

Opioid Use Disorder Identification and Management: A Resource for Healthcare Professionals

Opioid use disorder (OUD) is a chronic, treatable medical condition that affects **more than 2 million people in the US**. Not only does it affect the individual, OUD places a burden on the healthcare system and society at large. As such, healthcare professionals (HCPs), and policymakers should be familiar with and able to expand access to evidence-based, effective care for people with OUD.

Per the DSM-5-TR, OUD presents as “a problematic pattern of opioid use leading to clinically significant impairment or distress.” Previously, the DSM-IV classified OUD as “opioid abuse” or “opioid dependence”; it was also previously referred to as “opioid addiction.” However, it is now more commonly known that abuse or dependence does not necessarily equate to OUD and that the term “addiction” is stigmatizing and may prevent a person from seeking treatment.



IDENTIFYING OUD AND PROBLEMATIC DRUG USE

- Diagnosing problematic drug use requires a thorough evaluation, including:
 - Interviewing the patient and friends/family
 - Medical, social, and family histories
 - Personal history of illicit or other substance use disorders
 - Checking the patient's prescription drug monitoring program profile
 - Considering urine drug testing
- **Remember:** OUD exists on a continuum of severity
 - Level of severity has implications in guiding treatment decisions
 - Moderate to severe forms of OUD often require continuing care vs episodic, acute-care treatment

DSM-5-TR Diagnostic Criteria for OUD

In order to confirm a diagnosis of OUD, at least 2 of the following criteria should be observed within a 12-month period:

1. Opioids taken in larger amounts or over longer period than intended
2. Persistent desire or unsuccessful efforts to cut down or control opioid use
3. Great deal of time is spent obtaining, using, or recovering from effects of opioids
4. Craving, or a strong desire or urge to use opioids
5. Failure to fulfill major obligations at work, school, or home due to recurrent opioid use
6. Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by opioid effects
7. Important social, occupational, or recreational activities given up or reduced due to opioid use
8. Recurrent opioid use in physically hazardous situations

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The diagnostic criteria related to tolerance and withdrawal are not considered to be met for individuals taking opioids solely under appropriate medical supervision.

9. Continued opioid use despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
10. Tolerance, as defined by either of the following:
 - a. Need for markedly increased amounts of opioids to achieve intoxication or desired effect
 - b. Markedly diminished effect with continued use of the same amount of an opioid

Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

11. Withdrawal, as manifested by either of the following:
 - a. Characteristic opioid withdrawal syndrome
 - b. Opioids (or a closely related substance) taken to relieve or avoid withdrawal symptoms

Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

In ICD-10-CM, opioid use, abuse, and dependence are coded to category F11. Codes are chosen according to whether the patient is using, abusing, or is dependent on opioids, as well as any associated complications.

Refer to a coding reference for appropriate F11 sub-codes.

Table adapted from DSM-5-TR.

Remain compassionate and avoid stigmatizing patients

- Approaching OUD as a chronic illness (such as diabetes) can help HCPs establish a trusting, respectful relationship with patients and contributes to successful treatment that helps patients stabilize, achieve remission of symptoms, and establish and maintain recovery

	Instead of This:	Consider Saying This:
Use first-person language	[Patient] is an opioid addict .	[Patient] 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/dirty .	Your urine drug test was negative/positive for illicit substances.
	You have to stop your habit of using substances.	I would like to help you get treatment for your substance 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 substances.	We understand that no one chooses to develop a substance use disorder . It is a medical disorder that can be managed with treatment.

