# Working with Families with Opioid Use Disorders

## Introduction

START supports the use of evidence-based practices, including medication-assisted treatment (MAT) for opioid use disorders. Multiple research studies have demonstrated that individuals with opioid use disorders who use MAT show better outcomes than those who do not in terms of relapse to illicit substances, overdose, criminal activity, and employment. Medication in combination with psychosocial supports is more effective than either approach used separately (CSAT 2005, and CSAT 2004). A research study examining child welfare outcomes for START parents with opioid use found that MAT was positively correlated with children remaining in or returning to their homes, and the longer a parent was on MAT, the more likely the children were to be in the home at case closure (Hall, 2016).

This practice guide provides information and suggestions to support START Service Coordinators or other behavioral health professionals working with START clients, in addition to addressing child welfare considerations. This information may also be helpful to CPS in general.

## Behavioral Health Assessment

A thorough behavioral health assessment by an experienced behavioral health professional is necessary for every START client. Collateral information from family members, CPS, medical and behavioral health providers, and law enforcement is often necessary for a thorough assessment of substance use disorders. For opioid-abusing clients, consider the following ASAM domains and opioid-specific questions as part of the assessment process:

#### Withdrawal history and potential

* History of withdrawal and/or efforts to avoid withdrawal
* Frequency of withdrawal/use cycle (cycling through use and withdrawal daily indicates higher severity of dependence than weekly or occasional cycling)
* Withdrawal from opioids is rarely dangerous but is extremely uncomfortable and can last 7-10 days. Opioid withdrawal includes the following symptoms:
	+ Early withdrawal:
		- mild irritability or agitation, heightened anxiety and insomnia
		- soreness of the muscles or general muscle aches
		- sweating or fever similar to a cold
		- yawning that is uncontrollable as if exhausted
		- runny nose and increased tearing in the eyes similar to the flu or seasonal allergies
	+ Later symptoms:
		- diarrhea or abdominal cramping
		- loss of appetite, nausea or vomiting
		- dilated pupils
		- goose bumps, fever or chills

#### Co-occurring medical conditions

* Including pregnancy, liver disease, HIV

#### Co-occurring mental health concerns

* Such as depression, anxiety, suicidal ideation or attempts, history of trauma

#### Risk of relapse or continued use

* Past history of treatment, outcome of treatment, ability to maintain abstinence and for how long
* Prior attempts to use medication-assisted treatment, and if so what type and with what results? Off the street or from a clinic? In conjunction with psychosocial therapy and drug testing? If off the streets, was it for the purpose of avoiding withdrawal or use of other drugs? Was there a “high” from the medication?
* Safety concerns related to opioid use such as history of overdose or risks of harm to self or children

Client readiness or motivation to receive treatment

* What is the client’s stage of change? What sort of treatments are they interested in? What is their knowledge of their treatment options?

#### Whether the living environment is supportive of recovery

* Is the person in or leaving a controlled environment? Do they live with others using drugs/alcohol?

## Treatment Planning

In general, less than one year of opioid dependence may respond to psychosocial treatment without MAT, though medication is recommended during detoxification in order to alleviate the worst symptoms and increase the likelihood of continuation in treatment.

Exceptions to the one year minimum for consideration of MAT include pregnancy, Hepatitis or HIV, unsuccessful attempts to stop without medication, or history of overdose, in which case medication-assisted treatment should be considered. If a client is coming out of jail or other enforced abstinence, consider MAT if the client is at risk of relapse (reports cravings and urges to use), has a history of relapse after jail, and/or has Hep C. Client may not need MAT if they got treatment while in jail and has home/community/recovery supports.

If the person meets one of the above exceptions or has a history of dependence for at least one year, medication-assisted treatment should be considered and offered to the person as an option. See below for specific information related to medication-assisted treatment. Each individual should be allowed to make an informed choice regarding the use of medication. If the individual opts to explore a medication option, a referral should be made to a potential provider for further evaluation. It should be noted that medication is to assist or be an adjunct to psychosocial treatment in order to help the individual be able to focus on gaining recovery skills. Recovery support meetings should also be recommended for individuals using medication.

