VA | U.S. Department of Veterans Affairs

OPIOID USE DISORDER

A VA Clinician's Guide to Identification and Management of Opioid Use Disorder (2016)

VA Academic Detailing Service

REAL PROVIDER RESOURCES
REAL PATIENT RESULTS

These materials were developed by:

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Your Partner in Enhancing Veteran Health Outcomes

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Opioid Use Disorder (OUD)

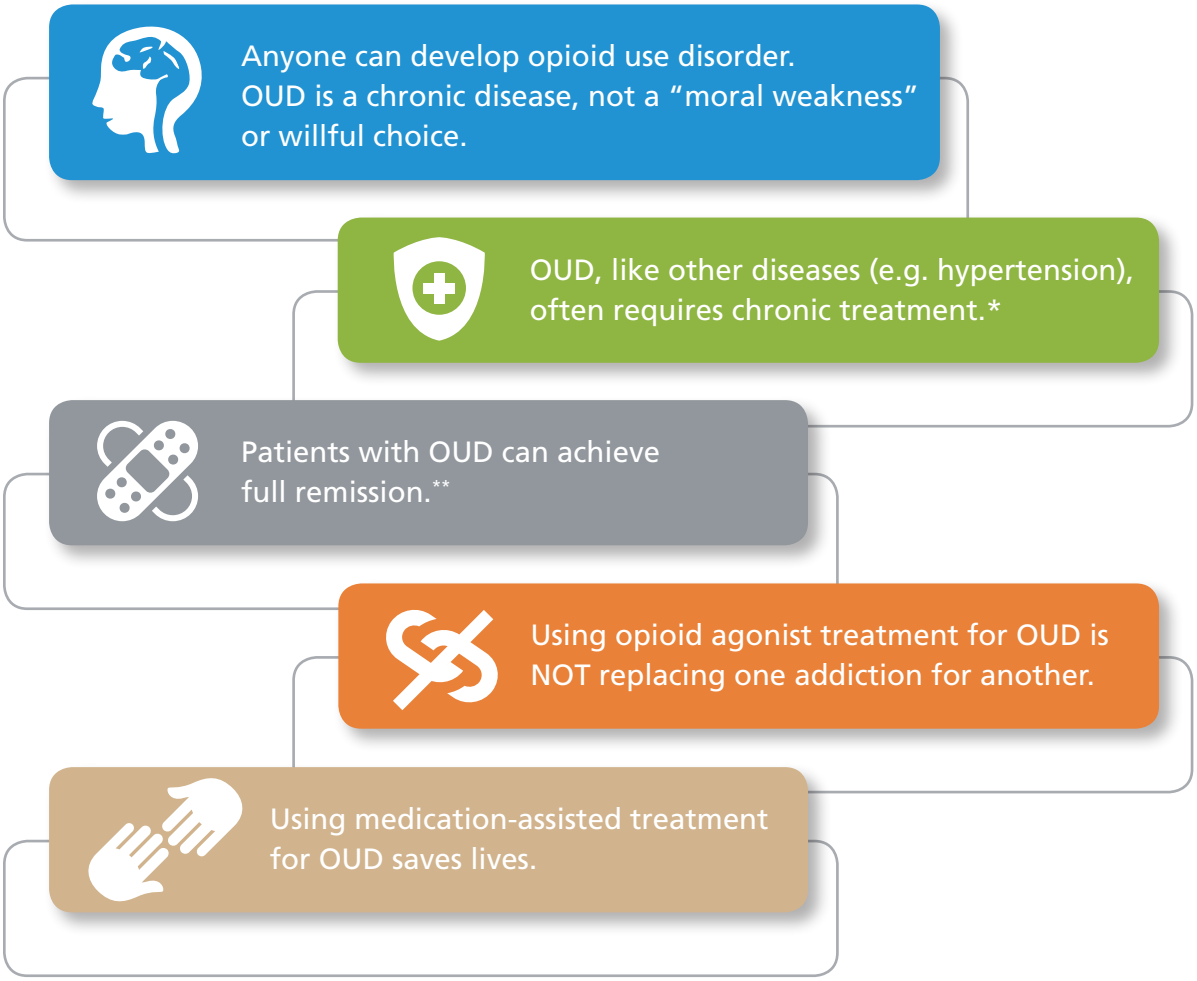
Opioid Use Disorder (OUD) is a **brain disease** that can develop after repeated opioid use.[1] Just like other diseases (e.g. hypertension, diabetes), OUD typically requires **chronic management**. *See Table 2 for OUD DSM-5 diagnostic criteria.*

