, but rather a tool to manage the disorder. Like other chronic conditions, medication can be paired with other treatments to ensure successful treatment management. For example, with diabetes, insulin is often paired with healthy eating and frequent exercise. For an opioid use disorder, MOUD medication can be paired with counseling and mutual support groups. Treatment management does not happen all at once, it happens over time.

## "MOUD CONTRIBUTES TO ABUSE & INCREASES AVAILABILITY OF STREET DRUGS."

MOUD does not hurt our communities, in fact, it helps them! MOUD benefits families and communities by reducing crime, lowering transmittable diseases such as HIV/AIDS and hepatitis C, and decreasing deaths by overdose.

We have to consider the impact when patients sell or give away medication illegally. Buprenorphine can be used illicitly; however, it is rarely used to get high. While a small number of individuals may use Buprenorphine for its euphoric effect, more often it is used to avoid or lessen withdrawal, to stop using other opioids, and/or because someone does not have access to MOUD treatment. The risk of overdose from Buprenorphine is very low, particularly if it is not mixed with other central nervous system depressants.

Methadone comes with a greater risk of fatal overdose when taken outside of a supervised treatment context. Most illicit use comes from prescribing for pain, not from people with OUD getting methadone from the clinic. People may also misuse methadone because they missed their dose at the clinic.

## "BUPRENORPHINE IS BETTER THAN METHADONE."

It is hard to compare the two, as the decision of which medication to take is completely individualized. What may work for someone, may not work for another. If your participants are concerned that one medication may work better for them than another, make sure they consult with their provider and treatment teams.

## "A POSITIVE DRUG SCREEN OR RETURN TO USE MEANS MOUD ISN'T WORKING & SHOULD BE DISCONTINUED."

MOUD is not always the beginning or end of treating an opioid use disorder. A return to use or "relapse" can be a normal part of treatment and is not a sign of weakness or failure. Instead, it is encouraged to treat a positive drug screen or return to use as an opportunity to adjust MOUD treatment, possibly changing or increasing medication, and/or providing referrals to other treatment supports, such as peer support, counseling, or mutual support (e.g. 12 step, SMART, All Recovery) group recovery meetings. Additionally, outright discontinuation of MOUD is not only punitive, but it can result in further substance use and increased risk of overdose.

People seeking recovery from OUD may also be engaging in polysubstance use. They may continue to use other substances while taking MOUD, but that does not mean the medication is not effective, as these medications do not treat other substance use disorders. They may need additional support for other such disorders. Peer Recovery Specialists can play a crucial role in facilitating conversations about support after a positive screen/return to use.

## "MOUD IS A CRUTCH, NOT TRUE RECOVERY."

There is no wrong or right way to achieve recovery. It is unique to each person. Recovery can be defined as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." and MOUD can help people in recovery through that process. Remember, MOUD, mutual-aid support groups, abstinence, or other common forms of recovery management are not necessarily "recovery" itself, rather a different pathway in the process.

Myths are not always rooted in fact but can have very real influence. Stigma can influence how support systems operate. For example, some 12-step or other mutual aid support organizations view MOUD as incompatible with recovery. Empower your participants to seek out support systems that work best for them and create environments that foster support and inclusivity.

**THINGS TO REMEMBER:**
What mutual aid supports are available in your area and accepting of MOUD?
https://www.smartrecovery.org/
https://www.mara-international.org/
https://www.facebook.com/harmreductionworks.hrw/
All Recovery meetings may be available in your area

**THINGS TO REMEMBER:**
Read more about the challenges faced when trying to use MOUD and 12-step support services concurrently:
https://www.recoveryanswers.org/research-post/negative-attitudes-towards-medications-opioid-use-disorder-12-step-groups/

### "IF YOU USE MOUD, YOU CANNOT RECEIVE MEDICAL PAIN MANAGEMENT."

Opioids serve medical purposes and are helpful for many people in treating pain. For example, following a surgical procedure, many receive opioid prescriptions to manage pain levels. Those on MOUD may feel they do not have an option for treating pain. However, there are options to maintain recovery while also managing pain. The best path in treating pain while on MOUD is open communication with providers to make sure both pain and OUD needs are met. Here are a few helpful points to help participants advocate for themselves:

- Patients can alert providers of MOUD status and feel empowered to request changes to traditional routes of pain management.
- Buprenorphine does not need to be stopped for effective opioid pain management, and in fact some evidence suggests maintenance of buprenorphine can be utilized for pain control. Treatment teams should consider adjusting pain treatment doses to meet specific needs (e.g. those on MOUD may need lower doses, or MOUD dosages could be raised temporarily to manage pain).
- Consider pairing opioid pain management with non-opioid alternative pain management strategies, such as physical exercises, mindfulness, acupuncture, etc.

### "MOUD DOES NOT WORK IF YOU HAVE BEEN TAKING FENTANYL."

There is no research to support this claim. Fentanyl, where its effects are typically stronger, is still an opioid. MOUD will still act the same and keep it from connecting to brain receptors and will continue to help with stabilizing brain functioning, managing withdrawal, and decreases risk of overdose.

There is some evidence that initiating certain forms of MOUD after Fentanyl use could precipitate stronger withdrawal symptoms and is something your participants can discuss with their prescriber.

# MOUD Medications

## MOUD Medications

Many medication options are available for people in recovery considering MOUD. The following information is an introduction. Learning about the pros and cons of each medication and how they work can help participants begin considering MOUD options. This information is meant to give your patients a starting point and some ideas for how to talk with their provider further.

All opioids work by activating receptors in the brain and body. Opioids tell the brain to block pain, but can also make us feel calm, euphoric, sleepy, side effects such as constipation and slow or stop our breathing (if there is too much in the system).

Three medications are approved and effective in treating people with OUDs: buprenorphine, methadone, and naltrexone. To think about how these types of medication work, imagine the receptors in your brain are on a dimmer switch:


- **Agonist (Methadone):** an opioid agonist medication will bind to the opioid receptors in the brain resulting in a full, strong opioid effect. An agonist will "turn on" the receptors (lights are on in the house). The more you increase the dose the more effect you get until the receptor is fully activated. Due to methadone being a full agonist, it has a similar affinity or pull to the receptor as other full agonists like heroin or fentanyl so it can be started in a participant with active use.
- **Partial Agonist (Buprenorphine):** an opioid partial agonist means that the medication will still bind to the same opioid receptors in the brain, but it only "partially" activates the receptors; so, the opioid effects are not as strong (lights are dim in the house). *This is called the ceiling effect* because at a point, high levels of a partial agonist do not cause increased effect so there will not be increased respiratory depression and other effects of agonist medications, thus they are less likely to be the cause of an overdose. While buprenorphine only partially activates the receptors, it has a higher affinity or attraction to the opioid receptors so it will kick off other opioids causing precipitated withdrawal.

- **Antagonist (Naltrexone):** an opioid antagonist medication still binds to the opioid receptors in the brain, but it completely blocks the effects of any other opioids. An antagonist has no opioid effect and reverses the effect of opioid agonists. Since naltrexone is an antagonist and does not have any opioid effects, it means that it does not manage withdrawal symptoms and has less significant relief of cravings. It has the highest affinity or attraction to the receptor, like naloxone the opioid reversal agent, so it is best suited for someone who is in remission or not using opioids.

