Bernalillo County Addiction Treatment Advisory Board

Standards for the Treatment of Opioid Use Disorder

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Bernalillo County Addiction Treatment Advisory Board

Members (2018)

Dr. Snehal Bhatt
Dr. Daniel Duhigg
Dr. Joanna Katzman
Dr. Miriam Komaromy
Dr. Harris Silver
Dr. Anjali Taneja
Dr. Bruce Trigg
Dr. William Wiese (Chair)

Staff Contact:

Katrina Hotrum, Director
Bernalillo County, Department of Behavioral Health Services
5901 Zuni SE, Albuquerque, NM 87108
Email: khotrum@bernco.gov
Tel: (505) 468-1550

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PREFACE

Most common chronic diseases are managed routinely at the level of the local medical community. As a common chronic disease, OUD likewise should be managed within the local medical community, including primary care whenever possible. OUD is associated with significant morbidity and a high risk of mortality.

Tools needed for identifying persons with or at high risk of OUD are widely available. There is a body of robust medical research documenting the management requirements for successful treatment. Several guidelines for treatment are available. (See Resources on final page of this document.)

Current evidence overwhelmingly demonstrates that the best chance for achieving and sustaining remission of OUD and recovery includes the use of medication-assisted treatment (MAT)[1] plus appropriate management of comorbid health conditions and adequate psychosocial care.

Treatment success for OUD is enhanced by tailoring the level of treatment to the patient's needs, access to specialists when needed, and support from ancillary disciplines. Assuring a supportive social environment (wrap-around care) is crucial.

This document serves as a foundation for standards for the treatment of individuals with OUD. In recognition that practitioners caring for patients with OUD, particularly patients with comorbidities, may have limited experience in aspects of care, supplemental documents are being developed to provide practice guidelines for use in specific treatment situations.

RESPONSIBILITY FOR ACTION

As with other substance use disorders, the possibility of OUD in any patient should not be dismissed or ignored. Any signs consistent with OUD should be followed up promptly either directly by the clinician or by referral for assessment and possible treatment.

DIAGNOSIS

Treating OUD requires making an accurate diagnosis using the diagnostic criteria defined by the Diagnostic and Statistical Manual, fifth edition. (See definition in Appendix 1.)

WHEN TO START TREATMENT

The interval between recognizing a person has having OUD and when assessment and treatment begin can be critically important. Delay should be avoided as during the interim the patient may be lost (and frequently is lost) to follow-up or incur a complication or death. Immediate referral is important and warm handoff is optimal.

[1] "MAT" is the abbreviation of "medication assisted treatment." Alternative phrasing for "MAT" as "medication for addiction treatment" is acceptable and favored by some addiction treatment authorities.

BEHAVIORAL HEALTH SCREENING

Individuals should be screened for psychiatric co-morbidities, symptoms of severe mental illness, and suicide risk, which are often associated with OUD and should be recognized and managed in order to maximize chances of responding to treatment. (See list in Appendix 2.)

SCREENING FOR MEDICAL SEQUELAE/RISKS

Individuals should be assessed for disorders and conditions associated with (a) OUD and illicit opioid use or (b) end-organ damage or (c) occurrence during detoxification and treatment. (See list in Appendix 3.)

SCREENING AND EVALUATION OF PSYCHOSOCIAL NEEDS

Individuals should have evaluation of psychosocial and environmental situations that can impact the chances for success in treatment. Case management and social service support are often needed for success in treatment. (See list in Appendix 4.)

SETTING AND INTENSITY OF CARE

The most appropriate care setting and level of care should take into account safety and intensity of management required for assessment and phases o treatment. Treatment phases may include detoxification, induction of MAT and maintenance, management of comorbid conditions, case management and social supports services, and management of rehabilitation and recovery. (See list in Appendix 5.)

MEDICATION FOR ADDICTION TREATMENT — OPTIONS

With rare exception, evidence-based MAT should be offered to all patients diagnosed with an OUD. Given the higher, morbidity and overdose death rates and shorter duration to relapse in those individuals not treated with MAT, it is generally not appropriate to recommend against treatment with MAT.

