An empathetic approach to patient management during the opioid crisis: recommendations for pharmacists

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I am a pharmacist and pharmacy owner in Regina, Saskatchewan. The community where my pharmacy is located has high rates of opioid use, and I interact with people seeking treatment for opioid use disorder every day.

Provincial regulations in Saskatchewan enable me to work closely with these patients, administering opioid agonist therapy to my patients directly in the pharmacy, without requiring the sign-off of a physician.[1] I can both dispense daily oral doses of opioid agonist therapies and perform subcutaneous injections. These policies enable me to take on an expanded role, providing a variety of therapeutic options to patients who might otherwise not have access to care.

Stemming from my extensive experience with this population, I will explain how I think pharmacists can embrace the important role of opioid stewardship. I will also outline the numerous benefits of offering medication for opioid use disorder for patients, pharmacists, and society. Finally, I will describe the recommendations and best practices I suggest for empathetic care of these patients.

People who use opioids need more support than ever, and as pharmacists we are uniquely positioned to offer empathetic, effective counselling, care, and support. All of these can help fight the epidemic of opioid use disorder.

The opioid crisis in Canada

Here in Canada, we are undeniably in the midst of an epidemic of opioid use disorder. Opioid use disorder is a physical and psychological dependency on opioids. People who are affected will experience withdrawal symptoms when they stop using opioids,[2] which leads to cravings and subsequent use. This epidemic has been called the opioid crisis, and it is devastating families across the country.

The opioid crisis is believed to stem from the over-prescription of opioid pain medication. Since the 1980s, the amount of opioid prescriptions in Canada has increased by over 3000%.[3] Patients who become dependent on prescription opioids may subsequently use illicit opioids, such as heroin and fentanyl. These drugs are significantly riskier than prescription pharmaceuticals because they may vary in strength or contain other substances.

Many opioid users in Canada are accessing diverted medications, that is, medications that are prescribed to a friend or family member rather than to the user themselves.[3] In addition, an Ontario study found that opioid overdose is the leading cause of death among young people aged 18-35 years.[4]

Medications for opioid use disorder

One major part of the solution to the opioid crisis is to support people with dependencies in seeking treatment. Although opioid withdrawal is difficult to manage, there are medications that can help a person stop using opioids compulsively and help stabilize their condition without having to go through withdrawal.

There are three main medication options for the treatment of opioid use disorder, including methadone and buprenorphine, which are opioid receptor agonists, and naltrexone, an opioid receptor antagonist.[5] Naltrexone tends to be used less often, because patients must stop using opioids for 7-10 days before they can receive the first dose. This discussion will focus on opioid agonist therapy (OAT), which is a focus of my practice.

While these medications are effective, it's important to understand that they are not a quick fix. Successful treatment with medication for opioid use disorder takes time and dedication, and a longer treatment duration with medication for opioid use disorder is associated with better outcomes.[6]

Methadone

Methadone is a full mu opioid receptor agonist which can be administered orally. There is strong evidence supporting its effectiveness.[6] This medication has been used in Canada since 1959.[7] The medication was regulated by Health Canada until 1995, at which point it became the responsibility of the provincial healthcare systems. Today, provincial methadone programs differ in their policies.[7]

Initially, patients must receive observed daily doses at the pharmacy, clinic, or physician's office.[7] As the pa-

tient-clinician dyad begins to build mutual trust, and as the patient stabilizes, the patient may earn "carry doses" which they can bring home and self-administer. In my experience, patient-pharmacist trust is important for this treatment because methadone is associated with a risk of overdose and life-threatening respiratory depression.

Buprenorphine

Buprenorphine is a partial mu and nociceptin agonist, and a kappa and delta opioid receptor antagonist. The medication can be administered orally, via subcutaneous injection, via subdermal implant, or transdermal patch.[5,8,9] It is often combined with naloxone to reduce the chances of diversion or misuse of the medication.[10]

There are benefits to both oral and injectable forms of treatment. Daily oral doses offer the subtle benefit of encouraging structure and scheduling into a patient's life. Patients' lives may be otherwise chaotic, but the daily ritual of visiting the clinic or the pharmacy can introduce some much-needed stability. The corollary is that the long-acting subcutaneous or injectable formats do not offer this same benefit.