Be in the know: Stop the stigma

OPIOID USE DISORDER (OUD)

Substance use disorders are more highly stigmatized than other health conditions and are often treated as a moral and criminal issue, rather than a health concern.[2]

Figure 1. Educate yourself on the facts[3,4]



*The goal of treatment is to produce a satisfying and productive life, not to see how fast the patient can discontinue treatment. **Methadone and buprenorphine maintained patients, with negative UDT's, and no other criteria for opioid use disorder, are physically dependent, but not addicted to the medication and can be considered in "full remission."

Change the conversation[2,3,4]

As health care providers, we can counter stigma by using accurate, nonjudgmental language to describe OUD, those it affects, and its treatment with medications.[2,5]

Table 1. Changing the conversation

	Instead of this:	Consider saying this:
Use person-first language	Mr. X is an **opioid addict.**	Mr. X **has a substance use disorder** involving opioids.
	That Veteran has a **drug problem.**	That Veteran is suffering from **problems caused by drugs.**
Avoid judgmental terminology	Your urine drug test was **clean.**	Your urine drug test was **negative** for illicit substances.
	Your urine drug test was **dirty.**	Your urine drug test was **positive** for illicit substances.
	You have to **stop your habit** of using opioids.	I would like to help you **get treatment for your opioid use disorder.**
Be supportive	There is **no cure** for your disease.	**Recovery** is achievable.
	I can't help you if you **choose** to keep using opioids.	We understand that **no one chooses to develop opioid use disorder.** It is a **medical disorder** that can be managed with treatment.

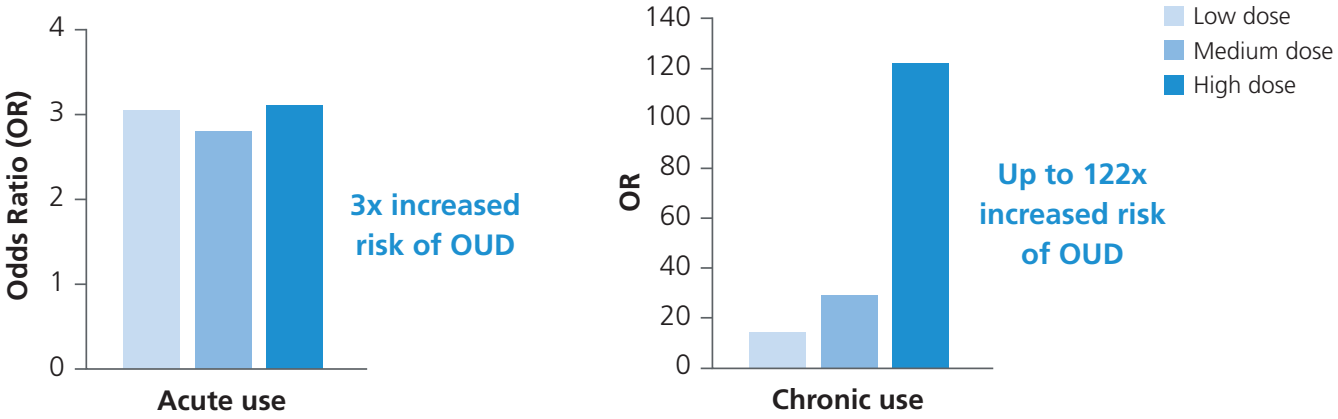
We are contributing to the problem

Prescription drug abuse is the nation's fastest-growing drug problem.[6] According to a recent report, nearly 2.5 million people aged 12 or older in the U.S. had an opioid use disorder (prescription drug or heroin) in the past year.[7]

In 2013, health care providers wrote for **nearly 250 million opioid prescriptions**—enough for **every American adult** to have their own bottle of pills.[8]

The lifetime prevalence for OUD among patients receiving long-term opioid therapy is estimated to be ~41%. Approximately 28% for mild symptoms, ~10% for moderate symptoms and ~3.5% for severe symptoms of OUD.[9]

Figure 2. Both dose and duration of opioid therapy have been shown to be important determinants of OUD risk[10]



According to a recent study (n=568,640) evaluating the incidence of OUD among those newly prescribed opioids, duration of opioid therapy was more important than dose in determining OUD risk; however the risk amongst those receiving chronic therapy increased dramatically with increasing dose (low dose, acute (OR = 3.03); low dose, chronic (OR = 14.92); medium dose, acute (OR = 2.80); medium dose, chronic (OR = 28.69); high dose, acute (OR = 3.10); high dose, chronic (OR = 122.45).

