OPIOID-RELATED DISORDERS

DSM-IV-TR Diagnostic Codes:

- 304.00 (Opioid Dependence)
- 305.50 (Opioid Abuse)
- 292.89 (Opioid Intoxication)
- 292.0 (Opioid Withdrawal)

This guideline for the diagnosis and treatment of opioid dependence, written in outline form, presents issues of diagnosis, assessment and treatment of this disorder that are considered by ValueOptions to require special emphasis. It has been developed to improve the quality, efficiency and consistency of treatment, but it is not meant to be comprehensive, prescriptive or to unnecessarily limit variations in practice. ValueOptions recognizes that each member has a unique presentation, history and set of preferences that may warrant deviation from the guideline.

All aspects of this guideline should be considered within the context of the patient’s cultural, ethnic, and spiritual values in order to maximize the accuracy of the diagnosis and to achieve the best possible outcome for the patient and family.

Definitions: The term opioid describes a class of substances that act on opioid receptors. These drugs can be naturally occurring substances such as morphine, semi-synthetics such as heroin (acetylmorphine), and synthetics such as meperidine and methadone. Other opioids include codeine (methylmorphine), Dilaudid (hydromorphone, oxycodone, and fentanyl. These drugs have analgesic and euphoriant effects. Opioid use disorders include opioid dependence and opioid abuse. Opioid dependence is characterized by the development of tolerance, withdrawal and compulsive use. Opioid abuse consists of intermittent use of one or more opioids in the absence of compulsive use and significant tolerance or withdrawal. In both opioid dependence and opioid abuse there may be significant psychosocial, legal, or medical problems.

Detoxification- this term refers to the measures taken to allow the elimination of an addicting substance from the body. This may be accomplished by gradually reducing the dose of the addicting substance or an agonist substitute or by replacing it with a drug of a different type that ameliorates the withdrawal symptoms.

Maintenance- this term refers to the continued therapeutic administration of an addicting substance or an agonist substitute in a dose that satisfies the need for self-administered drug use. This is done in a manner which does not intoxicate the individual and allows for rehabilitative efforts to occur. Methadone and LAAM (levo-alpha acetylmethadol) have been the only two opioids that have been permitted for maintenance.
Federal regulations require that methadone and LAAM be dispensed for maintenance treatment of Opioid Dependence only in approved program settings. To be approved such programs were required to provide counseling, to provide monitored urine testing for drugs, and to have an approved methadone or LAAM dispensing unit. Methadone or LAAM was to be provided to and consumed by patients on site until certain criteria were met to allow some methadone, but not LAAM, to be taken out of the clinic for outside consumption.

These restrictions on opioid agonist treatment have been seen by some as an impediment to providing treatment to all those in need because of the expense of providing a program as well as the inconvenience for the patient. There has been a movement to allow opioid agonists be used for treatment of opioid addicted patients by obtaining prescriptions from physicians without the necessity of program participation. To this end, a third opioid agonist, buprenorphine, has been approved by the Federal government and is to be made available by prescription. This treatment, called office-based treatment(OBT) will shortly be provided only by provider physicians who have gone through a certification process.

**Opioid Antagonist Treatment** - This is a long-term treatment for opioid addiction that utilizes the opioid euphoria blocking effects of opioid antagonist drugs. This treatment enhances the possibility of continued sobriety by blocking the effect of an opioid drug if a detoxified patient were to attempt to use one. The relapse potential of patients who have detoxified from opioids is thus significantly reduced. This treatment should be done as an adjunct to standard abstinence oriented outpatient chemical dependence treatment

I. Diagnosis and Assessment

A. Establish a DSM-IV-TR Diagnosis of Opioid Dependence

The first step in assessment is to determine the presence, nature and severity of the patient’s substance abuse problem. DSM-IV-TR should be used to establish the diagnosis of Opioid Dependence. In addition to this Axis 1 determination, the other four axes should also be considered and noted, as these axial determinations will influence the development of the treatment plan.

B. Develop a Treatment Plan Utilizing ASAM PPC-2 Assessment on Six Dimensions including the consideration of the appropriateness of recommending opioid maintenance instead of immediate detoxification.

