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Opioid Use Disorder – Assessment and Treatment Planning

Victorian Opioid Management ECHO
Department of Addiction Medicine
St Vincent's Hospital Melbourne 2021

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

Interesting titbits

Family of substances originally derived from the opium poppy

First seen as long ago as 5700BC

Used by most civilisations since. Most commonly used as an analgesic and sedative

Greeks used it for its sleep inducing properties and for pain (Morpheus origin)

The Latin phrase "Sedare dolorem opus divinum est" is used to describe its benefits

Paracelsus in the early 1500s reintroduced it as Laudanum

Thomas Sydenham used a tincture of opium and alcohol that he called Laudanum.

Byrne, A – Methadone in the Treatment of Narcotic Addiction. 1995

More…

Laudanum commonly used until the 20th century

Morphine derived in 19th century – isolated from opium – first alkaloid isolated from any medicinal plant

Prescribed widely – soldiers for pain and sleep in the US Civil War, unrestricted for analgesia, sleep, cough, diarrhoea – was assumed to be safe and non-addictive

Codeine discovered in 1832 – used widely as well

1874 – English scientist Charles Wright discovered diamorphine (diacetylmorphine – Heroin)

Diagnosing dependence

Following the ICD10 criteria for substance use disorder will help establish whether there is a dependence or not

Three or more of the following must have been experienced or exhibited at some time during the previous year:

1. A strong desire or sense of compulsion to take the substance;
2. Difficulties in controlling substance-taking behaviour
3. A physiological withdrawal when substance ceased or reduced
4. Evidence of tolerance, such that increased doses are required in order to achieve effects originally produced by lower doses;
5. Progressive neglect of alternative pleasures or interests because of substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
6. Persisting with substance use despite clear evidence of overtly harmful consequences

History

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Which opioid?

What route?

How much – points or $$

How frequently used

IV – where do they inject – both on body and physical location

Use with anyone?

Longitudinal history

- **When started**
- **When daily use**
- **When heavy use**
- **Previous withdrawal/abstinence periods**

Important questions

Ever overdosed?

Shared needles?

Complications from use?

Previous opioid agonist treatment (OAT)

Co-ingestants

Treatment planning

Must involve the patient in the planning

- **Individualised care**
- **Shared decision making**
- **Therapeutic alliance**
- **Trauma informed care**
- **Culturally safe care**

Treatment plans

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Determine modality of opioid treatment

- Discuss types of treatment
- Informed patient
- Risks/benefits

Safe induction to OAT

- Minimise withdrawal symptoms
  - Consider home vs withdrawal unit
- Reduced risk of harm during induction
- Contingency planning

Treatment

Comprehensive care

- **Trauma informed care model**
- **Involvement of other services**
  - **Case management**
  - **Psychological support**
  - **Group based care**
  - **Rehabilitation units**
- **Harm reduction strategies**