Duration (days of use out of 12 months): Acute = 1-90 days, Chronic = 91+ days; Average daily dose (morphine equivalents): Low = 1-36 mg, medium = 36-120 mg, high = 120+ mg.

Figure 3. Recent increase in heroin use

Emerging evidence suggests the recent increase in heroin use may be linked to patients who first become addicted to prescription opioids transitioning to heroin as their tolerance increases.[11] Heroin is viewed as being more reliably available, more potent, and more cost effective than prescription opioids.[12]

Identifying Veterans with OUD

OUD symptoms such as drug craving or inability to control one's use may go unrecognized if patients continue to receive an opioid analgesic. **Aberrant behaviors may become more apparent and reveal an opioid use disorder when opioids are tapered or discontinued or as tolerance begins to develop.**

When performing a physical examination in a Veteran with OUD or on an opioid:[13]

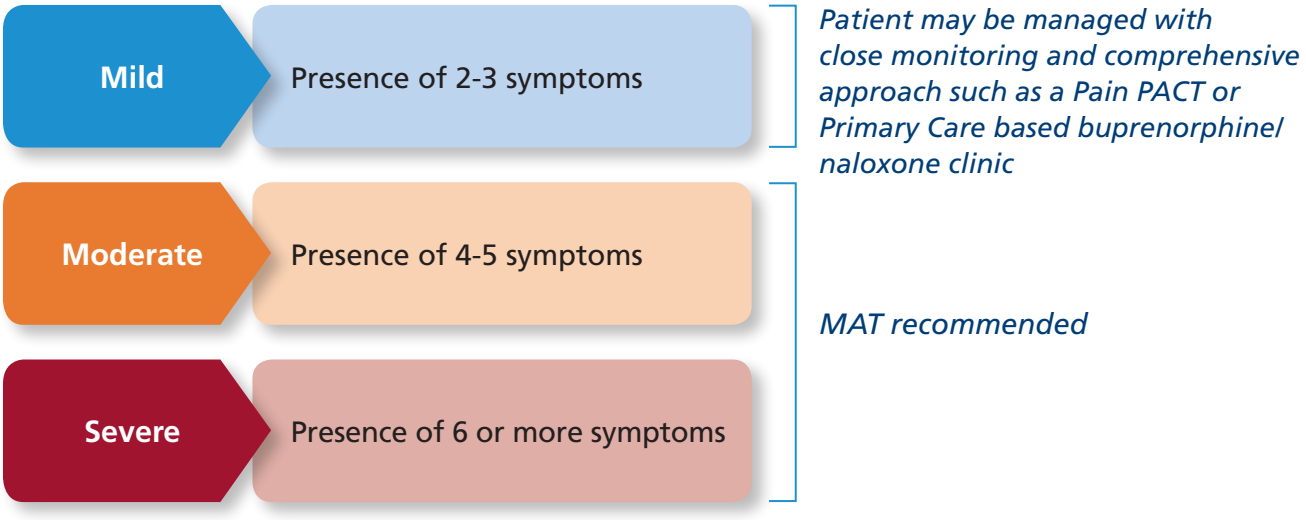
- Look for signs and symptoms of opioid intoxication and withdrawal *(see Quick Reference Guide)*
- Look for indications of IV drug use:
  - Needle marks
  - Sclerosed veins (track marks)
  - Cellulitis/abscess
- Order a random urine drug test (UDT) to check for unexpected findings.[14]

Table 2. DSM-5 Diagnostic Criteria for OUD* and example behaviors[15]