Apply ASAM Patient Placement Criteria, PPC-2 to determine appropriate treatment setting based on the six dimensions (i.e., potential for withdrawal, biomedical conditions, emotional/behavioral/cognitive conditions, readiness to change, relapse/continued use, and environmental issues). The outpatient setting
(Level I) is usually the setting that is appropriate for opioid detoxification. Inpatient detoxification should not be necessary unless there is co-occurring medical or psychiatric issues requiring inpatient monitoring and management or unless there is concomitant addiction to other drugs that requires an inpatient setting for detoxification. Opioid detoxification may often be delayed until a future time and opioid agonist maintenance treatment prescribed instead. This can also usually be done in a Level I outpatient setting.

1. **Dimension 1- Potential for withdrawal** - Opioid withdrawal symptoms may be extremely uncomfortable but are not life threatening in an otherwise healthy person. They are readily managed by administration of an opioid agonist such as methadone or buprenorphine. Clonidine is frequently prescribed in addition. Management of withdrawal symptoms for opioids only can be routinely done in an ambulatory setting. If there is co-occurring dependence on other substances, such as alcohol or sedatives including barbiturates and benzodiazepines, then an inpatient level of care for detoxification from these drugs may be needed. LAAM, a longer-acting opioid agonist, is not ordinarily used for detoxification. There is no clear correlation with the amount of the substance being used and the withdrawal symptoms. Heroin discontinuation symptoms last one week and are extremely painful, whereas methadone discontinuation symptoms are moderately painful and may last for one month or longer. Associated anxiety in relation to withdrawal can be a significant factor in the development of opioid withdrawal symptoms that occur.

2. **Dimension 2- Biomedical conditions** - Special consideration and assessment for conditions with a higher prevalence rate in patients with opioid dependence include but are not limited to HIV, TB, STD’s, liver disease, pancreatitis, GI and cardiovascular disease. Patients with moderate to severe, co-occurring medical problems are best detoxified on a medical unit. Less severe medical problems are not an indication for inpatient opioid detoxification. Patients who are pregnant require special attention. (see below, section C-3).

3. **Dimension 3- Emotional/behavioral/cognitive conditions** - Consider concomitant psychiatric disorders that may influence the required setting for treatment. Patients with acute, severe, co-occurring psychiatric conditions are most safely and effectively treated on a psychiatric unit for both disorders.

4. **Dimension 4- Readiness for change** – Assess patient’s engagement in treatment and willingness to attempt to change behaviors. Patients motivated to discontinue the use of non-prescribed or illicit opioids, but not motivated or able to successfully discontinue opioid use altogether, are candidates for opioid maintenance treatment.
5. **Dimension 5- Relapse, continued use problem or potential** - Assess the likelihood of the patient continuing to use opioids despite treatment efforts or after treatment has been provided. The pleasure and euphoria may far outweigh the fear of the resultant discomfort when withdrawal occurs. In addition, the patient’s internal sense of self-control and efficacy in directing his/her behavioral change is essential. Opioid antagonist treatment or agonist treatment should be considered to lessen the likelihood of relapse in whatever setting the patient is being treated.

6. **Dimension 6- Recovery environment** – Assess the ability of the familial, significant other and social environment to support sobriety. This includes workplace supports, legal implications, and transportation. Determine the environmental stressors that would impede motivation to remain drug-free and consider possible need to find alternative living arrangements. One goal of treatment, however, should be to enhance the patient’s ability to deal with these stressors. The patient’s history of refraining from use despite availability of opioids in the environment is a factor in determining relapse potential.

C. **Considerations of special importance during the assessment**

1. **Dangerousness to self or others**

   Lethality is assessed to determine what treatment setting meets the safety needs of the patient. States of depression due to long-term substance abuse or the effects of polysubstance abuse leading to unpredictable impulsive behavior must be assessed.

2. **Inappropriate requests that do not meet ASAM criteria**

   There is potential for inappropriate use of the treatment system, for example, to avoid incarceration or to satisfy housing requirements. In addition, patients may be inappropriate for a detoxification program but should be referred to a maintenance program instead.