Long-acting subcutaneous or injectable forms of OAT may be more convenient for patients who must travel long distances to their nearest provider. These formulations may also reduce the potential for diversion or misuse of carry doses since the medication is only administered in the pharmacy or clinic.

Provincial regulations in Saskatchewan allow me to administer opioid agonist therapy to my patients directly, without requiring the sign-off of a physician.[1] I am able to perform subcutaneous injections into the abdomen of patients receiving injectable OAT. The policies in Saskatchewan have enabled me to provide a variety of therapeutic options to patients who might otherwise not have access to care.

Stigma and opioid use disorder

Despite the efficacy of medications for opioid use disorder, stigma surrounding the use of methadone and buprenorphine remains. This stigma, coupled with lack of access, means many people are unable to benefit from potentially life-changing treatment.

Patients receiving opioid agonist therapy also experience discrimination, further discouraging treatment. My patients have told me that they are treated like "junkies" when they seek healthcare for an unrelated reason, when the provider sees OAT on their records.

It is essential to recognize the barriers this stigma places on seeking help and successful treatment, and to do our best as providers to dismantle this stigma and treat patients with OUD taking OAT as we would any other patient.

While many people who use opioids may come from poverty or a history of generational trauma, it is important to recognize that opioid users can and do come from all walks of life. I have found in my practice that it is beneficial to listen to each patient and treat them like an individual, rather than applying stereotypes or generalizations which may be harmful.

Pharmacists as opioid stewards

Several clinicians and pharmacists have noted that pharmacists can play an important role as opioid stewards.[11] Pharmacists are one of the most visible and accessible healthcare providers, and in my experience, patients tend to trust their pharmacist. We are therefore uniquely positioned to act as opioid stewards.

When patients approach me seeking help with an opioid use disorder, I aim to provide them with help immediately. This is because when the person leaves the pharmacy, there's no guarantee I'll ever see them again. Therefore, I try to connect them with a clinic or a physician or another program that can help as soon as they ask.

In addition, my clinic offers opioid agonist therapy to patients, which I view as another crucial building block in fighting the opioid crisis and acting as an opioid steward.

How pharmacies can improve access to opioid agonist therapies

There are numerous benefits to offering opioid agonist therapy. Firstly, there are many benefits to patients. Being able to access this therapy in a pharmacy can make the process more attractive to patients, as well as significantly more accessible and convenient. During treatment, the patient has daily contact with a healthcare provider who has their best interests at heart. Regular treatment intervals can help create a routine, which in my experience, can help a person become stable enough to work or care for their children again.

For the pharmacy, the program offers the ability to get to know patients personally over the course of many months or many years. In my experience, many mutually beneficial relationships have been formed through OAT. Although we typically start off managing a patient's opioid use disorder, we often end up managing their other health and medication needs over time.

There is an unfortunate stigma against OAT patients, where some pharmacy owners may assume the patients are likely to steal or frighten other patients, which discourages them from offering OAT. In my experience, it is hard to predict who will shoplift from the pharmacy, and I do not believe offering OAT has had any negative impact on my pharmacy.

Recommendations and best practices for pharmacists

Based on my experience as a pharmacist on the front lines of the opioid epidemic, I offer several recommendations for pharmacists during the opioid crisis.

1. Become someone patients can trust. Patients who trust their pharmacist may be more likely to seek help for a dependency, and to adhere to therapy.
2. Don't hesitate to communicate with prescribers if you are concerned about a patient's opioid use. This is a practice that, in my opinion, can save lives.
3. Consider the language you use when communicating with and counseling patients. I have found that switching from the word addiction to the word dependency has made patients feel more comfortable and less stigmatized, while still conveying the same essential information.
4. Familiarize yourself with opioid use disorder treatment options for patients before they ask. When a patient asks for help, provide a phone number, an appointment, or a clinic location immediately so that the patient has an action they can take to get help. Never let a patient leave without help.
5. Become educated about the medications for opioid use disorder that are available. Know the policies and regulations in your jurisdiction, such as whether you are permitted to administer opioid agonist therapy injections with or without physician sign-off.
6. Consider whether your pharmacy has a suitable location for confidential patient counseling and administration of OAT.
7. If you want to administer injectable OAT, consider adapting the pharmacy for this purpose. Our clinic uses a private room with a massage table, allowing the patient to lie flat and receive the subcutaneous injection.