	DSM-5 Criteria	Example Behaviors
1.	Craving or strong desire or urge to use opioids	Describes constantly thinking about/needing the opioid
2.	Recurrent use in situations that are physically hazardous	Repeatedly driving under the influence
3.	Tolerance	Needing to take more and more to achieve the same effect (asking for increased dose without worsened pain)**
4.	Withdrawal (or opioids are taken to relieve or avoid withdrawal)	Feeling sick if opioid is not taken on time or exhibiting withdrawal effects**
5.	Using larger amounts of opioids or over a longer period than initially intended	Taking more than prescribed (e.g. repeated requests for early refills)
6.	Persisting desire or unable to cut down on or control opioid use	Has tried to reduce dose or quit opioid because of family's concerns about use but has been unable to
7.	Spending a lot of time to obtain, use, or recover from opioids	Driving to different doctor's offices every month to get renewals for various opioid prescriptions
8.	Continued opioid use despite persistent or recurrent social or interpersonal problems related to opioids	Spouse or family member worried or critical about patient's opioid use; spouse divorcing Veteran because of use
9.	Continued use despite physical or psychological problems related to opioids	Unwilling to discontinue or reduce opioid use despite non-fatal accidental overdose
10.	Failure to fulfill obligations at work, school, or home due to use	Not finishing tasks at work due to taking frequent breaks to take opioid; getting fired from jobs
11.	Activities are given up or reduced because of use	No longer participating in weekly softball league despite no additional injury or reason for additional pain

*OUD DSM-5 diagnostic criteria: A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least 2 of the symptoms in the table above, occurring within a 12-month period. **Tolerance and withdrawal are not criteria for OUD when taking opioid pain medicine as prescribed.

Figure 4. Determining severity of OUD[15]



MAT = Medication assisted treatment

Figure 5. Other OUD risk factors for patients on long-term opioid therapy[9]

- Age < 65 years
- Current pain impairment
- Trouble sleeping
- Suicidal thoughts
- Anxiety disorders
- Illicit drug use
- History of SUD treatment

Identify Veterans with an OUD and engage them in treatment.

Engaging Veterans with OUD

Many Veterans may initially decline treatment, or at least express ambivalence, but encouragement and support may improve their willingness to pursue treatment.[16]

Table 3. Fundamental principles for engaging Veterans with OUD

Treatment works	Treatment is more effective than no treatment; medication-assisted treatment (MAT) has been shown to be most effective
Respect patient preference	Consider the patient's prior treatment experience and respect patient preference for the initial intervention
Use motivational interviewing (MI) techniques	Emphasize common elements of effective interventions (e.g. improving self-efficacy for change, promote therapeutic relationship, strengthen coping skills, etc.)
Emphasize predictors of successful outcomes	• Retention in formal treatment • Adherence to medications for OUD • Active involvement with community support for recovery
Promote mutual help programs*	Narcotics Anonymous (NA)
Address concurrent problems	Coordinate addiction-focused psychosocial interventions with evidence-based intervention(s) for other biopsychosocial problems
Promote least restrictive setting	Provide intervention in the least restrictive setting necessary to promote access to care, safety, and effectiveness
Emphasize that options will remain available	If unwillingness remains, maintain MI style, emphasize that options remain, determine where medical/psychiatric problems managed,** look for opportunities to engage

*Please note, mutual help program participants may not support the use of medications to treat OUD; it is important that your Veteran is educated on this possibility. **Even when patients refuse referral or are unable to participate in specialized addiction treatment, many are accepting of general medical or mental health care.[16]

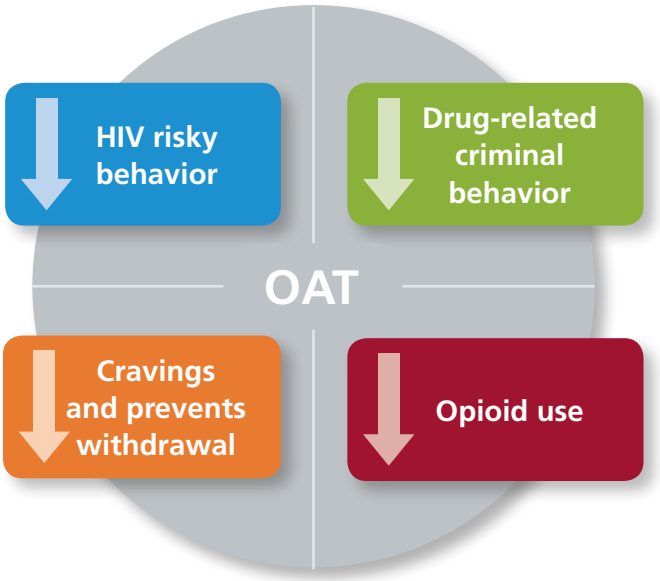
Treating Veterans with OUD

Figure 6. Offer a menu of care settings to Veterans with OUD

Offer Veterans with OUD a SUD Specialty Care treatment referral. If they decline, offer them treatment that can meet their needs in the setting they feel most comfortable.

