Alosa Health

Balanced information for better care

Helping patients manage opioid use disorder

Opioid use disorder (OUD) is a chronic, relapsing, treatable medical condition

Repeated use of opioids, whether illicit or by prescription, can cause neurochemical changes in the brain that often require treatment to overcome.[1]

OUD is problematic opioid use that leads to clinically significant impairment or distress.[2]

It is marked by at least two of the following over the past 12 months:	using opioids at higher doses or longer than prescribed
	unsuccessful attempts to control or reduce use
	significant time lost obtaining, consuming, or recovering from opioids
	craving for opioids
	failure to fulfill obligations because of opioid use
	persistent social or interpersonal problems caused by opioids
	opioid use displaces social, work, or recreational activities
	opioid use creates hazardous situations (e.g., while driving)
	use continues despite physical or psychological problems caused or worsened by opioids
	tolerance: a reduced effect of the drug despite increasing dosages (in patients taking opioids other than as prescribed)
	withdrawal (in patients taking opioids other than as prescribed)

The severity of OUD is defined by the number of these criteria that are present: mild: 2-3; moderate: 4-5; severe: 6 or more

More than 2 million Americans suffer from opioid use disorder, and the number is growing.[3,4]

OUD can be successfully managed, but effective treatments are vastly underused.[5,6]

Even though medical treatment greatly improves outcomes, only about 1 in 5 people with OUD receives it.[5]

Identify patients with OUD

FIGURE 1. Begin with **SBIRT** (**S**creening, **B**rief **I**ntervention and **R**eferral to **T**reatment)[2,7,8]

Screening

- **Ask** all patients about substance misuse at least annually:
  "In the past year, have you used alcohol, tobacco products, prescription drugs for non-medical reasons, and/or illegal drugs?" If the answer is "Yes" for drug use:
  - Ask about the drug being misused.
  - Use a standardized tool to screen patients reporting misuse (e.g., Drug Abuse Screening Test [DAST]-10). Go to AlosaHealth.org/OUD for DAST.
- **OR** use the Tobacco, Alcohol, Prescription medication, and other Substance use tool (TAPS). Go to drugabuse.gov/taps/#/.
- **Assess** for OUD in patients who screen positive.

Initiate a Brief Intervention

- **Advise** the patient about your concern and recommendations.
- **Assist** with setting goals of care.
  - Use motivational interviewing techniques to encourage safer behavior and engage the patient in effective treatment.
- **Arrange** follow-up and support.

Refer to or initiate Treatment for those with OUD

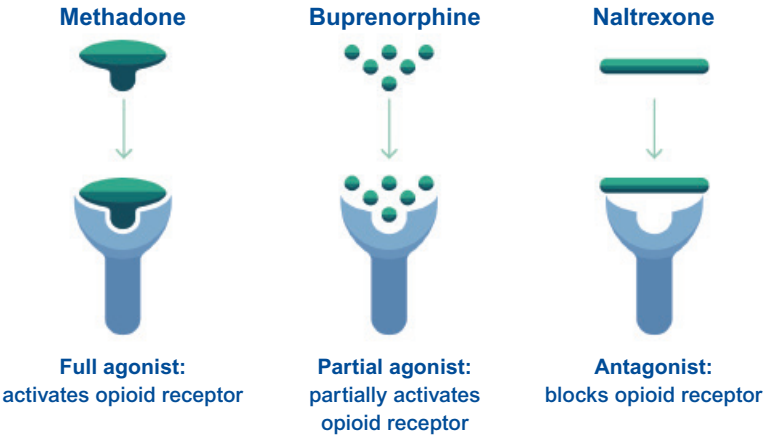
Ideally, medication-based treatment, with psychosocial support as appropriate

Follow-up and monitor.

Engaging and retaining patients in medication-based treatment can help to successfully manage OUD and reduce the risk of death.[9,10]

Medications for opioid use disorder can work well

Three medication classes are FDA-approved to treat OUD.