**Why is Naloxone often included with buprenorphine medication?**

The combination product of buprenorphine and naloxone is most commonly prescribed due to decreased risk for misuse compared to the mono product or buprenorphine alone. Buprenorphine films or tablets are absorbed transmucosal under the tongue. If buprenorphine were to be misused, naloxone is thought to increase withdrawal symptoms and decrease the potential for euphoria. Buprenorphine is only active if the medication is taken as intended, such as letting the medication dissolve under the tongue. If a dissolvable form of buprenorphine is accidentally swallowed it will not work. If buprenorphine is misused, the naloxone kicks in and can cause uncomfortable withdrawal symptoms.

| | Buprenorphine (monoproduct or combination with naloxone) | Methadone | Naltrexone |
|---|---|---|---|
| **Most Common Prescription Names** | Suboxone | Methadone | Vivitrol |
| | Butrans | | |
| | Sublocade | | |
| | Zubsolv | | |
| **Opioid Class** | **Partial Agonist** | **Full Agonist** | **Antagonist** |
| **How it Works** | Decreases cravings and withdrawal symptoms | Decreases cravings and withdrawal symptoms | Blocks the effects of any opioid drug. |
| | | | No withdrawal relief, less evidence for significant help with cravings |
| **Benefits** | Low likelihood of overdose<br>Lower potential for misuse, due to ceiling effect | Most well studied and used for >40 years to treat OUD | FDA approved as monthly injection |
| | Convenience: can take prescription home or start in an office setting. Also available as long-acting injection | Can be started before withdrawal symptoms begin | Good option if person does not want opioid medication. |
| | Refills are available | Highest retention rates | |
| | Many providers can prescribe | Can be taken once a day | |
| | Can be used in pregnancy | Can be used in pregnancy | |
| | Helps with pain | Helps with pain | |
| **Drawbacks** | Can be diverted | Long-acting medication: the maintenance dose is titrated to reduce the risk of overdose | Requires full detox from opioids for 7-10 days prior to initiation |

| | | | |
|---|---|---|---|
| | Risk for overdose when using with other central nervous system depressants | Increased risk for overdose when used with other CNS depressants | Increased risk for overdose when there is a return to use |
| | | Only provided in specialty settings: locations are limited | Some evidence that it is less effective than methadone or buprenorphine for reducing overdose |
| | | Limited doses provided, such as daily onsite dosing | No relief with pain |
| | | | Pain at site of injection |
| **Forms** | Sublingual tablet | Liquid | Injection |
| | Sublingual films | Pill | *Oral naltrexone exists but is not FDA approved as MOUD. |
| | Injectable | | |

## Key Takeaways

- Buprenorphine is more convenient and comes in both injectable and transmucosal forms. Patients sometimes experience withdrawal before initiation or could experience acute withdrawal due to the medication.[3] It has also been shown to be effective through many studies. Buprenorphine has a lower misuse potential.

- Methadone has been shown repeatedly to be effective. It is not necessary to experience withdrawal and is compatible for those who also need pain management. Some can benefit from the daily structure while others may find the structure challenging. These issues are discussed in more detail in the **What to Expect** section.

- Injectable naltrexone is the newest form of MOUD. Injectable naltrexone requires abstinence from opioids, so it is more difficult to start for someone with active use. Evidence is more limited that it decreases cravings and overdose. It does not reduce the chances of a fatal overdose and could increase the risk of overdose.[4]

**RESOURCE CHECKLIST:**
More information about MOUD options:
- https://www.recoveryanswers.org/resource/pharmacotherapy-medication-assisted-treatments/
- https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002

# What to Expect

# What to Expect from MOUD Treatment

There is much to think about before starting medication for opioid use disorder. People in recovery that you work with likely have many questions regarding starting and maintaining treatment.

Encourage your participants to work closely with medical providers who can help them decide what type of MOUD is best based on their unique situations and preferences. This section reviews the process of starting MOUD, what to expect from follow-up appointments, and questions to ask providers. This information is general and may not reflect real-life experiences or local medical resources. It is important to add personal knowledge to help your participants become better informed.

## Buprenorphine

**Getting Started**:

- Only certain providers can prescribe buprenorphine. The rules about who can prescribe have changed recently and more providers are able to prescribe, however, individuals still need to ask about prescribing capabilities.

- If participants take buprenorphine while they have another opioid in their system, it can cause intense withdrawal symptoms. This is called **precipitated withdrawal.**[5] Some participants may have experienced this and may think they just have a "bad reaction" or allergy to buprenorphine medications. They could express reluctance to this treatment option as a result.

- Often a prescriber will work with a patient on timing the medication to start taking it right after the first signs of withdrawal in order to avoid the more intense withdrawal symptoms that come from taking it too early. If your participants are worried about experiencing withdrawal symptoms, you can suggest they talk with their provider about:

    - Starting buprenorphine at home, in an outpatient or in an inpatient setting.

    - Alternative dosing strategies that can minimize withdrawal: **micro-dosing**[6] **or high-dosing**[7] done in an inpatient setting.

    - Ask about medications to manage opioid withdrawal symptoms to support participants in this process.

- People already on methadone might want to switch to buprenorphine. This can be challenging but possible. Participants may need to taper down their methadone doses before starting buprenorphine. If participants are considering this switch, help them understand that they may experience withdrawal symptoms, and encourage them to work closely with their medical teams. Here are some things they may want to consider:
    - Are they open to resuming higher doses of methadone if the taper is putting them at risk of relapse?
    - Encourage them to ask prescribers about other medications that can help with withdrawal symptoms.

**Maintenance Appointments:**

- Weekly appointments initially or every 2-3 days depending on needs. Once some stability has been established, they may then move to monthly appointments. At this time, participants can often receive a month-supply prescription for buprenorphine/naloxone in oral form or an injectable, depending on patient and prescriber preference.
- Providers may utilize urine drug screens and medication counts as safety precautions.
- Safe prescription storage, treatment plan follow-up, asking questions about other drug use, and checking in on side effects are generally discussed during appointments.
- Clients should continue to discuss how the medication is working, other substances used, mood, and general well-being at these appointments.

## Methadone

**Getting Started:**

- Methadone for opioid use disorder can only be dispensed and given at a certified Opioid Treatment Program.
- Participants can consult with providers who specialize in addiction medicine. Some clinics only offer methadone, others may provide other MOUD options as well.

- Participants should expect behavioral health resources such as counseling or group therapy.
- As part of a federal initiative patients will receive education regarding HIV and other infectious diseases.[8]
- Unlike buprenorphine or naltrexone, participants do not have to be in active withdrawal from other opioids to initiate methadone.
- Encourage participants to share about recent use with their provider. Help them understand the risk of having too much opioid in their system before starting methadone.
- Urine drug screenings (UDS) are used to ensure opioid dependence and to detect the presence of other central nervous system depressants. Co-use of benzodiazepines (Xanax, Ativan) can increase risk of overdose. Encourage your participant to keep their provider informed of substances they have used.
- Methadone is regulated on a state and federal level so starting doses and how much dosages can increase or decrease is less flexible. Patients must start on a low dose and slowly increase over time to a dose that manages their cravings and withdrawal.
- Once stable dosing is accomplished, the prescribing provider may slowly raise the dose to optimal levels, so the patient is not experiencing withdrawal symptoms. Raising the dose slowly is called **titration** and is a good thing for participants to talk to their prescriber about.[9]

**Maintenance Appointments:**

- Again, methadone is only dispensed through specific clinics.
- Initially participants must come in daily for their dose.
- When the clinic deems it safe (through clinic adherence and attaining goals) they may allow take-home doses. If this is a participant's goal, learn specific clinic requirements to help participants make informed decisions about where they will go for treatment.
- Clinics utilize regular substance screening.