In many cases clients using medication can receive services alongside clients who are not using medication. In some cases specialized services have been developed and are acceptable. Clients should be given a psychosocial treatment recommendation of a sufficient dose to their situation; if that dose is not available through the medication provider, refer the client to additional treatment elsewhere (i.e. detoxification for other substances, residential, intensive outpatient, mental health therapy, etc.). Work with the medication provider to establish collaborative or complementary treatment plans.

Cost is unfortunately a barrier for some clients. In Kentucky, Medicaid will cover the cost of buprenorphine and naltrexone in many cases, and many psychosocial treatments and medical appointments are also covered. Some methadone providers may be able to bill KY Medicaid for psychosocial and medical appointments as well, though at this point the cost of methadone itself is not covered by KY Medicaid. The expense of medication-assisted treatment should be discussed with the client and their family in order for them to determine whether this is the right option for them. Induction (getting on the medication and up to the proper dose) can often be the most expensive phase due to the increased contact with the medical provider, but the client and their family should consider whether they are able to afford medication-assisted treatment over time. The START service coordinator, supervisor, worker, and mentor can assist with sustainability discussions during which the client is encouraged to weigh the costs and benefits of MAT.

## Collaborating with Buprenorphine Prescribers

Buprenorphine was intended to be an office-based approach to opioid use disorders which could be provided in a non-stigmatized setting such as family practice. An eight-hour training is required by federal law prior to prescribing buprenorphine, and psychosocial therapy and drug tests are recommended but not required by law. The Kentucky Board of Medical Licensure has best practice guidelines related to buprenorphine which involve drug testing and psychosocial treatment. However, some buprenorphine prescribers are not as knowledgeable about substance use disorders treatment as others. Consider developing a list of buprenorphine prescribers with whom collaboration is possible. The following questions are helpful:

* Is the physician willing to communicate with the START team regarding the client’s treatment, drug test results, illicit use, diversion, and medication side effects (both to receive and provide information with client consent)?
* Are patients given prescriptions for no more than 10 days at a time until they are stable?
* How quickly can patients earn 30 day prescriptions?
* Are patients drug tested? Is the prescriber interested in receiving drug test results from the START team?
* Does the prescriber do medication counts and call-backs to ensure that the patient is taking the medication as prescribed?
* Is the patient required to participate in counseling?
* What is the maximum dose generally prescribed?

## Child Welfare Considerations

Even when MAT is used appropriately and according to instruction, there may still be some considerations for child welfare, such as the following:

* It should be made clear to a parent that medication-assisted treatment is a choice that they can make and that START supports their efforts to address their substance use disorders and provide a safe home to their children. Include on the case plan that the parent is to take their medication as prescribed. They are not to abuse the medication by taking more than prescribed, and they are not to take less than prescribed, sell or give away their medication. The parent must also sign a release so that the START team can communicate with their MAT provider about their treatment plan, compliance, and drug test results.
* During the induction period or when not yet stabilized on methadone or buprenorphine, individuals can be overly sedated shortly after their dose and can fall asleep without intending to, sometimes called “nodding.” Because being overly sedated can present child safety concerns related to driving, co-sleeping, or supervision of children, it is important to plan for childcare after dosing until the sedation issue has been resolved, which can take around 7 days once the dose is adjusted. Over-sedation is not usually an ongoing issue as long as it is addressed. The MAT provider should be notified that over-sedation has been observed, along with the timing relative to dosing and severity of the sedation. (Note that co-sleeping is never advisable, especially for parents with substance use disorders. Co-sleeping should be addressed verbally and in written plans with the family.)
* If the parent is on buprenorphine or has take-home methadone, safe storage should be addressed. Include requirements for safe storage on the safety plan and/or case plan, including requiring a locked box that is child safe. If there are concerns that the parent is not stable enough to be responsible for their own medication, the plan can include a relative holding the medication in a secure location and handing it out per dose. Random pill or strip counts should also be part of the plan, in which the worker/mentor count the remaining pills/strips and compares them to the number that would be expected to ensure that they are being taken as prescribed. The worker/mentor should not handle the medication but ask the parent or family member to do so.
* A long-term plan for the cost of medication is important to child safety. Should a client have to suddenly discontinue the medication before it is clinically indicated due to financial constraints, the risk of relapse to illicit substances is high. Discussions should be held with the family about budgeting and how to pay for the medication over time, including sustaining the plan once their case is closed.
* There is no reason to keep the case open until the medication is discontinued, which may be a long time and is a matter to be decided by the provider and the patient. It is also unnecessary and unethical to require discontinuation or reduction of the medication as part of the case plan, and to do so is to risk triggering a relapse to illicit drug use. If a client has been stable on medication for at least six months (i.e., taking it as prescribed, not using any illicit substances, and completely compliant with program requirements that may include psychosocial treatment and recovery supports), it is possible for their child welfare case to be closed while they are on the medication. If a client is to continue on medication after case closure, ensure that the plan is documented in the CPS Aftercare Plan. Discuss with the MAT provider what supports the parent will receive from them after case closure and include them on the plan. In the future, the parent may also choose to work with the medication provider to discuss discontinuing the medication when clinically indicated and in a carefully planned way.