OUD Pharmacotherapy

Figure 7. Opioid Agonist Therapy (OAT) is considered 1st line treatment for OUD.[16]

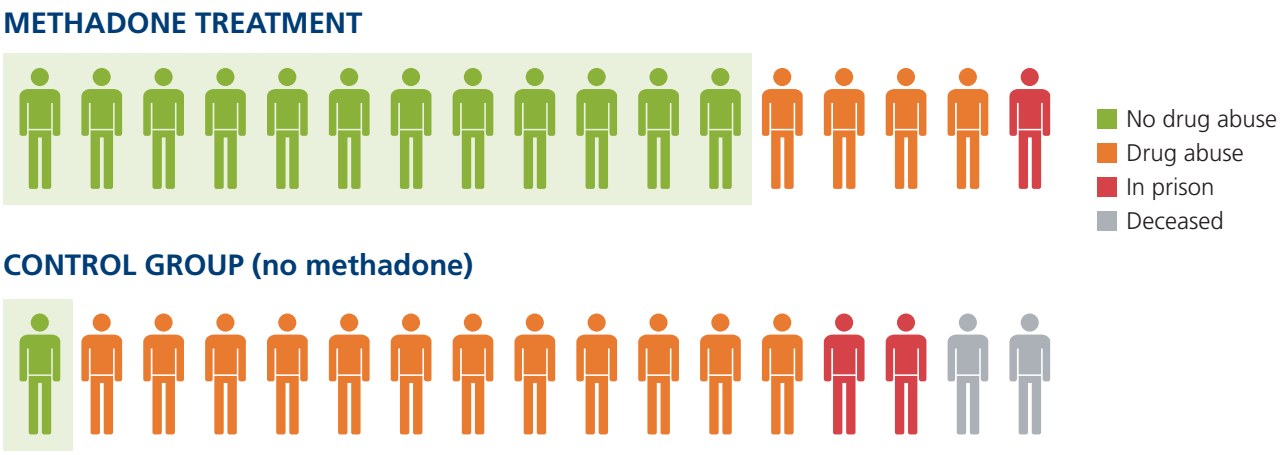


OAT allows the patient to focus more readily on recovery activities by preventing withdrawal and reducing cravings; helps achieve long-term goal of reducing opioid use and the associated negative medical, legal, and social consequences, including death from overdose.[17,18]

Goals of Pharmacotherapy for OUD[19]

1. To suppress opioid withdrawal
2. To block the effects of illicit opioids
3. To reduce opioid craving and stop the use of illicit opioids (eliminate or reduce)
4. To promote and facilitate patient engagement in recovery-oriented activities

Figure 8. Medication for OUD saves lives[20]



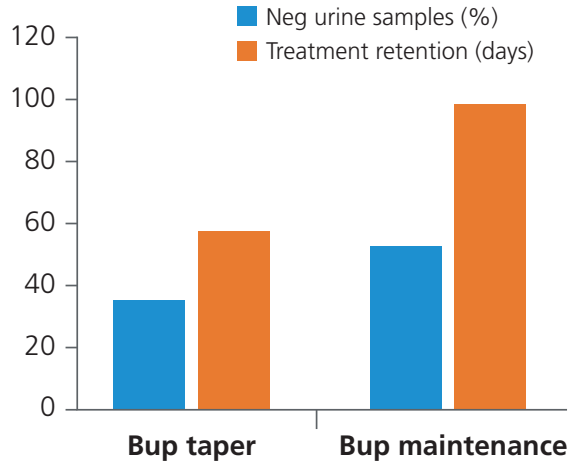
According to a study evaluating methadone treatment versus control (no methadone) after 2 years, participants receiving methadone were more likely to be drug free and had fewer adverse outcomes associated with use (e.g. death, prison).