- Participants may be required to attend counseling or support groups to continue treatment. Ideally, they can use these appointments to discuss mental health and social needs, cravings and triggers, and issues related to general well-being.

- Methadone dispensing sites often have strict rules about how to receive a dose. This can include needing to come in a specific time frame (often early in the morning or late in the evening). Discuss with your patient how you can support them in meeting these requirements to avoid missing the dosing time established by the clinic.

- Rules can also include consequences for a missed dose such as returning to daily doses if the patient was getting take-home doses or refusing to treat a patient that misses a certain number of doses.

**THINGS TO REMEMBER:**

The challenges of methadone treatment are real and are probably something you encounter in meetings with participants regularly. The OTP system is far from perfect. It can be difficult for people in recovery to adhere to strict rules while still having jobs, caring for children, and because these rules don't acknowledge individual differences and challenges. People in recovery can often feel punished or demeaned by the current system. Here are some ideas on how to support participants receiving methadone treatment for OUD:

- Validate feelings of frustration and anger
- Offer to advocate directly to OTP regarding participant needs and barriers
- Communicate directly with OTPs to stay updated on policies and procedures
- Brainstorm ways to support participants that are struggling to meet OTP requirements:
    - Do they need reminders about dosing schedule? Is that something you could provide on a short-term basis?
    - Is transportation an issue? Are there transportation resources in your area to help overcome this barrier?
    - Are there childcare resources that you can help your participants access?
- Continue local advocacy to changes in the current system, such as expanded dosing hours, humane drug screening, and research-driven practices.
- Access The Methadone Manifesto here for more information:
- https://sway.office.com/UjvQx4ZNnXAYxhe7?ref=Link&mc_cid=9754583648&mc_eid=51fa 67f051

## Naltrexone

**Getting Started:**

- While additional licensure is not required to prescribe naltrexone, participants may still benefit from providers who specialize in addiction medicine.
- Starting naltrexone requires abstinence from opioids for 7-10 days which can be challenging and may increase overdose risk for some. This is to avoid **precipitated withdrawal** which is extremely uncomfortable and lasts for a few days.[4]
- Inpatient opioid withdrawal management and the use of non-opioid medications to ease withdrawal symptoms are options for those interested in naltrexone but are unsure if 7-10 days of being opioid-free is attainable. Discussion with a medical provider is recommended for more information.
- Patients taking naltrexone for OUD **will have reduced opioid tolerance.** At the end of a dosing cycle, if a dose is missed, or if treatment is discontinued, the patient is more vulnerable to fatal overdose if there is a return to use. It is particularly dangerous if an individual uses the same amount of opioids as they used prior to starting naltrexone.[4]
- The injectable form of naltrexone is highly preferred. The oral form of the medication has not been shown to be effective in treating OUD.[10] It is an effective treatment for alcohol use disorder.

**Maintenance Appointments:**

- Injectable naltrexone only needs to be administered monthly.
- Participants can use monthly appointments to discuss other relevant issues such as mental health, social challenges, cravings and triggers, as well as communicating any side effects.

## What Does Withdrawal Feel Like?

You may have experienced withdrawal yourself or have supported others through withdrawal. Given that withdrawal is a common experience for those engaging in MOUD treatment, it is important to inform your participants of all possible symptoms so they can be active partners in their treatment and recovery.

- Cravings for opioids
- Sweating
- Nausea and vomiting
- Diarrhea
- Increased muscle aches and pains
- Insomnia
- Fever
- Cold sweats
- Excessive yawning
- Sneezing
- Coughing
- Runny nose

## Providing Extra Support

Think about different types of support you can provide during MOUD initiation given your role as a Peer Recovery Specialist. Is it possible to check in, and if so, how often? For example, a patient switching from Methadone to Buprenorphine may need multiple check- ins a day initially. Discuss and negotiate an appropriate schedule that considers the timing of swapping medications. Talk about boundaries around the times you are not available, reaching you on the weekend, and other issues that might surface. Brainstorm a backup contact person for times you are not available.

In some areas, it may be difficult to find a supportive prescriber, which can add extra challenges to the medication process. Your role includes advocating for your participants to providers and institutions. In addition, you can offer support and empower your clients to advocate for themselves.

Below are examples and experiences which caused participants to feel unsupported:

- Providers or staff using stigmatizing language (addict, referring to substance use disorder as a matter of choice).
- Being spoken to with less respect than other patients: different tone, hostile facial expressions.
- No partnership in decision making.
- Having a different provider experience with MOUD treatment versus being treated for another medical condition.

- Having different requirements or screening processes for patients with a known history of SUD, such as only requiring some individuals to provide a urine drug screen for a prescription for benzodiazepines or amphetamines.

- Punitive measures related to drug use, such as refusing to prescribe medication after a return to use.

- Individuals with lived experience may feel an internal bias towards or against certain forms of MOUD based on their own experience. It is important to refrain from conveying that bias to effectively assist the participant in receiving a form of MOUD that is best for them.

## How Can You Help Participants Who Are Having These or Similar Experiences?

Remind your participants they are able to choose their medical teams and should feel empowered to seek treatment elsewhere if their prescribers are not treating them with the dignity all patients deserve. Have resources ready to help participants find providers with experience treating OUD.

Many areas may not have multiple prescribers who can utilize MOUD and even when there are options wait-lists are often unrealistically long. Here are some ideas to support participants who may have no choice but to continue to see a prescriber by whom they feel stigmatized:

- Help them identify a trusted friend or family member who is supportive of their recovery and can help them feel less alone at appointments.

- If it is within the scope of your role, offer to attend appointments with the participant. These appointments can be debriefed afterwards to identify what the participant did well and what questions or issues were unaddressed.

- Help your participants make a list of questions to talk with their prescriber about. It can be challenging to remember such questions when a participant is anxious. Encourage your participant to write these down (bring index cards) or, if it is appropriate, offer to text the participant the list so they have it handy.

- Work with participants to identify what it is about going to their prescribers that is challenging for them. Is this something they feel safe addressing with the provider? For example, can they ask, “is this urine screen required for all patients who are prescribed this medication?”

- Participants who do not feel supported by their providers may need extra positive feedback. Remind them they are doing this for their own recovery, help them remember their "why". Point out the positive steps they are taking, like continuing to make appointments even though it is difficult to continue to go.

- Assist in increasing recovery support outside of their medical provider.

- In certain circumstances in which a patient feels their medical care is being compromised due to stigma from the provider, there are ways they can advocate for themselves (e.g., patient complaints or file a complaint with your local department of health for serious cases).

The reality is it may not always be possible to find a provider that is knowledgeable about substance use disorders and the complications that can come with stopping use. Addressing stigma and advocating for best practices directly with providers and institutions is an important strength of the PRS network. Validate how difficult and dangerous these realities can be for your participants. Help them grow their self-efficacy so they can advocate for themselves. Work with them on how they can feel empowered to take ownership of their recovery without letting the ignorance of others derail them.