3. **Patients who are pregnant**

   Special assessment for this high-risk population will require coordination with additional health services and possibly social services. Detoxification can induce premature labor/delivery and poses the risk of relapse on multiple illicit drugs that pose further risk to the fetus. The standard of treatment is to stabilize and maintain the pregnant patient on an opioid agonist for the duration of her pregnancy. Because this population is at risk for birth complications, a thorough pre-partum history is needed. However, pregnancy by itself is not a reason to change the treatment protocols.
4. **Age inappropriate interventions**

Certain age-related issues should be considered during the assessment process because this will affect the treatment plan. Included in this category is an assessment of age appropriate cognitive and behavioral functioning, as well as family dynamics. In addition, the geriatric and adolescent population may need special considerations in relation to the placement setting for treatment (see ASAM Patient Placement Criteria, PPC-2).

5. **Co-existing medical illness**

There is a higher prevalence of disease states in this population that include but are not limited to, HIV, TB, liver dysfunction, hypertension, etc. Coordination with medical providers is essential to good outcomes for the patient. Co-occurrent stable but chronic conditions are considered, but may not change the prescribed interventions.

6. **“Ultra Rapid” Detoxification requests**

Ultra rapid detoxification is a research procedure whose safety and efficacy has not been established. ValueOptions and current literature do not support preferences for this method of detoxification. In this procedure, the patient is sedated or anesthetized and given naltrexone, an opioid antagonist, which precipitates withdrawal. Intensive medical management, usually in the ICU (Intensive Care Unit) has been the norm, but there have been reports of this procedure occurring in the outpatient setting. Anesthesia related deaths have been reported. In addition there is no indication that detoxification by this method is more likely to result in a continuing drug free state.

7. **Dual Diagnosis and the need to place the patient in the appropriate treatment setting (capable & enhanced).**

ASAM PPC-2R defines a “capable program” as one that has the ability to offer substance abuse treatment and coordinate care with other Behavioral Health Providers. An “enhanced program” has the behavioral programs (groups, individual, medication management etc.) in-house and can provide the mental health services as part of the regular program.

Coordination between the Substance Abuse and Mental Health treatment providers is necessary in order to assure that the proper psychopharmacology, counseling, psychological monitoring and consultation occur.
8. Licensing and regulatory issues

Regulatory licensing needs to be considered for placement. For example, the OASIS requirements for ambulatory setting dictate that there be a stable home setting with telephone access. This may preclude an outpatient setting for some individuals. In addition, some rehab settings require a period of “drug-free time” prior to admission.

C. Outcomes Measures

*ValueOptions* strongly encourages the use of standard outcomes measurement tools to measure the extent of functional impairment or intensity of symptoms in the addicted patient, and the patient’s response to treatment. To date, the literature does not identify a specific tool for measuring outcomes of opioid maintenance and detoxification treatments. The following are some possible standardized tools for measuring different aspects of the addicted patient in response to intervention: Addiction Severity Index (ASI), and the Chemical Use, Abuse and Dependence Scale (CUAD).

II. Communications

*ValueOptions* believes that direct, honest, open and accessible communication between all parties to the treatment is essential to achieving positive outcomes. There are three dimensions of treatment-related communication; these must take into account all laws and regulations related to confidentiality and protection to the patient.

A. Between Patient and Provider

Because of the nature of addiction, it is common for “filtered” information to be given to a provider. The provider must create a sense of trust and safety, which is necessary for successful treatment. It is common for the patient to have had a past history of difficulty in communicating in a straightforward manner, not only with the treatment team, but also with family, friends and employers as well. This is related to the social stigma of addiction and the deviant behaviors that the patient may have had to engage in to support the addiction.
B. Between Provider and Provider

An effective treatment plan is based on obtaining information on past and current approaches that did or did not work. It is not unusual for the addicted patient to have multiple treatment providers over time. This challenges the current treatment team to obtain all the necessary consents in order to share information with past or current providers. This would include but is not limited to medical caregivers, past SA treatment programs, behavioral treatment providers, and possibly parole officers if there is legal involvement.

C. Between Provider and Patient Support System

Addiction is a disease that affects the whole family and support system of the patient. Much has appeared in the literature regarding co-dependent behaviors that contribute to keeping the cycle of addiction active. In many cases, the patient may have lost significant supports. This challenges the provider to identify healthy supports for the patient that can be strengthened through the treatment process.

III. Treatment Plan

The treatment plan is dependent on the assessment and goals of the patient, collaterals, and the treatment team. There are significant differences in the interventions and treatment setting of choice for patients who are, or will be, in withdrawal that requires detoxification, and those that are on long-term maintenance treatment and are dependent on long-term medication management. The six dimensions of the ASAM-PPC-2 criteria are the preferred tools to evaluate the patient. The following are issues to consider when developing a treatment plan for a detoxification regime or a long-term maintenance intervention.