# Options for opioid use disorders:

|  |  |
| --- | --- |
| Approach | Considerations |
| Naltrexone1. Vivitrol (injection)
2. Revia (oral)
 | * Can be used for both opioid and alcohol disorders.
* Must have no opioid use for 7 days prior or will precipitate withdrawal (alcohol has no wait period).
* Client must be very motivated to stop using or they will not follow through, especially with the daily pill. Research shows poor compliance with the daily pill unless client is supervised taking medications. Compliance is better with the injection.
* Does not eliminate cravings but can decrease them somewhat. Decreases pleasure if opioids or alcohol are used while on medication, so use is less likely to occur and slips are less likely to become full-blown relapse.
* May work best for younger and less addicted opioid users and older clients with alcohol use disorder.
* Results are not great for longer-term substance use disorders.
* Must check for liver damage before taking or monitor liver during use.
* Unbiased assessment needed for each client situation.
* Psychosocial treatment and recovery support groups are also recommended.
 |
| Buprenorphine1. Suboxone (film bup/naloxone)
2. Zubsolv (oral bup/naloxone)
3. Bunavail (film bup/naloxone)
4. generic bup/naloxone (oral)
5. generic bup only (formerly Subutex)
 | * Partial agonist buprenorphine (a chemical that binds to a [receptor](http://en.wikipedia.org/wiki/Receptor_%28biochemistry%29) and activates the receptor to produce a biological response), sometimes combined with the antagonist naloxone (blocks the action of the agonist) to help prevent overdose and IV use.
* Not recommended for poly-substance abusers, especially if opioids are just one of many substances abused or if benzodiazepines are also abused.
* Works for more people than Vivitrol but less than methadone.
* Have to meet dependence diagnosis for one year or more – daily heavy use, withdrawal if stop using, compulsive use. There may be exceptions for pregnancy, shorter-term heavy IV use, or long-term overall substance abuse with various substances.
* Less research for pregnant women than methadone. Neonatal abstinence syndrome (withdrawal in the baby after birth) may be less with buprenorphine than methadone.
* Safe to get a prescription to take at home IF home is stable enough.
* 16mg is the usual maximum dose. 24 mg is also sometimes used.
* Okay to refer for buprenorphine if client was using buprenorphine off the street to avoid withdrawal, but not if it was their preferred drug or if they were injecting it.
* Can also help alleviate pain, so can be beneficial for clients with co-occurring chronic pain.
* Since federal regulations suggest but do not require drug testing and counseling for buprenorphine-assisted treatment, ensure that clients are referred for the appropriate counseling services and drug testing. Self-help groups are recommended.
* Note that clients perceive that various forms work differently (i.e. Zubsolv seems to have less buprenorphine that other forms to many who take it).
 |
| Methadone | * Full agonist (a chemical that binds to a [receptor](http://en.wikipedia.org/wiki/Receptor_%28biochemistry%29) and activates the receptor to produce a biological response).
* Have to meet dependence diagnosis for one year or more (daily heavy use, withdrawal if stop using, compulsive use) plus multiple unsuccessful treatment attempts in the past and unable to abstain from illicit drug use. If pregnant, dependence can be for less than one year.
* Consider methadone if the client goes into withdrawal within hours of last use; if they go into withdrawal multiple times a day or week; or if they cycle through obtaining opioids, using, and withdrawing.
* Most effective for clients who need structure with the medication because dosing is on-site daily until the patient is stable.
* Methadone can be taken with benzodiazepines at some clinics with monitoring and usually lower doses of methadone and KASPER (Kentucky All-Schedule Prescription Electronic Reporting) check.
* 60-80mg is the average dose. Can be up to 160mg due to high metabolism, liver damage, or pregnancy.
* Can also help alleviate pain, so can be beneficial for clients with co-occurring chronic pain.
* If the patient has a heart condition, they may need regular EKGs during methadone use, or they may not be able to take methadone.
* Methadone clinics are highly regulated. For instance, in KY, methadone for substance use disorders is dispensed only at Opioid Treatment Programs which are approved and monitored by the state Office of Inspector General and the federal Drug Enforcement Agency, as well as being accredited as medical organizations. Patients must be drug tested, monitored during dosing according to strict protocols, and provided with outpatient counseling.
* Some patients fall asleep involuntarily or “nod” after taking their dose, which can be addressed by adjusting the dose amount or timing.
* Self-help meetings are recommended.
 |
| Detox and abstinence based treatment(may be in combination with Vivitrol/Revia) | * If client refuses methadone/buprenorphine.
* Less than one year of dependence.
* Mild severity of opioid use disorder.
* If psychosocial treatment of sufficient intensity is available and is client preference.
* If this route is selected, medication-supported withdrawal (with medications such as buprenorphine or clonidine) is recommended in order to support completion of detoxification.
 |
| NaloxoneNarcan (injection or nasal spray) | * Reverses overdose until the patient can get medical attention. Without medical attention, person may return to overdose. Multiple doses sometimes needed.
* A “full kit” includes the naloxone and an atomizer or injectable naloxone.
* If possible, all individuals at risk of overdose should have naloxone available. Some community groups are distributing naloxone kits, and some pharmacies stock them.
* In some communities, first responders have naloxone.
* Some physicians will provide addicted individuals and their family members with a prescription to have a kit on hand in case of overdose.
 |