**RESOURCE CHECKLIST:**

1. Compile a list of providers in your area that can prescribe MOUD: https://www.samhsa.gov/medication-assisted-treatment/find-treatment
2. Contact providers to confirm their prescribing capabilities, insurance acceptance, hours and location.
3. Check for specific providers that you know are research-driven and accepting of patients with SUD.
4. Use your local peer community to get more information: peer chat groups, peer trainers, etc.

# Addressing Timeline

## • Addressing Timeline


Oftentimes participants may want to discuss discontinuing MOUD treatment. Treatment decisions are ultimately up to them but stopping MOUD is associated with negative outcomes such as return to use, hospitalization, overdose and even death.[11,12] Given this, participants should be made aware that medical guidance supports staying on their medication as long as needed. Such conversations can be difficult to navigate because there are no clear guidelines on duration and there are many factors that contribute to the outcomes for any given participant.[9,13] This section will provide guidance on how to have these conversations. Remember that this dialogue is **not intended for giving medical advice**. Instead, these discussions help participants explore their reasons for wanting to discontinue MOUD and clarify risks of doing so. The discussion goal is aid them in making an informed decision.

When discussing discontinuation with prescribers, people in recovery sometimes report that the only response they hear is to stay on MOUD. They may feel their desires are not being heard. Conversations with peers can be an opportunity for you to hear the person out while also explaining some of the concerns prescribers may have. This may also be a good time to share your own positive experiences with MOUD. Many patients hear negative feedback from friends and family about MOUD, so it could be especially valuable to hear a different perspective from someone in recovery who normalizes the medical nature of MOUD. Ask permission before sharing and reiterate that the patient is still autonomous:

> *"You are your own person, but sometimes it can be helpful to hear what others have experienced. Can I share about how I have thought about MOUD in my recovery?"*

Peer Recovery Specialists should emphasize that staying on or going off medication is a personal choice and that participants should remain on the medication as long as they want to in order to support their recovery. Some recommendations suggest that the longer individuals remain on MOUD treatment the better the outcomes.[14] Opioid use disorder is a chronic medical condition, and long-term medication may be the best treatment. If your participant is considering coming off MOUD, remind them that working closely with their prescriber will likely result in the best outcome. Below are suggestions and considerations for conversations with medical providers about tapering off MOUD:

- Discuss reasons for wanting to taper MOUD. Some reasons might be:
    - Medical reasons
    - Social pressure
    - Causing issues at work
    - In conflict with their values
- If there are logistical barriers, is the participant open to talking through those and exploring solutions?
    - Transportation to appointments
    - Schedule of dosing
    - Taking a sublingual dose reliably
    - Adverse reactions
    - Cost

- Would a different MOUD work better?
- Are there myths about MOUD that can be addressed?
- Let the patient know you respect whatever they decide then ask, *"would it be ok if I share some things we know about stopping MOUD so you have more information?"*
    - Relapse rates are high for people in recovery who decide to discontinue buprenorphine[12] or methadone.[15]
    - People in recovery are more likely to stop or lessen illicit drug use when they continue to use medication for as long as it is providing them a benefit.[9]
    - Research has shown that discontinuing MOUD puts people in recovery at a high risk of overdose.[16,17]
    - This is not a clear guideline however and many factors are involved.
- When participants decide they do wish to discontinue MOUD, ideally they can work with their prescribers to come up with a plan they can agree on. Such a plan might mean

agreeing to start tapering when they have achieved stability in several areas of life. Factors to discuss and consider:

- Are there areas of the participant's life that may contribute to a higher risk of return to use? Are they feeling stable financially, socially, etc.?
- What fears do they have about experiencing withdrawal symptoms?
- Are they willing to taper down slowly? Some evidence suggests a slower taper (at least 4 weeks) may have a more positive response.[18]
- Are they willing to pause the taper or return to a higher dose if they feel at risk for relapse?
- While currently there is a lack of evidence to support that mental health therapy or mutual support groups increase the positive outcomes of discontinuing, having a plan for after tapering may still be a reasonable topic to discuss:
  - Alternative forms of MOUD may be considered.
  - Mutual support groups
  - Individual or group therapy
  - Continued follow up with medical team

**THINGS TO REMEMBER:**
There should be no pressure to taper off medication if it is working. Medical guidance supports that using MOUD for as long as needed is the safest option. This can mean using MOUD for years, or indefinitely.

# Is MOUD Safe for Everyone?

## Is MOUD Safe for Everyone?


At this point, it is clear that there is robust evidence MOUD has been found to be effective in helping those with an opioid use disorder find and sustain recovery. Studies have shown that MOUD reduces overdose risk and death, reduces opioid use/misuse, reduces criminal justice involvement, improves HIV and hepatitis C outcomes, increases the likelihood that a person will stay in treatment, increases the likelihood of employment, improves quality of life, and is cost effective.[19] However, it is normal to ask: “Is MOUD safe for everyone?” "What about those who are pregnant and/or breastfeeding?” “What about adolescents or those with co-occurring disorders?” These are questions that clients may likely ask, and here are some facts:

### Pregnancy

- Methadone and buprenorphine are the preferred treatment for OUD in pregnancy.
- Division of Child and Family Services (DCFS) involvement and reporting is different in each state. Peer Recovery Specialists should be informed on state laws and rules around MOUD in pregnancy.
- Help participants find an OB/GYN with whom they can have open and honest conversations. In some communities, there are not OB/GYN providers that understand substance use disorders and their implications in pregnancy. Help participants locate other types of birth workers that may be supportive, such as doulas or midwives. There is research that indicates doula care can be beneficial to birthing people in OUD recovery in the pregnancy and postpartum period. Additionally, utilize the suggestions in the above section **What to Expect** that outlines how to support participants that feel stigmatized by their providers.
- Continuous use of MOUD during pregnancy reduces preterm births and improves pregnancy outcomes, including less severe neonatal abstinence syndrome, particularly with buprenorphine use.
- Pregnant participants should receive care from an addiction specialist AND obstetrician or an obstetrician with experience in treating addiction. Providers such as these do not exist in all spaces. If such providers do not exist in your community, provide participants with additional support and resources.
- Methadone and buprenorphine in combination with prenatal care decrease pregnancy risks, improve retention and decrease symptoms of withdrawal in baby after delivery[20]. If available, seek out programs that offer one-stop care with social workers, mental health counselors, case managers, and prenatal care.

**"[My doctors] told me Suboxone was the preferred medication to take while pregnant and they also told me I would be monitored weekly. After having my baby, during my postpartum, I felt it helped lots with pain management & keeping my mind off addiction."**
**- Leslie L.**

## Breastfeeding

- Encourage breastfeeding in individuals who are stable on their MOUD, not using illicit substances and are not at risk of having HIV.[20] The amount of methadone and buprenorphine that passes into breast milk is small and unlikely to have long-term negative effects on babies.[21]

## Adolescents/Young Adults

- Buprenorphine, methadone, and naltrexone are all FDA approved for this age group. Buprenorphine is the only medication with full FDA approval for under 18. Methadone can only be prescribed for youth under 18 with strict regulations, including parental consent and evidence that other attempts at managing withdrawal have not been successful. Naltrexone is approved only for those 18 and older.
- Both methadone and buprenorphine are effective in treating adolescents with moderate to severe OUD.
- Naltrexone is safe for adolescents with a mild OUD that report craving and social isolation. It may not be a good fit for adolescents who are physically dependent and would need to experience withdrawal before receiving the medication.
- Opioid related deaths among adolescents are on the rise. MOUD increases retention in treatment and decreases relapses to opioid use for adolescents and young adults[22,23].
- Some things to consider when working with adolescents and young adults:
    - Oftentimes they are not engaging with treatment out of intrinsic motivation. This can make MOUD adherence difficult.
    - Finding a new social network may be particularly important for this age group; are there groups in your area who would meet this need?
    - If there is involvement from legal guardians, it will be important to engage with them. They may benefit from their own mutual aid support group or mental health therapy.