Buprenorphine*

- Has been shown to be effective in a variety of treatment settings[17,18,21-26]
- Should be initiated along with addiction-focused medical management[16] (see page 16); can be offered with or without additional psychosocial interventions[16,27-29]
- Higher doses (≥ 16 mg) of buprenorphine may be more effective for some patients[30]
- Treatment must be provided by physicians with a DEA-X waiver

*Buprenorphine refers to buprenorphine/naloxone unless otherwise stated.

Figure 9. Buprenorphine in patients with OUD[31]



This 14-week, randomized, open-label study conducted in primary care in patients with prescription opioid dependence assigned patients to a buprenorphine taper or buprenorphine maintenance after 6 weeks of buprenorphine stabilization. The patients who received a buprenorphine taper had a lower average of opioid-negative urine samples (35.2%, 95% CI=26.2-44.2%) compared to those assigned to buprenorphine maintenance (53.2%, 95% CI=44.3-62.0%), a lower mean number of days retained in treatment (57.5 vs 98.7 days, $p < 0.001$), more days of illicit opioid use, and fewer weeks of continuous abstinence.

Methadone

- Methadone as a treatment for OUD should not be prescribed outside of Methadone Maintenance Program.
- Methadone treatment has been shown to be as effective as buprenorphine treatment at suppressing illicit opioid use, but with slightly better treatment retention.[32]

Table 4. Comparison of OAT (buprenorphine/naloxone and methadone)[33]

	Buprenorphine/Naloxone**	Methadone
Treatment setting	Office-based	Specially licensed OTP
Mechanism of action	Partial opioid agonist*	Opioid agonist
FDA approved for OUD	Yes	Yes
Reduces cravings	Yes	Yes
Best for mild, moderate, or severe OUD?	Mild—Moderate	Mild, Moderate, and Severe
Candidates and history of failed treatment attempts	None/few failed attempts	Many failed attempts
Recommended for OUD candidates with pain conditions requiring ongoing short-acting opioids?	No	Yes
Psychosocial intervention recommendations	Addiction-focused MM	Individual counseling and/or contingency management

OTP = Opioid Treatment Program; MM = Medical Management

Note: Please see the quick reference guide for information on how to acquire a DEA-X waiver.

*Also contains naloxone which is inactive when taken as directed but will become an active opioid antagonist if used illicitly (e.g. snorted or injected).[34]

**In every clinical situation, except when pregnant or documented intolerance/hypersensitivity to naloxone, the preferred formulation of buprenorphine is buprenorphine/naloxone. Pregnant patients should be carefully educated about the benefits and risks of buprenorphine versus methadone during pregnancy. (Pharmacy Benefits Management (PBM) Buprenorphine/Naloxone Criteria For Use)[34]

Other Pharmacotherapy options

EXTENDED-RELEASE INJECTABLE NALTREXONE

- FDA-approved for the prevention of relapse in adult patients with OUD following complete detoxification from opioids
- Recommended for patients unable/unwilling to take OAT and have not used an opioid in the past week[16]

CLINICAL PEARL

Consider Naltrexone IM in patients with comorbid OUD and Alcohol Use Disorder

In patients with an active OUD, opioid withdrawal management should be followed by treatment with OUD pharmacotherapy. Do NOT provide withdrawal management alone due to high risk of relapse and overdose.[16]

Use buprenorphine or methadone (in an OTP) as first-line treatment options in Veterans with OUD.

ADDICTION-FOCUSED MEDICAL MANAGEMENT[16]

Structured psychosocial intervention designed to be delivered by a medical professional (e.g., physician, nurse, physician assistant) **in a primary care setting.**

Figure 10. Components of addiction-focused medical management*

*Session structure varies according to the patient's substance use status and treatment compliance; BAM = Brief Addiction Monitor

Follow-up for patients receiving OUD treatment

Offer and encourage ongoing systematic relapse prevention efforts or recovery support for patients who have initiated an intensive phase of outpatient or residential treatment.

RELAPSES[16]

Do **NOT** stop OUD treatment for a Veteran because they have an opioid relapse.

Opioid relapse does not mean that treatment has failed. It is a signal that the current OUD treatment strategy needs to be adjusted, reinstated, or changed in order to move toward recovery.[35]

If the Veteran is using substances other than an opioid, consider referring that Veteran to the SUD specialty care program for management.