In addition, the involvement of support networks, sponsorship and 12 Step programs of NA, AA, ALANON, etc. must not be minimized and should be considered an effective method of treatment to be stronger in support of these modalities which tend to be the long-term treatment for this population.
Detoxification/Withdrawal

1. A multi-modality approach to detoxification has the greatest likelihood of succeeding. Such treatment includes medication, combined with medical, psychiatric, psychosocial interventions and drug counseling. Two general strategies for pharmacological management of withdrawal include: 1) suppression of withdrawal by a cross-tolerant medication, and 2) decreasing the signs and symptoms of withdrawal by alteration of related neuro-pharmacological process. Either or both of these can be used to manage a withdrawal syndrome effect (page 3 ASAM Detoxification Principles 1/2001).

The goal of opioid detoxification is to free the patient of the physiological need for continuing use of the drug while minimizing discomfort and avoiding adverse effects of withdrawal. The length of a detoxification protocol is dependent on the medication being used and the residual half-life as it affects the patient. The indicators for intervention are the signs and symptoms of withdrawal experienced by each patient. Titration of medications and the duration of the detoxification must be individually determined based on the patient’s response, amount of use, medications being prescribed, past history and tolerance for withdrawal.

It is important to recognize that the biochemical changes that have occurred in the addicted patient over the course of time can take more than a year to reverse, if they do at all. The use of antidepressants, anxiolytics, sleep medications, opioid antagonists and analgesics during this protracted period of withdrawal requires close monitoring and medication management to alleviate discomfort and reduce the potential for relapse.

The multidisciplinary staff of such programs are trained and/or credentialed in addictions. Treatment includes individual therapy, case-management, health education, medications, and additional therapies as needed.

2. Initial assessment includes severity of co-existing medical or psychiatric conditions.

3. The literature supports a slow rate of detoxification for long-term maintenance patients, no shorter than 30 to 180 days, leading to a greater number of patients remaining abstinent.

4. Ultra –Rapid detoxification with Naltrexone and general anesthesia is currently under investigation and is considered experimental in nature. ValueOptions does not endorse this treatment choice for those reasons.
### Opioid Agonist Maintenance

1. The goal of a maintenance program is to avoid the inappropriate use of opioids while psychosocial rehabilitation occurs. Quite often the long-term user turns to treatment after repeated failures to decrease or cut down opioid use.

2. There are discrete subgroups of opioid-dependent people. Treatment must be relevant to each of these subgroups, for example: 1) those who have maintained average or above functioning ability in society, employed, intact families etc; 2) those that have marginal functioning ability; 3) those whose primary treatment impetus has come from the justice system 4) those who have obtained their drugs primarily by prescription and 5) those whose primary source of drugs has been illicit purchase on the street.

3. ASAM PPC-2 discusses the most appropriate treatment settings for patients in opioid maintenance programs. Treatment setting needs to support the patient’s goals and confidentiality. Although a “drug free” state represents optimal treatment outcome, research has demonstrated that this goal cannot be achieved or sustained by many opioid users (NIH consensus statement 1997) Factors to consider for “take-home” medication in methadone programs include, but are not limited to, absence of recent drug/alcohol abuse, absence of criminal activity, stability of home environment, length of time in maintenance treatment, assurance that “take home meds” can be safely stored, emergency circumstances, rehabilitative benefits of decreasing clinic contacts.

4. “Office Based Treatment” is an option in some states. A benefit of this treatment setting is the availability of different treatment options such as buprenorphine. The patient is not exposed to potential people, places and things that can be a “trigger” for using. However, the patient must be sufficiently involved in the recovery process not to abuse the responsibility of having to regulate use of the prescribed opioid independently.

5. Immediate introduction of supportive services and drug counseling improves outcomes. Vocational and rehabilitative services are useful adjuncts in treatment.

6. The potential for HIV infection and other medical complications are of great concern in the addicted individual. Educational information and instruction about and risk are an essential part of the treatment planning process.
Psychopharmacology:

1. Opioids produce similar withdrawal syndromes. The specific drug and dose being used influences the severity and onset, interval of time between use, duration of use, individual sensitivity and co-existing medical conditions.