## Co-Occurring Disorders

- Often those with opioid use disorder have other disorders, such as an additional substance use disorder or a mental health disorder, like anxiety and depression.
- It is recommended to treat co-occurring disorders simultaneously with opioid use disorder using MOUD. Individuals may require a higher level of treatment or a referral to/participation in mutual support resources.
- Encourage patients to talk to their provider about starting MOUD. Providers should assess for medication interactions with mental health medications.

> ***"I can't stress enough the challenges faced by dually diagnosed patients. Treating both disorders at the same time is the standard of care, but there's a lot of barriers to connecting folks to behavioral health supports, at least in our city. Systemic issues, insurance limitations, and lack of understanding around MOUD and psych meds and how they play together are always looming to sabotage a treatment plan."***
> **- Kenneth F.**

## Incarcerated/Formerly Incarcerated Individuals

- Many incarcerated individuals have OUD and experience withdrawal due to their incarceration. This puts them at high risk of overdose post release.
- If you have participants that know they will be detained, help them talk with their providers about a plan for prescriptions.
- If you are working with people in jail or prison, help them be successful by creating a plan together on how to find MOUD treatment following release from incarceration.

**THINGS TO REMEMBER:**
Encourage patients to talk to their provider about MOUD and medication for mental health issues improves outcomes.

- Advocate directly to detention facilities in your community, educating staff on MOUD to reduce stigma, advocating for naloxone distribution at release, and offering to connect people in recovery with resources (insurance, treatment) before release.

- Read up on what is being done to advocate for reform of MOUD policies in detention centers: https://americanhealth.jhu.edu/news/medications-opioid-use-disorder-jails-and-prisons-moving-toward-universal-access

**RESOURCE CHECKLIST:**

1. Find specialty providers who support people in recovery: pediatricians, psychiatrists, OB/GYNs
2. Click for More information on Pregnancy and MOUD
3. Do some legwork to locate low or no cost birth support, such as doulas in training, nonprofit doula agencies, and those with a sliding-fee scale.
4. Check out AMERSA's Transitional Age Youth and Substance Use Webinar Series

# Laws, Rules, & Regulations

# Laws, Rules, and Regulations


Like most pharmaceuticals, medications for opioid use disorder are regulated by the Food and Drug Administration. Legal guidance must be followed, such as the 2018 SUPPORT Act, which provides practitioners greater flexibility in providing MOUD. Generally, most MOUD laws, rules, and regulations acknowledge that OUD is a medical disorder and warrants medical interventions.

However, how those interventions are delivered, or even the basis of the intervention, are not as clearly defined. Additionally, decisions around laws, rules, and regulations are not always made in scientific medicine, which can further complicate matters.

Laws, rules, and regulations around MOUD can be especially complicated to understand because they significantly change from state to state. MOUD laws, rules, and regulations are determined by a myriad of multilateral stakeholders and systems, including state government and various federal public health organizations.[24]

Peer Recovery Specialists hold a special role in their participant's lives, commonly being a place of support, guidance, and education. For this reason, it is vitally important for PRSs to understand MOUD laws, rules, and regulations in their local communities. It is of equal importance that PRSs continue expanding their knowledge base around this topic on a frequent basis to remain informed about how MOUD patients are protected, or possibly at risk. We offer several suggestions on how to stay informed and take action.

## Research

Educating yourself is a crucial first step in knowing what is regulated (or not regulated) in your community. Many resources are available that break down MOUD laws by state, provide an explanation of federal statutes, and explore how those on MOUD are protected. See just a few below:

- "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery "from the U.S. Department of Justice Civil Rights Division: https://www.ada.gov/opioid_guidance.pdf This document outlines protections given under the ADA for those with OUD. Some examples are the ADA protects individuals denied the right to continue taking prescribed MOUD in detention centers or treatment centers.
- "Overview of Opioid Treatment Program Regulations by State" from the PEW Research Center: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/09/overview-of-opioid-treatment-program-regulations-by-state

- "Statutes, Regulations, and Guidelines" from the Substance Abuse and Mental Health Services Administration (SAMSHA):

  https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines

It is important that your research not end there. Insurance can be one of the more difficult parts of MOUD guidelines to understand, and many patients will have similar confusion and concern around how MOUD care will be financially covered. Be as familiar as possible, as this is something that will certainly come up as a potential barrier to care.

- The Affordable Care Act and Medicaid expansion across the US has greatly expanded MOUD coverage and other SUD treatment options.
- All states (Medicare and Medicaid) cover some form of MOUD.
- Qualified private insurance plans must also offer some coverage of MOUD. There are many plans that are exempt from this though.
- Insurance coverage contains many limitations. Often only one form of MOUD is covered in both private and public plans.
- Some insurance plans have high out-of- pocket costs and limitations to benefits.
- Calling insurance companies and verifying coverage details is necessary. If appropriate, call participants' insurance providers with them. It can be an opportunity to model communicating clearly and advocating for what they need. Afterwards you can process what participants did well on the phone call, and what questions they still need answered.
- Many opioid treatment programs (OTPs) are funded through federal block grants, so depending on the state and facility a person in recovery may be able to get treatment free regardless of insurance status.

**RESOURCE CHECKLIST:**

SAMHSA provides treatment locators that can be filtered by insurance type:
https://www.samhsa.gov/find-treatment

They also have a Helpline for referrals that accounts for insurance carrier:
https://www.samhsa.gov/find-help/national-helpline

## Empowerment

Laws, rules, and regulations can be scary and keep many from engaging in MOUD treatment. Putting together a plan can foster empowerment.

When talking to participants about MOUD laws, rules, and regulations - here are some ways to start conversations:

- **Ask permission**

  *"Would it be okay if we talked more about laws about MOUD?"*

- **Explore what participants already know to determine where to start**

  *"What laws and resources do you already know about?"*

  *"What is most important for you to know more about?"*

- **Don't be afraid to correct**

  Many of us get our information about MOUD via word of mouth or from a source with incorrect information. It is okay to gently correct and provide education and resources.

Providers and treatment teams are here to dispense medication and help navigate the entire treatment process - that includes answering questions about what is and is not allowed. They may not know everything however, and helping your participants feel armed with knowledge is valuable. If they are facing discrimination that is now illegal, there are resources available. Each journey is unique and facing various challenges together facilitates empowerment and recovery.

**RESOURCE CHECKLIST:**
Compile a list of local free and low-cost legal services.
These may include:

1. Legal Aid
2. Pro bono programs
3. Free legal clinics

Remember SUDs qualify as a disability, and there are many services for persons with disabilities, including legal services.