There are currently just three pharmacotherapeutics used for MAT that have firm evidence supporting effectiveness in treatment of OUD. Two are used as opioid agonist therapy (OAT); one is an opioid receptor antagonist:

1. OAT with buprenorphine maintenance treatment
2. OAT with methadone maintenance treatment
3. Opioid receptor antagonist treatment with naloxone (long acting injectable)

Patients should understand that each of these MAT options is effective as the primary MAT agent for OUD—each having advantages and disadvantages depending on the patient situation and coexisting conditions.

It is currently not acceptable to use a medication to directly treat OUD other than those listed above.

It is not acceptable to promote treatment without MAT as being superior.

It is not acceptable to promote the misconception that OAT is replacing one addiction for another. (OAT does continue dependency, but demonstrably reduces “addiction-related “ behaviors and consequences seen in OUD.)

OAT with buprenorphine may be used to combat effects of opioid withdrawal during detoxification from opioid use. Without immediate follow-up with implementation of a treatment plan, such isolated use is not considered MAT in the context of this standard.

Use of buprenorphine as a bridging agent to carry a person for a period of time until an unavoidably delayed treatment program can begin may be justifiable and appropriate if it reduces risks associated with illicit opioid use, complications, or death. (Evaluation of this strategy is currently incomplete.)

SUPPLEMENTING MAT

Non-MAT pharmacological and psychosocial therapies can be important adjuncts and synergistic with MAT, improving a patient's chances of success, but are not necessary for all patients. (See list in Appendix 6.)

PATIENT PREREQUISITES FOR THE INITIATION OF OPIOID REPLACEMENT THERAPY

1. Meets diagnostic criteria for opioid use disorder
2. Desires treatment of OUD
3. Understands of the risks and benefits of treatment, and a willingness to follow safety precautions
4. Commits to secure storage medication supplies
5. Accepts an expectation of reasonable compliance with treatment

OTHER REQUIREMENTS FOR TREATMENT

The following are important components of OUD treatment:

1. Provider encourages patient's full participation in management decisions
2. Patient understands the nature and natural history of substance use disorders
3. Patient understands treatment options including likelihood for benefit, risks, complications, roles and responsibilities of various provider participants, and expectation for patient's compliance
4. Patient is willing to enter an agreement or contract for various responsibilities including drug testing
5. Provider is willing to seek consultation in situations that require management choices beyond his/her experience or training or when comorbidities require additional or separate concurrent management
6. Patient provides consent

CONCURRENT USE OF ILLICIT OR LICIT DRUGS

MAT only treats OUD, and it is common for patients to use other classes of drugs, either legal or illegal, before and/or during opioid MAT. Discontinuation of MAT solely due to use of other drugs is not an evidence-based practice and should be discouraged since it will almost certainly result in relapse of illicit opioid use. Experience and evidence show that over time many patients will decrease and eventually may discontinue use of other substances especially once their mental health and other psychosocial needs have been addressed.

DURATION OF TREATMENT

Clinical evidence suggests that a longer duration of MAT use is associated with better treatment outcomes, including recovery for problematic substance use and reduced risk of death due to

opioid overdose. Clinical evidence consistently shows that when patients discontinue or are taken off of MAT for OUD, relapse rates soar and are associated with increased lethal opioid overdose. For this reason, patients should be encouraged to continue their MAT for as long as possible, including indefinitely.

ANTICIPATING RELAPSE

Relapse from MAT including resumption of illicit opioid or concurrent use of other drug happens and should be anticipated. Response should prioritize review and modification of the treatment plan and program. A punitive response is counterproductive in not addressing the reasons for relapse possibly driving continued drug use underground and risking complications, including death.

SPECIAL SITUATIONS WITH EXTRA RISKS THAT CAN IMPACT CHOICE OR USE OF MAT MEDICATION

Certain circumstance pose special risks and care is required to maximize benefit and safety and minimize risk. These situations require experience and awareness of pitfalls. Reference materials should be consulted for guidance. Consultation or referral may be prudent or necessary. (See Appendix 7 for list of examples of such situations.)