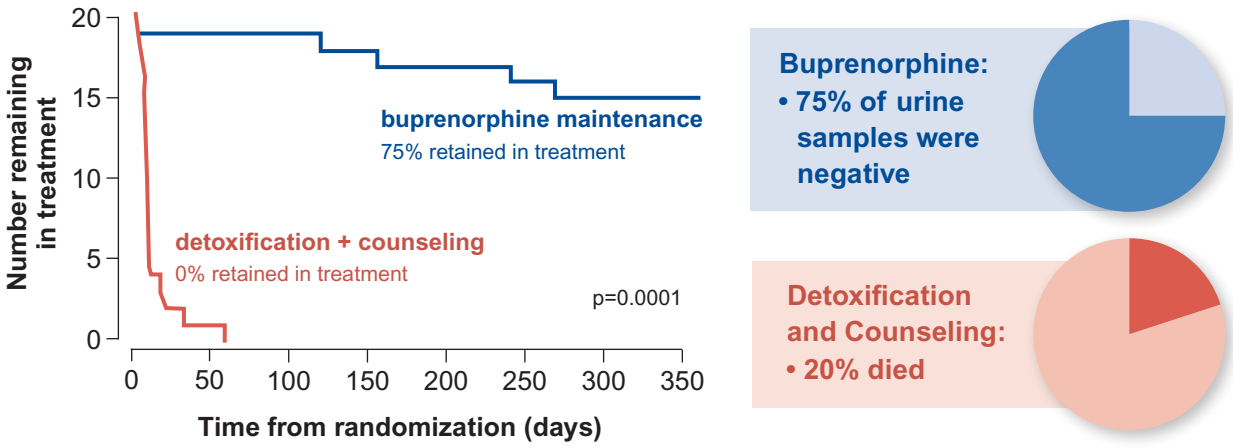


Buprenorphine is often combined with naloxone (such as Suboxone) to prevent misuse if injected; the naloxone in this formulation has little to no effect if taken as prescribed.

Methadone, buprenorphine, and naltrexone can all:

- reduce the risk of death[10,11]
- improve retention in addiction treatment programs[12]
- reduce cravings[13]
- decrease opioid misuse[12-14]
  - reduce urine samples that test positive for opioids
  - increase time abstaining from opioids[14]

FIGURE 2. In a randomized trial, buprenorphine lowered the risk of death, improved retention in treatment, and reduced illicit opioid use compared to detoxification and couseling alone.[9]



Medication-based treatment is more effective than detoxification and abstinence-based therapy alone.[15]

Matching the person with the treatment

TABLE 1. The three medications available to treat OUD

	buprenorphine (e.g., Suboxone, Bunavail)	methadone	naltrexone IM injection (Vivitrol)
When to start	patient must have mild to moderate withdrawal symptoms	any time	requires 7-10 days of abstinence from opioid use prior to starting
Who can provide treatment	anyone with a DEA X-waiver*	certified opioid treatment program	any prescriber
Treatment delivery	no daily clinic visits required	generally requires daily visits to a clinic for supervised administration	monthly injection
Patient characteristics	preferred as first line treatment for most patients	helpful for patients with multiple unsuccessful prior treatment attempts, and/or need daily support	mild OUD or those who can't use agonist treatment
OUD severity	moderate to severe	moderate to severe	mild
Initiating treatment	home or in office	certified opioid treatment program locations	in office
Commonly used dosage forms	sublingual film or tablet, buccal film, long-acting injection or implant	liquid	long-acting injection

*Anyone licensed to prescribe opioids (e.g., M.D., D.O., nurse practitioner [N.P.], physician assistant [P.A.]) can complete the training and receive an X-waiver to prescribe buprenorphine. N.P. and P.A. prescribing regulations are subject to state law.

While medication-based treatment is sometimes provided along with behavioral therapy, it is so effective that it should be offered whether or not behavioral interventions are available.[16]

The choice of treatment should be a shared decision between the health care professional and the patient; the setting of treatment is an important consideration as well.[1]

Promoting recovery

1 Recommend or prescribe naloxone (e.g., Narcan) to prevent a potentially fatal overdose.[17] It saves lives.

2 Use "person-first language" to reduce stigma.

Language to avoid	Recommended language
addict, abuser, user, junkie	a person with OUD
clean/dirty urine	urine that is positive/negative for opioids or other substances
treatment failure	return to use, recurrence, relapse

3 Support patients who return to using opioids.

- As in helping a patient to stop smoking, it may take several attempts to achieve sustained remission.
- OUD is a chronic condition, and these patients will need ongoing support as they work toward recovery.

4 Continue medications for OUD as needed.

- Patients may require medications to treat OUD for several years, or indefinitely.[1]
- Patients who taper buprenorphine quickly may be more likely to return to use.[18]

Prescribing a medication to treat OUD can build on the trust and relationship a primary care clinician has already established with the patient.