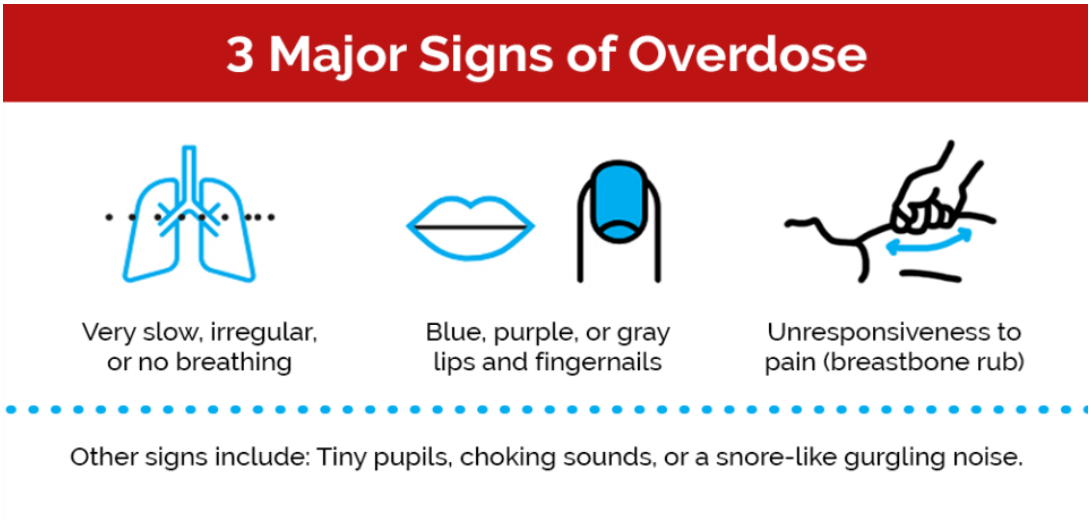
# Overdose Prevention

## Overdose Prevention

Anyone taking opioids in any amount, prescribed or not, may be at risk of overdose and should know how to take action. Even if participants have high opioid tolerance, are using only in small amounts, or do not think they are at risk of an overdose, it is important for a Peer Recovery Specialists to feel confident in having overdose prevention conversations.

The most important part of overdose prevention is education. The more informed we are, the more proactive we can be in recognizing overdose, overdose risks, and how to utilize overdose resources.

Witnessing an overdose can be scary and shocking, which can make it difficult to recognize, and then even more difficult to respond to. As a PRS, you may be in settings where overdose may occur. If you are unsure of how to recognize an overdose, remember the 3 signs:




**"Having had people close to me die because of OUD (Opioid Use Disorder), I know how complex and devastating this issue is. The more information we all have about OUD and MOUD, and the more we all talk about it, the less stigmatizing it all becomes. Stigma holds so many people back from receiving treatment that may work for them."**
**- Dustin E..**

## Signs of Overdose Risk

Here are the signs that participants may be at higher risk of overdose and how to talk a conversation with them:

1. **Using Alone**

   *"Do you use opioids by yourself or with someone else?" If alone, "is there someone you could spend time with when you use opioids so they can make sure you're okay?"*

   ***Tip to Participant:** Try not to use substances alone and arrange for others to check on you.

2. **Using Too Much**

   *"If it is ok with you, can I give you some information about what might make someone more likely to experience an overdose?"*

   ***Tip to Participant:** More is more - meaning that a higher amount is a higher risk of overdose.

3. **Mixing Substances**

   *"What do you know about the dangers of taking more than one substance at a time?" or "taking more than one substance at a time can increase your chances of an overdose, what do you think we could do to keep it at one?*

   ***Tip to Participant:** Try not to mix substances, as it is extremely dangerous, particularly with other substances that slow breathing and heart rate (e.g., alcohol, benzodiazepines, sleeping medications)

4. **Following a Period of Lower Tolerance**

   *"You mentioned that you haven't used substances in quite a while, how are you doing in your recovery? What do you know about opioid overdose?"*

   ***Tip to Participant:** Tolerance level is lowered after not using for a prolonged period of time, such as being recently discharged from a jail or opioid withdrawal management program, or due to illness/poor health. Using the same amount of substances you used before puts you at significant risk of an overdose.

## Naloxone

Conversations about overdose prevention are great opportunities to educate people about naloxone, provide naloxone kits and/or information about how to obtain one.


Naloxone is a safe medication that reverses the respiratory depression caused by taking too many opioids. Naloxone binds to opioid receptors and blocks the effects of other opioids. This allows the person to breathe again. Naloxone is one of the leading harm reduction methods that have been used to save lives.

The goal is to get naloxone kits in the hands of your participants. We suggest having kits on hand to distribute. If participants are showing hesitancy or concern around naloxone, here are some possible prompts:

*"What are your concerns about having naloxone on hand?"*

*"What are your own pros and cons around naloxone?"*

*"Is there anyone you live with or spend time with that would be willing to learn more about naloxone and hold onto it for you?"*

Your local community may also have resources on how to learn more about Naloxone and how to get kits, do your research!

**RESOURCE CHECKLIST:**

1. Naloxone can be obtained through Harm Reduction Agencies (Syringe Service Programs): https://harmreduction.org/resource-center/harm-reduction-near-you/.
2. Naloxone kits can be mailed to your home through Next Distro, www.nextdistro.org.
3. Find out if there are Fentanyl test strip resources in your community

# Resources

- Resources

## Ways to Deepen the Conversation

Now that you have reviewed MOUD information with participants, answered questions, and shared your personal experiences, consider taking some time to assess and enhance motivation around MOUD. Here are some suggestions:

### USE OARS

**O:** Open-Ended Questions

**A:** Affirmations **R:**

Reflections **S:**

Summaries

OARS help to convey empathy, understanding and collaboration.

### DISCUSS PROS & CONS

Talk the patient through their pros and cons of taking a next step with MOUD:

*"What would be the drawbacks of using MOUD? What would be some positive things?"*

*"I'm hearing on the one hand you think it could be hard to fit dosing/extra medical appointments into your work schedule, and you are afraid of your boss finding out about the medication. On the other hand, you acknowledge that being on MOUD could give you the ability to be more stable at work and keep your job."*

### EXPLORE VALUES

Try using some of these suggestions on how to get conversations around values started:

*"How would using MOUD in your recovery enhance your life?"*

*"I'm hearing that [work, family, stability, independence] is very important to you."*

*"What would you be able to accomplish if you incorporated MOUD into treatment for your substance use disorder?"*

### USE READINESS RULERS

If you are picking up on some signs that a patient is considering making a change, whether that includes the use of MOUD or not, you can assess how important that change is to them.

*"On a scale of 1-10 how important is it for you to make this change?"* When they give a number, ask *"Why are you a [given number] and not a [0 or other number lower than the number given]?"* This will encourage patients to talk more about the reasons why this change is important to them.

You can also ask *"What would it take to get from a [given number] to a [higher number]?"* This will help them explore their barriers and how to address them.

If you are hear participants are thinking of taking action, you can use similar questions to assess how confident they are about making that change.

## Assessing Strengths

People in recovery may have a difficult time identifying their own strengths. Your role can encompass seeing their strengths and reflecting them back. Doing so will help them see a path forward where they can be successful in their goals around recovery, based on abilities they already have or actions they have already taken. This may help mobilize them to make healthy changes, whether that is learning more about MOUD, seeking further care, or reducing their risk of infectious disease and death.