Other important considerations

Pain management and OUD

Figure 11. When managing pain in patients with OUD[36]

AVOID:

- **Opioid analgesics**
- **Sedative-hypnotics**
- **Muscle relaxants**
- **Other medications with potential for addiction**

RECOMMEND:

- **Nonpharmacological therapies**
  - Cognitive behavioral therapy for pain
  - Pain school or behavioral groups
  - Support groups/Community support
  - Rehabilitation therapies (e.g. physical therapy and occupational therapy)
  - Specialty procedures (e.g. injections, nerve blocks)
  - Complementary and alternative therapies (e.g. acupuncture, massage, tai chi)
- **Non-opioid medications**
  - APAP, NSAID
  - SNRI, TCA
  - Gabapentin
  - Topicals (e.g. lidocaine, capsaicin)
- **Assessment for and treatment of co-morbid psychiatric conditions* (e.g. PTSD, insomnia, anxiety)**

*Emotional and social distress in a patient with persistent pain may lead to self-medication of these uncomfortable feelings with opioids.[37]

Figure 12. Goals of pain treatment in patients with OUD[37]

CLINICAL PEARL

Morning withdrawal symptoms may be misinterpreted as an exacerbation of pain

Table 5. Using opioids in patients with OUD

If opioid analgesics are considered necessary after weighing the risks versus benefits for patients with OUD in remission, consider the following strategies:[37-40]

Medication considerations	Monitoring	Comprehensive treatment planning and support
• Consider consulting pain management specialist • Use non-opioid adjuvant therapies when possible • Offer naloxone • Prescribe smaller amounts of opioids and at the lowest effective dose • Avoid automatically refilling opioid prescriptions • Conduct pill counts when possible	**Schedule frequent office visits:** • Assess opioid use behaviors and signs of relapse (e.g. early refill requests, unexpected UDT results, requests for dose increase despite worsening of pain) • Assess opioid efficacy and functional restoration (see figure 14) • Perform frequent UDTs and reviews of PDMP reports (2-4 times/year)	• Assess for and manage co-morbid psychiatric conditions* (e.g. PTSD, insomnia, depression) • Expand the pain treatment plan to include specific relapse-prevention strategies and directed relapse management • Offer addiction treatment and support resources (e.g. outpatient treatment, 12-step meetings, individual counseling)

UDT = Urine drug test; PDMP = Prescription drug monitoring program; PTSD = Post-traumatic stress disorder

Figure 13. Managing pain in patients on OAT (buprenorphine/methadone)[37]

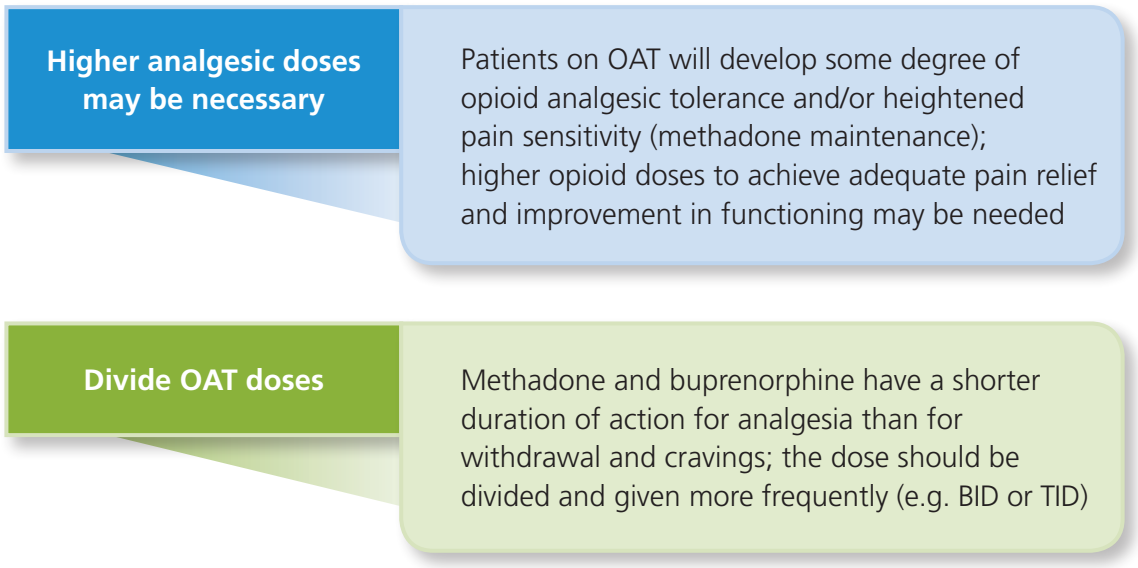
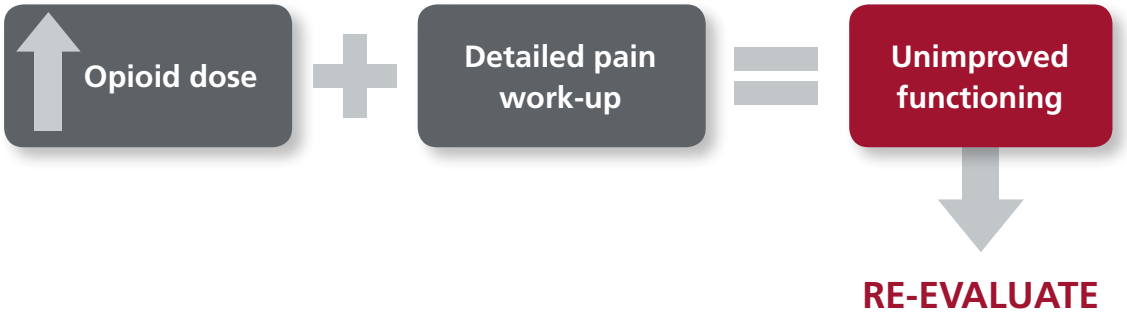