## In Case of Non-compliance

Non-compliance on MAT might involve using illicit substances, not taking the medication as prescribed, diverting the medication, or missing doses, counseling, or drug tests. Methadone programs have written policies related to non-compliance and how it impacts privileges such as take-home doses. Buprenorphine prescribers should have some way of responding when patients do not comply with their program requirements.

Many individuals with opioid use disorders are addicted to or misuse other substances as well. Some patients will require more psychosocial treatment than is provided by MAT providers, which is an outpatient level of care, so START might find more intensive treatment for the patient in conjunction with their MAT. If patients are unable or unwilling to discontinue the use of other substances, the MAT provider determines how to respond based on the client situation. Combining methadone or buprenorphine with benzodiazepines can cause fatal overdose, so the response to benzodiazepine use is likely to be stricter, possibly including no privileges/take home doses, more frequent counseling, doctor visits, and drug tests, and possibly reduction in the medication dose or administrative discharge from the program. Use of substances which are not dangerous in combination with MAT may be addressed with less strictness, possibly with reduced privileges and increased counseling. The provider may or may not decide to administratively discharge someone who is using alcohol, marijuana, or cocaine while on medication.

Because MAT is medical, START should communicate with MAT providers about compliance issues and concerns about patient safety, but ultimately the decision about the medication rests with the prescriber. Concerns about unethical prescribing practices can be reported to the board of medical licensure for investigation.

## References

American Society of Addiction Medicine. (2015). *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.* Chevy Chase, MD: American Society for Addiction Medicine.

Center for Substance Abuse Treatment. (2005). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.*Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2004). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.*Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Hall, M. T., Wilfong, J., Huebner, R. A., Posze, L., & Willauer, T. (2016). Medication-assisted treatment improves child permanency outcomes for opioid-using families in the child welfare system. *Journal of Substance Abuse Treatment,* 71, 63-67.

Revised: 3-21-17