You can assess strengths during conversations with participants. Notice times they talk about their skills, resources, things they have already done, and their natural abilities. Take mental notes of these, or even write them down. Reflect these back to participants, maybe repeatedly throughout conversations. You can also ask specific questions about strengths and abilities. It might be most effective to ask these questions right before you start to talk about goal planning.

**THINGS TO REMMEBER:**
Having this conversation shows strength! Don't hold back from sharing the positive you see with your patients

**Here are some possible questions for a conversation about a patient's strengths:**

*"What are you good at?"*
*"Tell me about a time that you felt like most things were going well and what you were doing to make them go well?"*
*"What would your [mom/ dad/ partner/ friends] say they like most about you?"*
*"What strengths do you think you have?"*
*"What are your abilities?"*
*"When did you successfully overcome barriers, and what did you do to overcome them?"*

**Strengths in Life Domains**:
It can be helpful to expand our ideas about what traditional strengths include:

**General Life Skills**: Shops for groceries and life necessities, uses public transportation, ID driver's license is kept current.

**Relationships**: Able to trust others, resolves conflict assertively, maintains family interaction.

**Living arrangements**: Maintains independent living situation, provides upkeep on residence, pride in living arrangements.

**Health:** Maintains adequate diet, takes medications as prescribed, seeks medical care, exercises, is on time to appointments, asks questions about health.

**Internal Resources:** Understands how own behavior affects others, accepts responsibility for behavior when appropriate, considers consequences of behaviors before acting.

**Recovery:** Makes attempts to deal with addiction, avoids persons, places where substance use prevalent, seeks out mental or behavioral health treatment.

## Making A Plan & Goals

Treating OUD is a journey. Journeys are often best navigated with a plan and goals to keep us on track. Peer Support Specialists can work closely with patients to make plans and goals in treating OUD. Below we offer suggestions and resources for conversations with participants.

Sometimes participants may not have plans or goals in mind, or if they do, it may not always be clear. Here are some prompts to begin conversations:

### ASK PERMISSION

*"I think it would be a great idea to set up a plan for your next 6 months or so. Would it be okay to talk more about this?"*

### EMPHASIZE AUTONOMY

*"You are unique, and only you know what is going to work for you. What do you think would work best for you?"*

### GAUGING PLANS/GOALS

*"What goals would you like to explore?"*

*"What goals do you have about your next step in recovery?"*

*"A lot can happen in six months; how would you like your life to be different by then?"*

*"What are things you currently do in your life that help you feel happy and good about yourself, which do not involve the use of substances?"*

If your participant is not sure, maybe ask a **miracle question** - *"when thinking about your perfect life, what do you think about? How can we make some of that happen?"*

## USE SMART GOALS

*When making goals with your participant, make sure they are **SMART**:*

**Specific:** Make sure goals are clear and detailed. Being vague makes it hard to know what participants are actually trying to achieve.

**Measurable:** Make sure goals can be easily tracked. It can help monitor progress and keep things manageable and less overwhelming.

**Attainable:** Make sure goals are realistic. When goals are too massive or intimidating, we are less likely to follow through.

**Relevant:** Make sure goals are relevant to the work you are doing together. All goals are valid, but we want to stay on track.

**Timely:** Make sure goals are not left indefinite, they should have a clear beginning, middle, and end.

## Acknowledge Barriers

To be best prepared in facing barriers head on, it is important to recognize possible obstacles and set up plans to overcome them. This should be done by the participant with your support. Here are some prompts on how to talk about barriers:

*"What do you see getting in the way of accomplishing these goals?"*

*"How have you overcome barriers in the past?"*

*"Can you consider three ways you might overcome this barrier if it comes up this time?"*

*"Imagine you are able to follow through with this goal, how do you see it benefiting you?"*

## Provide Resources

Before wrapping up this conversation this is the time to provide your participant with resources. This could be a warm handoff referral to mutual support or providing contact information for their treatment team, a naloxone kit, etc. This should be specific and unique to your community and treatment agency.

It is important that resources are not just given to participants and then ignored. If something is handed to the participant, it should be reviewed together and explained. Here are some suggestions:

*"I know we talked about this earlier, but before giving you this Naloxone kit, let's confirm that you know how to use it."*

*"This is contact information for a therapist in town. Would it be okay if we gave them a call and set up an appointment?"* If not, *"what are the pros and cons of making this appointment right now?" or "that's okay, when would be a better time for us to do this?"*

*"This is a flyer for a support group that happens on Tuesday nights. I think it would be really beneficial for you to go. What do you think? Have you ever been to something like this?"*

*"This is contact information for our clinic if you ever need it. We may not always be able to answer, but we will try to get back to you when we can. If there is an emergency, do you know who else to contact?"*

- **Warm Handoff Referral**

  A warm handoff is a transfer of care, where the handoff ideally occurs in collaboration with the patient. This transparent handoff of care allows patients and families to hear what is said and engages patients in the referral process, giving them the opportunity to clarify or correct information or ask questions about their care.[25]

  If possible, walk with the patient to the referral source and have a conversation as a group about what the patient will expect, review newly established goals and plans, etc.

If physical referral is not possible, try doing it over the phone with the patient or help the patient craft an email and prepare a plan for follow up: *"if we haven't heard back by your next appointment, we will give them another call or find a new referral. Does that sound okay to you?"*

Despite this being called a handoff, you should continue to help participants navigate systems of care. Follow up with participants and see if they were able to follow through on an appointment, ask how they were treated at the facility, and see what else you can do to support them in engaging with resources.

## Summarize and Wrap Up

The appointment is done, the conversations have wrapped up, and you have provided and connected to resources, now it is time to wrap up! During this time, review and summarize the appointment and time spent together between you and the patient. Make sure to provide time for the patient to ask any final questions that they may have regarding their medication, goals, and next steps.

## Use Your Voice

It is true that MOUD guidelines and regulations seem to change frequently. This can be confusing or even overwhelming, but it can also be empowering to use your voice for MOUD advocacy!

- Be familiar with your local representatives and legislators as they have great influence on current and future MOUD law.
- Make sure you are registered to vote so when the time comes, you are able to have a say in what laws might have an influence on MOUD.
- Know your stakeholders - who are the biggest voices when it comes to MOUD treatment in your community? Knowing what those voices are saying can empower you to be informed.
- Keep up to date on AMERSA's advocacy actions and positions: https://amersa.org/advocacy-statements/

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**THINGS TO REMMEBER:**
OUD can happen to anyone but disproportionately impacts marginalized communities. Make sure that your activism is inclusive and intersectional to have the strongest community support.