APPENDICES

Appendix I: Definition of opioid use disorder (OUD) – Diagnostic and Statistical Manual, 5th Edition:

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifest by at least 2 of the following, occurring in a 12-month period:

1. *Use results in failure to fulfill major obligations*
2. *Continued use despite interference with social or interpersonal function*
3. *Important social, occupational, recreational activities reduced due to use*
4. *Difficulty cutting down or controlling use*
5. *Great deal of time spent obtaining, using, recovering from use*
6. *Cravings/strong desire to use*
7. *Taking more/longer than intended*
8. *Recurrent use when physically hazardous*
9. *Continued use despite worsening physical or psychological symptoms*
10. *Developing tolerance*
11. *Experiencing withdrawal*

Appendix 2: Psychiatric co-morbidities, which should be recognized and managed in order to maximize chances of responding to treatment of OUD:

1. Alcohol use (including identification of "risky drinking") or alcohol use disorder
2. Benzodiazepine/sedative/hypnotic/anxiolytic use (including “risky” use) or use disorder
3. Tobacco use disorder
4. Methamphetamine use disorder
5. Other problematic drug use
5. Major depressive disorder

6. Posttraumatic stress disorder
7. Generalized anxiety disorder
8. Symptoms of severe mental illness
9. Suicidal ideation
10. Somatic symptom disorder (especially patients with chronic pain).

Appendix 3: Additional screening for medical sequellae/risks:

1. Acute infections, including abscesses and cellulitis that may result from injection drug use
2. Renal failure and disturbance of electrolytes, and metabolism
3. Liver disorders including cirrhosis and hepatitis C
4. Sleep-disordered breathing
5. HIV/AIDS
6. Heart disease, including endocarditis
7. Chronic obstructive pulmonary disease and other compromising pulmonary diseases
8. Chronic pain syndromes
9. Pregnancy

Appendix 4: Evaluation of psychosocial needs:
Individuals should have evaluation of psychosocial needs in order to best position them for success in treatment.

1. Housing status
2. Employment/income
3. Food security
4. Insurance status
5. Primary care provider relationship
6. Social support network
7. Transportation
8. Criminal justice involvement

Appendix 5: Setting and intensity of care:
The most appropriate care setting and level of care should take into account safety, intensity of management required for detoxification and induction of therapy, management of comorbid conditions, as well as timely access and availability.

1. Ambulatory treatment
2. Medically supervised detoxification
3. Intensive outpatient
4. Partial hospitalization
5. Residential rehabilitation
6. Intensive inpatient
7. Psychiatric inpatient

Appendix 6: Non-pharmacological therapies and supports that can be helpful supplementing MAT and other elements in the treatment of OUD.

1. Early engagement with peer support

2. Cognitive behavioral therapy
3. Community reinforcement approaches
4. Motivational enhancement therapy
5. 12-step/mutual help groups that encourage MAT
6. Finding personal safety
7. Contingency management
7. Dispensing naloxone rescue kit (with training)
8. Awareness of benefits and location for syringe exchange

Appendix 7: Special situations with risks that can impact choice or use of MAT:

1. Pregnancy
2. Newborn from mother actively using opioids or on MAT
2. Concurrent use of benzodiazepines, barbiturates, or large amounts of alcohol
3. Unstable or serious cardiac disease
4. Untreated sleep disordered breathing
5. Concurrent need for pain management

RESOURCES RELATED TO MEDICATIONS FOR TREATING OPIOID USE DISORDERS

Substance Abuse and Mental Health Services Administration. (2018)
TIP 63 Medications for Opioid Use Disorder

Substance Abuse and Mental Health Services Administration. (2016)
Pocket Guide: Medication-Assisted Treatment of Opioid Use Disorder
HHS Publication No. (SMA) 16-4892PG

Komaromy M, Buser R, Silver H, Hayes L, Bohan J, Duhigg D, Mount BK, Block J, Weiss J, Cianciabella S. (2012)
New Mexico Treatment Guidelines For Medical Providers Who Treat Opioid Addiction Using Buprenorphine
New Mexico Behavioral Health Collaborative, 37 Plaza la Prensa, Santa Fe, NM 87507

Duff JH. (2018)
Buprenorphine and the Opioid Crisis: A Primer for Congress
Congressional Research Service, R45279
Available at https://fas.org/sgp/crs/misc/R45279.pdf

SAMHSA publications may be ordered or downloaded for free from SAMHSA's Publications Ordering webpage at https://store.samhsa.gov .