- **OUD is common**, and it is likely that one or more patients in any given practice suffer from it.
- **Doctors who prescribe opioids for chronic pain are already managing risks** associated with opioid use (e.g., diversion, misuse, demands for increased dose).
  - — Prescribing buprenorphine or naltrexone can help address these concerns and actually make care less stressful for both the patient and clinician.

Summary

- Opioid use disorder is a **chronic, treatable disease** that affects millions of Americans.
- Because of neurochemical changes in the brain caused by exposure to opioids, **medication treatment is key to addressing OUD for many patients.**
- Patients who are treated with FDA-approved medications for OUD have **better outcomes** than those who are not.
- **Identify patients with suspected OUD and initiate treatment** using SBIRT: Screening, Brief Intervention, and Referral to Treatment.
- **Ensure that naloxone (e.g., Narcan) is available** to patients with OUD and those who take high-dose opioids; it can be life-saving.
- **Obtain an X-waiver** to be able to prescribe buprenorphine to manage OUD and improve patient outcomes.

Visit AlosaHealth.org/OUD
for links to treatment information, resources, and more.

References:

(1) *National practice guideline for the use of medications in the treatment of addiction involving opioid use.* American Society of Addiction Medicine;2015. **(2)** *Diagnostic and statistical manual of mental disorders (5th ed.)*. Arlington, VA: American Psychiatric Association;2013. **(3)** Substance Abuse and Mental Health Services Administration. *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health*. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services;2018. **(4)** Han B, Compton WM, Jones CM, Cai R. Nonmedical Prescription Opioid Use and Use Disorders Among Adults Aged 18 Through 64 Years in the United States, 2003-2013. *JAMA*. 2015;314(14):1468-1478. **(5)** Wu LT, Zhu H, Swartz MS. Treatment utilization among persons with opioid use disorder in the United States. *Drug Alcohol Depend*. 2016;169:117-127. **(6)** U.S. Department of Health and Human Services. *Clinical use of extended-release injectable naltrexone in the treatment of opioid use disorder: a brief guide.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; February 2, 2015. **(7)** Substance Abuse and Mental Health Services Administration. *Medications for opioid use disorder. Treatment Improvement Protocol (TIP) Series 63, Full Document*. Rockville, MD: Substance Abuse and Mental Heatlh Services Administration;2018. **(8)** McNeely J, Wu L, Subramaniam G, Sharma G, Cathers LA, Svikis D, et al. Performance of the Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) Tool for Substance Use Screening in Primary Care Patients. *Ann Intern Med*. 2016;165:690-699. **(9)** Kakko J, Svanborg KD, Kreek MJ, Heilig M. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. *Lancet*. 2003;361(9358):662-668. **(10)** Gunne LM, Gronbladh L. The Swedish methadone maintenance program: a controlled study. *Drug Alcohol Depend*. 1981;7(3):249-256. **(11)** Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550. **(12)** Strain EC, Stitzer ML, Liebson IA, Bigelow GE. Dose-response effects of methadone in the treatment of opioid dependence. *Ann Intern Med*. 1993;119(1):23-27. **(13)** Fudala PJ, Bridge TP, Herbert S, et al. Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone. *N Engl J Med*. 2003;349(10):949-958. **(14)** Krupitsky E, Nunes EV, Ling W, Illeperuma A, Gastfriend DR, Silverman BL. Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled, multicentre randomised trial. *Lancet*. 2011;377(9776):1506-1513. **(15)** Sees KL, Delucchi KL, Masson C, et al. Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence: a randomized controlled trial. *JAMA*. 2000;283(10):1303-1310. **(16)** National Academies of Sciences E, and Medicine 2019. Medications for opioid use disorder saves lives. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310. **(17)** U.S. Department of Health and Human Services. Naloxone: the opioid reversal drug that saves lives. 2018. https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf. Accessed April 9, 2019. **(18)** Sigmon SC, Dunn KE, Saulsgiver K, et al. A randomized, double-blind evaluation of buprenorphine taper duration in primary prescription opioid abusers. *JAMA Psychiatry.* 2013;70(12):1347-1354.

About this publication

These are general recommendations only; specific clinical decisions should be made by the treating clinician based on an individual patient's clinical condition. More detailed information on this topic is provided in a longer evidence document at AlosaHealth.org.

This material is provided by Alosa Health, a nonprofit organization which is not affiliated with any pharmaceutical company.

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