# RECOVERY-WELLNESS PLAN

Here is a plan you can use with your participants if it is helpful. It Is designed to be created and maintained by the participant:

*This is intended as a way for you to identify and pursue the goals of your own personal journey. This can also be helpful in guiding conversations between you and the Peer Recovery Coach.*

**What is my overall recovery wellness goal?** _____

_____

_____

_____

*It is often helpful to break down Recovery-Wellness into smaller parts. These are listed below. Under each heading, you will find some questions to get you thinking. Some will strike you as more important than others. Pay attention to these. There is an opportunity to make a goal under each heading, yet you do not need to have a goal under each heading (it can get confusing to have more than 1-2 goals at a time).*

## 1) CONNECTION TO THE RECOVERY COMMUNITY

| | | | | |
|---|---|---|---|---|
| a) | **Do I have regular contact with people in recovery?** | ❑ Yes | ❑ No | |
| | ***If involved,* am I active in the support group?** | ❑ Yes | ❑ No | |
| | **Comments:** | | | |
| b) | **Am I, or do I want to be involved in a recovery support group?** | ❑ I am Involved | ❑ I want to be Involved | ❑ I am not Involved |
| | ***If involved,* do I have, and communicate regularly with, a sponsor/mentor?** | ❑ Yes | ❑ No | |
| | **Comments:** | | | |
| c) | **Am I, or do I want to be involved with a faith/spirituality community?** | ❑ I am Involved | ❑ I want to be Involved | ❑ I am not Involved |
| | ***If involved,* am I active in the faith/spirituality community?** | ❑ Yes | ❑ No | |
| | **Comments:** | | | |
| d) | **Do I spend social time with people in recovery?** | ❑ Yes | ❑ No | |
| | **Comments:** | | | |
| e) | **Are there any other questions I should be asking myself?** | ❑ Yes | ❑ No | |
| | **Comments:** | | | |

*Recovery Goal: _____

_____

*Steps I need to take to reach my goal:_____

_____

_____

*Who else might be involved: _____

_____

*When do I want to have this goal accomplished: _____

2) **PHYSICAL HEALTH**

| | | |
|---|---|---|
| a) **Do I eat a balanced diet?** | ❑ Yes | ❑ No |
| **Comments:** | | |
| b) **Do I exercise regularly?** | ❑ Yes | ❑ No |
| **Comments:** | | |
| c) **Do I get enough good quality sleep?** | ❑ Yes | ❑ No |
| **Comments:** | | |
| d) **Do I need to see a doctor or dentist?** | ❑ Yes | ❑ No |
| **Comments:** | | |
| e) **Do my health care providers know I am in recovery?** | ❑ Yes | ❑ No |
| **Comments:** | | |
| f) **If I have been prescribed medication for my physical health, am I taking it as prescribed?** | ❑ Yes | ❑ No |
| **Comments:** | | |
| g) **Are there any other questions I should be asking myself?** | ❑ Yes | ❑ No |
| **Comments:** | | |

*Recovery Goal:_____

_____

_____

*Steps I need to take to reach my goal:_____

_____

_____

_____

*Who else might be involved: _____

*When do I want to have this goal accomplished: _____

## 3) EMOTIONAL HEALTH

| | | | |
|---|---|---|---|
| **a) Do I work at being in healthy relationships?** | ❑ Yes | ❑ No | |
| Comments: | | | |
| **b) Am I seeing a therapist/counselor, or need to be seeing one?** | ❑ I am seeing a therapist/ counselor | ❑ I need to be seeing a therapist/ counselor | ❑ I do not need to see a therapist/ counselor |
| Comments: | | | |
| **c) Do my providers know that I am in recovery?** | ❑ Yes | ❑ No | |
| Comments: | | | |
| **d) If I have been prescribed medication for my emotional health, am I taking it as prescribed?** | ❑ Yes | ❑ No | |
| Comments: | | | |
| **e) Are there any other questions I should be asking myself?** | ❑ Yes | ❑ No | |
| Comments: | | | |

*Recovery Goal: _____

_____

_____

*Steps I need to take to reach my goal: _____

_____

_____

_____

*Who else might be involved: _____

_____

_____

*When do I want to have this goal accomplished: _____

| 4) SPIRITUAL HEALTH | | |
|---|---|---|
| a) **Am I comfortable with my spirituality?** | ❑ Yes | ❑ No |
| Comments: | | |
| b) **Do I need to develop a spiritual sense and spiritual practices?** | ❑ Yes | ❑ No |
| Comments: | | |
| c) **Am I disciplined about my spiritual practices?** | ❑ Yes | ❑ No |
| Comments: | | |
| d) **Do I take time each day for prayer, meditation/mindfulness, and personal reflection?** | ❑ Yes | ❑ No |
| Comments: | | |
| e) **Are there any other questions I should be asking myself?** | ❑ Yes | ❑ No |
| Comments: | | |

*Recovery Goal: _____

_____

_____

*Steps I need to take to reach my goal: _____

_____

_____

_____

*Who else might be involved: _____

_____

_____

*When do I want to have this goal accomplished: _____

| 5) LIVING ACCOMMODATIONS | | |
|---|---|---|
| **a) Does where I live support my recovery?** | ❑ Yes | ❑ No |
| Comments: | | |
| **b) Does who I live with support my recovery?** | ❑ Yes | ❑ No |
| Comments: | | |
| **c) Do I need to make any changes in my living situation?** | ❑ Yes | ❑ No |
| Comments: | | |
| **d) Are there any other questions I should be asking myself?** | ❑ Yes | ❑ No |
| Comments: | | |

*Recovery Goal: _____

*Steps I need to take to reach my goal: _____

*Who else might be involved: _____

*When do I want to have this goal accomplished: _____

| 6) JOB/EDUCATION | | | |
|---|---|---|---|
| **a) Do I have or need a job?** | ❑ Yes, I have a job | ❑ I need job | ❑ No |
| Comments: | | | |
| **b) Does my job support my recovery?** | ❑ Yes | ❑ No | |
| Comments: | | | |
| **c) Am I satisfied with my education status?** | ❑ Yes | ❑ No | |
| Comments: | | | |
| **d) Do I need training in any area?** | ❑ Yes | ❑ No | |
| Comments: | | | |
| **e) Are there any other questions I should be asking myself?** | ❑ Yes | ❑ No | |
| Comments: | | | |

*Recovery Goal:_____

_____

_____

*Steps I need to take to reach my goal:_____

_____

_____

_____

*Who else might be involved: _____

_____

_____

*When do I want to have this goal accomplished: _____

| 7) PERSONAL DAILY LIVING MANAGEMENT | | |
|---|---|---|
| **a) Can I manage money successfully?** | ❑ Yes | ❑ No |
| Comments: | | |
| **b) Do I know how to use and balance a checking account and/or online accounts?** | ❑ Yes | ❑ No |
| Comments: | | |
| **c) If I have credit, do I manage it successfully?** | ❑ Yes | ❑ No |
| **Credit score?**_____ | | |
| Comments: | | |
| **d) Do I pay my bills on time?** | ❑ Yes | ❑ No |
| Comments: | | |
| **e) Am I able to save any money?** | ❑ Yes | ❑ No |
| Comments: | | |
| **f) Are there any other questions I should be asking myself?** | ❑ Yes | ❑ No |
| Comments: | | |

*Recovery Goal:_____

*Steps I need to take to reach my goal:_____

*Who else might be involved: _____

*When do I want to have this goal accomplished: _____

| 8) OTHER | | |
|---|---|---|
| a) **Are there any other areas of my life I wish to explore?** | ❑ Yes | ❑ No |

Comments:

*Recovery Goal:

*Steps I need to take to reach my goal:

*Who else might be involved:

*When do I want to have this goal accomplished:

*This Recovery Wellness Plan was adapted from the Connecticut Community for Addiction Recovery (CCAR) as part of the Recovery Coach Academy training curriculum. January 2015.

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