Figure 14. Unimproved functioning: it's time to re-evaluate[37]



When managing pain in a Veteran on an opioid, a detailed pain work-up and an increase in opioid dose should result in improved patient functioning. If the patient's functioning does not improve, re-evaluate your current treatment plan. The patient could have opioid-non responsive pain, be suffering from opioid-induced hyperalgesia, have an untreated or undertreated psychiatric illness, or be suffering from addiction and is in need of opioid use disorder treatment.

Relapse

Patients with OUD in remission are at **very high risk for relapse** when taking opioids for treatment of pain.

WARNING[33]

- If relapse is identified, do not abruptly discontinue opioid treatment without providing addiction treatment.
- Abruptly discontinuing the opioid without addiction treatment in place sets the patient up for progression of an active disease.

Opioid Overdose Education and Naloxone Distribution (OEND)[41]

- Education and training for patients on how to prevent, recognize, and respond to an opioid overdose
- Naloxone is available for outpatient dispensing

Figure 15. OEND and basic steps for responding to an opioid overdose

*If the person doesn't start breathing in 2-3 minutes, give the second dose of naloxone; naloxone wears off quickly so a second dose may also be needed if the person stops breathing again.

Offer naloxone to Veterans with OUD.

Disposing of controlled substances[42]

Educate your patients on how to safely dispose of unwanted or unneeded controlled medications.

Figure 16. Voluntary options to safely dispose of unwanted/unneeded medications

Take-back events 	The DEA holds National Prescription Take-Back Days. Check this site for dates, times, and locations: **www.deadiversion.usdoj.gov/drug_disposal/takeback**
On-site receptacles 	• VA facilities may have an on-site receptacle for use; check with your pharmacy on what options are available • There may also be community disposal options available; please see DEA website link to locate an on-site receptacle in the community
Mail-back packages* 	VHA has purchased mail-back envelopes for distribution (allows Veterans to place their unwanted medications in pre-paid envelopes and drop the envelope in the mailbox)

*Controlled and non-controlled medications may be co-mingled in the envelope; however, illicit drugs may not be placed in the envelope. The filled envelopes are sent to a reverse distributor where they are destroyed in an environmentally responsible manner.

Important Resources

- Management of Substance Use Disorder VA/DoD Clinical Practice Guidelines (2015): **www.healthquality.va.gov/guidelines/MH/sud**
- VA Treatment Programs for Substance Use Problems: **www.mentalhealth.va.gov/substanceabuse.asp**
- VA Substance Use Disorder Program Locator: **www.va.gov/directory/guide/SUD.asp**
- Providers' Clinical Support System for Opioid Therapies (PCSS-O): **pcss-o.org**
- Substance Abuse and Mental Health Services Administration (SAMHSA): **www.samhsa.gov/atod/opioids**
- Narcotics Anonymous: **www.na.org**
- SMART Recovery: **www.smartrecovery.org**
- Prescribe to Prevent: **prescribetoprevent.org**

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