Offering OAT also creates a significant benefit to the community and to society as a whole. This form of treatment is one of the best ways to fight the opioid crisis. By reducing opioid dependence, it may reduce the number of illicit drugs in the community, as well as reducing the number of syringes and other drug paraphernalia found in public spaces.

Summary

Here, I have outlined several best practices pharmacists can begin using that will help fight the epidemic of opioid use disorder and ultimately benefit society. Pharmacists should view themselves as important players in the fight against the opioid crisis and take the role of opioid steward seriously. This involves communication with prescribers and patients, as well as self-education on treatment options available in the community in which you practice.

In my experience, administering opioid agonist therapy is a meaningful and important service that more pharmacies should offer. It offers innumerable benefits to patients, pharmacies, and society in general. Pharmacists should consider offering this service and become educated on the options available in their jurisdiction, as well as the policies surrounding various forms of administration.

We are in the midst of an opioid crisis. People with opioid use disorder are clearly in need of additional support. As pharmacists, we are uniquely positioned to offer help to this population, and I urge all pharmacists to consider what else they can do to act as opioid stewards in the community.

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References

1. Saskatchewan College of Pharmacy Professionals. Prof Practice - Administration of Drugs by Injection... - Saskatchewan College of Pharmacy Professionals. Published 2021. Accessed October 17, 2021. https://saskpharm.ca/site/profprac/adminofdrugs?nav=sidebar
2. Health Canada. Opioids. Published September 23, 2020. Accessed October 18, 2021. https://www.canada.ca/en/health-canada/services/opioids.html
3. Belzak L, Halverson J. Evidence synthesis - The opioid crisis in Canada: a national perspective. *Health Promot Chronic Dis Prev Can.* 2018;38(6):224-233. doi:10.24095/hpcdp.38.6.02
4. Gomes T, Mamdani MM, Dhalla IA, Cornish S, Paterson JM, Juurlink DN. The burden of premature opioid-related mortality. *Addiction.* 2014;109(9):1482-1488. doi:10.1111/add.12598
5. Coon SA, Hill LG, Hutchison RW, et al. Mobilizing pharmacists to address the opioid crisis: A joint opinion of the ambulatory care and adult medicine practice and research networks of the American College of Clinical Pharmacy. *JACCP J Am Coll Clin Pharm.* 2020;3(8):1493-1513. doi:10.1002/jac5.1331
6. Bell J, Strang J. Medication Treatment of Opioid Use Disorder. *Biol Psychiatry.* 2020;87(1):82-88. doi:10.1016/j.biopsych.2019.06.020
7. Eibl JK, Morin K, Leinonen E, Marsh DC. The State of Opioid Agonist Therapy in Canada 20 Years after Federal Oversight. *Can J Psychiatry.* 2017;62(7):444-450. doi:10.1177/0706743717711167
8. Government of Canada HC. Drug Product Database Online Query. Published April 25, 2012. Accessed November 10, 2021. https://health-products.canada.ca/dpd-bdpp/info.do?lang=en&code=96515
9. Government of Canada HC. Drug Product Database Online Query. Published April 25, 2012. Accessed November 10, 2021. https://health-products.canada.ca/dpd-bdpp/info.do?lang=en&code=82676
10. Blazes CK, Morrow JD. Reconsidering the Usefulness of Adding Naloxone to Buprenorphine. *Front Psychiatry.* 2020;11:958. doi:10.3389/fpsyt.2020.549272
11. Gondora N, Versteeg SG, Carter C, et al. The role of pharmacists in opioid stewardship: A scoping review. *Res Soc Adm Pharm.* Published online July 2021:S1551741121002357. doi:10.1016/j.sapharm.2021.06.018