DRUG & ALCOHOL FINDINGS *Abstract*

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## ▶ Medications for opioid use disorder: for healthcare and addiction professionals, policymakers, patients, and families: Treatment Improvement Protocol: TIP 63.

**Substance Abuse and Mental Health Services Administration**
**[US] Substance Abuse and Mental Health Services Administration, 2018**

*Expanding access to medication is an important public health strategy for tackling opioid use disorder, concludes US government agency guidelines. While some people stop using opioids without medication, many benefit from access to methadone, naltrexone, and buprenorphine for varying lengths of time, including lifelong treatment.*

**SUMMARY** The Substance Abuse and Mental Health Services Administration (SAMHSA) is a US government agency which works to reduce the impact of substance abuse and mental illness on America's communities. The featured treatment improvement protocol provides guidance on three medications – methadone, naltrexone, and buprenorphine – approved by the Food and Drug Administration for use in the treatment of opioid use disorder, and the accompanying strategies and services needed to support recovery. This extends beyond heroin to dependence on fentanyl and prescription opioids.

## A guide to the treatment improvement protocol

**Part one** offers a general introduction to providing medications to address opioid use disorder, and is relevant to healthcare and addiction professionals, policymakers, patients, and families.

**Part two** is for healthcare professionals who work in general medical settings, and who care for patients who misuse opioids or have opioid use disorder.

**Part three** is for healthcare professionals, and describes the general principles of the medical treatment of opioid use disorder, including different formulations of methadone, naltrexone, and buprenorphine, their uses, and recommended dosing. It also discusses patient management and monitoring in outpatient and hospital settings.

**Part four** is for addiction treatment professionals and peer recovery support specialists who work with people prescribed methadone, naltrexone, or buprenorphine, but who do not prescribe the drugs themselves. These providers have a 'helping' relationship with their clients, and often interact with healthcare professionals who prescribe or administer medications.

**Part five** provides resources related to medications for opioid use disorder, segmented for healthcare and addiction professionals, policymakers, patients, and families.

## Key messages

Addiction is a chronic, treatable illness. Opioid addiction – which generally corresponds with moderate to severe forms of opioid use disorder – often requires continuing care for effective treatment rather than an episodic approach.

Approaching opioid use disorder as a chronic illness can help providers deliver care that supports patients to stabilise, achieve remission of symptoms, and establish and maintain recovery.

Patient-centered care empowers patients with information that helps them make better treatment decisions with the healthcare professionals involved in their care. Patients should receive information from their healthcare team that will help them understand opioid use disorder and the options for treating it, including treatment with approved medication.

Patients should have access to mental health services as needed, medical care, and addiction counselling, as well as recovery support services.

Providers should be aware that language can reinforce prejudice, negative attitudes, and discrimination, which can deter people from seeking treatment, make patients leave treatment prematurely, and contribute to worse treatment outcomes. The expert panel responsible for developing the protocol recommends that providers always use medical terms when discussing substance use disorders (eg, referring to a 'positive' or 'negative' urine sample, as opposed to a 'dirty' or 'clean' sample), and use what is known as person-first language (eg, referring to a 'person with a substance use disorder', rather than a 'user', 'alcoholic', or 'addict').

There is no 'one size fits all' approach to treatment. While some people stop using opioids on their own, and others recover through support groups or treatment with or without medication, many benefit from treatment with medication for varying lengths of time, including lifelong treatment:
• Methadone and buprenorphine can be prescribed for reducing or eliminating symptoms of withdrawal.
• Methadone, naltrexone, and buprenorphine can be prescribed for blunting or blocking the effects of illicit opioids.
• Methadone, naltrexone, and buprenorphine can be prescribed for reducing or eliminating cravings to use opioids.

Ongoing outpatient medication treatment is linked to better retention and outcomes than treatment without medication.

The science demonstrating the effectiveness of medication for opioid use disorder is strong. For example, in randomised clinical trials – the 'gold standard' for demonstrating efficacy in clinical medicine – methadone, extended-release injectable naltrexone (effects last a month), and buprenorphine, have each been found more effective in reducing illicit opioid use than no medication. Methadone and buprenorphine treatment have also been associated with reduced risk of overdose death.

The evidence also indicates that medications for opioid use disorder are cost effective.

Some people achieve remission without medication, just as some people can manage type 2 diabetes with exercise and diet alone. However, just as it is inadvisable to deny people with diabetes the medication they need to help manage their illness, it is also not sound medical practice to deny people with opioid use disorder access to approved medications for their illness.

Medication for opioid use disorder should be integrated with outpatient and residential treatment, including outpatient counselling, intensive outpatient treatment, inpatient treatment, and long-term therapeutic communities; and patients in these settings should have access to medication.

Patients prescribed medication can benefit from individualised psychosocial support, such as medication management and supportive counselling.

Expanding access to medication is an important public health strategy. The gap between the number of people needing treatment for opioid use disorders and the capacity to treat them with medication is substantial. In 2012, the gap was estimated at nearly one million people in the United States.

**FINDINGS COMMENTARY** This document was prepared in the context of the US 'opioid epidemic'. According to the Department of Health and Human Services, in 2016 11.5 million people had misused prescription opioids, 2.1 million of these doing so for the first time, compared with 948,000 having used heroin, 170,000 for the first time. There were also 17,087 deaths attributable to people overdosing on commonly prescribed opioids and 15,469 on heroin.

The overarching message from the Substance Abuse and Mental Health Services Administration in the featured document was that recovery from opioid use disorder is a *process* through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential; and medication is one way of supporting recovery. Methadone, buprenorphine, and naltrexone – the three medications considered – are safe and effective when used appropriately,

and can help patients reduce or stop illicit opioid use and improve their health and functioning. Importantly, the document only supported the use of injectable naltrexone (not oral naltrexone), which is not currently licensed for medical use in the UK.

Last published in 2017, there is no more important document for UK clinicians involved in treating problem drug use than the so-called 'Orange guidelines' (summarised and appraised in the Effectiveness Bank), offering detailed guidance on the range of problems, settings, and patients clinicians encounter, substantially informing judgements of what constitutes good medical practice. This includes evidence-based information on the use of naltrexone for relapse prevention, and choosing an effective opioid substitute (methadone versus buprenorphine). Respecting different paths to recovery, the orange guidelines state:

> *"It is inappropriate, in providing ethical, evidence-based treatment, for services to create a sense that those opting for [maintenance on an opioid substitute] are making a poorer choice than those opting for an abstinence-oriented or abstinence-based treatment. Equally, prescribing services should not discourage a patient who wishes to pursue detoxification, but should provide the best information on benefits and risks, and support the patient's considered decision. Staff should convey all the options suitably optimistically and realistically, and with sensitivity to the service user's personal situation and risks."*

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