2. Determination of which medication to use is considered within the context of the goals of treatment. The patient’s choice of detoxification from a maintenance regimen or the decision to replace street use with a maintenance program needs to be considered. The most widely used medication is methadone. In addition, the opioid agonist levo-alpha acetylmethadol (LAAM) and the opioid antagonist, naltrexone are used.

3. Methadone maintenance is an effective method of reducing the adverse effects of opioid dependence. The primary goal of methadone maintenance is rehabilitation, not abstinence (Lowinson, 1981). There is some controversy over time-limited use of methadone. However, one must consider the consequence of detoxification simply because of arbitrary time limitations imposed (Zweben & Sorensen 1988).

4. Medically supervised detoxification from methadone should occur slowly due to protracted discontinuation symptoms, with greater likelihood of relapse. However, methadone can also be used briefly to detoxification from opioids. Additional medications used in the detoxification and maintenance aspects of opioid dependence include but are not limited to LAAM, Clonidine, and Naltrexone.

5. Alpha-adrenergic agonists such as Clonidine and Guanfacine are useful in decreasing opioid withdrawal symptoms. These drugs should be administered only if blood pressure is greater than 90/60.

6. Detoxification alone rarely constitutes adequate treatment. Although symptomatic medications are needed to provide relief, ongoing support and treatment is required for the best chance of success. Adjunctive medications are often necessary.
   - Benzodiazepines should be avoided during detoxification or if necessary for anxiety, given only for a short period of time.
   - Non-addicting anti-anxiety medications, such as Buspar, SSRIs, and Effexor are preferable to benzodiazepines.
   - Non opioid analgesics (NSAIDs) for joint and muscle pain
   - Antidepressants
   - Sleep medication (Trazodone –sometimes higher doses to overcome significant sleep disturbance related to awakening due to withdrawal). Avoid sedatives.
7. Opioid antagonists such as naltrexone are used after detoxification to assist in the continuation of an opioid-free state. This drug should be given for a period of at least 6 months and discontinued, at which time the risk of relapse is considered to be minimal.

8. A partial agonist that may be effective in managing opioid withdrawal or maintenance is buprenorphine. (O’Connor, Constantino, et al., 1993). As of December 2002 this drug was not yet available for general use for these purposes.

<table>
<thead>
<tr>
<th>Naturally Occurring Opioids</th>
<th>Semisynthetics</th>
<th>Synthetics</th>
<th>Agonist-antagonists</th>
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</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>heroin</td>
<td>alphaprodine</td>
<td>buprenorphine (Buprenorphine)</td>
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<tr>
<td>morphine</td>
<td>hydrocodone (Tussionex)</td>
<td>diphenoxylate</td>
<td>butorphanol (Stadol)</td>
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<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>meperidine (Demerol)</td>
<td>nalbuphine (Nubain)</td>
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<tr>
<td>Oxycodone (Percodan)</td>
<td>methadone</td>
<td>pentazocine (Talwin)</td>
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<tr>
<td>Oxymorphone (Numorphan)</td>
<td>Propoxyphene (Darvon)</td>
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IV. Guideline Adherence Indicators

The following treatment indicators, extracted from the ASAM PPC-2 criteria, may be used to measure adherence to the guidelines (Note: Indicators in bold will be monitored by ValueOptions):

- Withdrawal evaluation completed within 24 hours to determine the level of detoxification services needed (level I D through level IV D, refer to ASAM PPC-2)
- The evaluation includes the documentation of consideration of appropriate pharmacotherapy for substance abuse disorder. Rationale is provided for each component of the treatment plan including additional medications.
- Co-occurring) disorders should be assessed to identify both medical and psychiatric symptoms, which may be masked by substance abuse. If a co-occurring disorder is present, there must be evidence of coordination of care with the medical provider.
- Evaluation of behaviors correlated with continues use and abuse of illicit drugs.
- Family/support system involvement in treatment, when appropriate.
- Evidence that education has been provided regarding detoxification vs. maintenance, and that the patient has an adequate understanding.
- MSE/risk assessment completed at each visit
- Patient’s informed consent that includes communication with other treatment providers is documented.
- A multidisciplinary approach to the treatment plan
- Documentation of goals in measurable terms to evaluate improvement and/or reduction of symptoms in a specified period of time
- Inclusion of updated consent in the treatment planning record.