TREATING OUD

- **Goal:** Remission of the disorder leading to lasting recovery
- ***There is no one-size-fits-all approach***
- OUD is best treated with an individualized multidisciplinary treatment plan including social, behavioral, and pharmacologic interventions
 - Any medication for the treatment of OUD (MOUD) should be prescribed as part of a comprehensive and individualized treatment plan that includes counseling and other psychosocial therapies, as well as support group programs
- Behavioral therapies can help modify thought patterns, manage triggers, and reinforce positive behaviors to help support long-term recovery
 - Cognitive behavioral therapy
 - Contingency management
 - Motivational interviewing
- MOUD should be considered for *all* patients with OUD
 - Safe and effective when used appropriately
 - Can help reduce illicit opioid use, retain people in treatment, and reduce risk of opioid overdose death better than treatment with placebo or no medication
 - Can be taken on a short- or long-term basis, including as part of medically supervised withdrawal or maintenance treatment
- Before prescribing MOUD, inform patients of:
 - Risks and benefits of medication, treatment without medication, and no treatment
 - Where and how to obtain MOUD
 - How to store and properly dispose of these medications
- Naloxone should be provided to all patients with OUD, regardless of treatment regimen

What Is Recovery?

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Finding Recovery Resources

If your practice does not have the resources to meet a particular patient's needs, refer them for more intensive or specialized services at a local substance use treatment facility.

Find programs in your area by using SAMHSA's Behavioral Health Treatment Services Locator: findtreatment.samhsa.gov

MOUD

	Buprenorphine	Methadone	Naltrexone
Mechanism of Action	Partial agonist at mu-opioid receptor to manage cravings and withdrawals	Full agonist at mu-opioid receptor to manage cravings and withdrawals	Antagonist at mu-opioid receptor to help manage cravings as well as prevent opioid intoxication and physiologic dependence
Formulations	• Sublingual film/tablet taken once daily; also available as a combination with naloxone • SC extended-release injection given once weekly or once monthly • Buccal, subdermal implant, transdermal patch, IV/IM injection	• Oral liquid/powder/diskette given once daily • IV/IM/SC injection	• Oral tablet taken daily (or based on clinical judgement) • IM extended-release injection given once monthly
Phase of Treatment	Medically supervised withdrawal, maintenance	Medically supervised withdrawal, maintenance	Prevention of relapse to opioid misuse
Initiation	May begin immediately	May begin immediately	Should abstain from opioids for ≥ 7 days prior to initiation
Adverse Effects	Constipation, nausea, precipitated opioid withdrawal, hyperhidrosis, insomnia, pain, peripheral edema, respiratory depression, misuse, neonatal abstinence syndrome Implant only: nerve damage, accidental overdose or misuse, local migration or protrusion SC only: injection site itching or pain, death from IV injection	Constipation, hyperhidrosis, respiratory depression, sedation, QT prolongation, sexual dysfunction, severe hypotension (including orthostatic hypotension and syncope), misuse, neonatal abstinence syndrome	Nausea, anxiety, insomnia, precipitated opioid withdrawal, hepatotoxicity, vulnerability to opioid overdose, depression, suicidality, muscle cramps, dizziness/syncope, somnolence/sedation, anorexia, decreased appetite IM only: pain, swelling, induration

	Buprenorphine	Methadone	Naltrexone
Regulations and Availability	• Schedule III • Sublingual: in-office or home available, no waiver requirements • Implant: must be certified in REMS program; special training required for HCPs who want to insert/remove implant • SC: must be certified in REMS program; administration only by certified provider	• Schedule II • Only available at federally certified OTPs and acute inpatient setting	• Not a scheduled medication, not included in OTP regulations • Requires prescription; office-based treatment or specialty substance use treatment programs, including OTPs
Monitoring	• Visits vary from daily to monthly • Regular urine drug testing and counseling preferred	• Visits typically begin at 6 days/wk and lessen over time • Regular urine drug testing and counseling required	• Visits vary from weekly to monthly • Regular urine drug testing and counseling preferred
Other Considerations	• Has a ceiling effect to limit respiratory depression or overdose • Milder withdrawal symptoms • Easily obtained at pharmacies • Consider combination with naloxone for those at higher risk of relapse or overdose	• Long half-life (8-59 hr) may lead to delayed and longer-lasting respiratory depression • Utility for those with very high opioid tolerance • Colocation of services is common (dosing, counseling, physician evaluation)	• Treatment with naltrexone not providing a positive, but preventing a negative • Overdose and death more likely with relapse due to decreased tolerance

OTP, opioid treatment program.

References

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