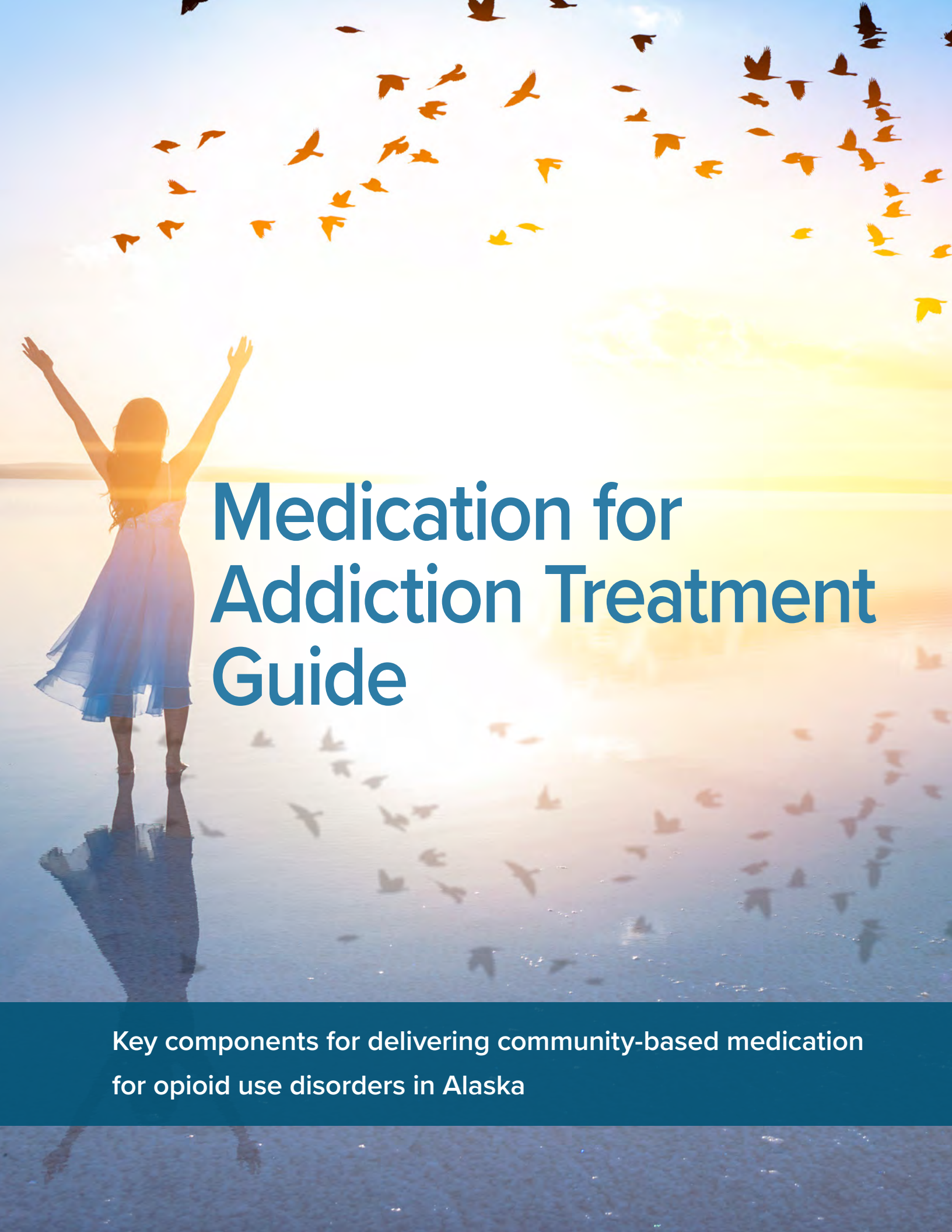

Medication for Addiction Treatment Guide

Key components for delivering community-based medication for opioid use disorders in Alaska

Disclaimer

Information contained in the Alaska MAT Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Links provided in the guide are for reference and informational purposes and do not represent an endorsement by the Alaska Department of Health.

Medications for Addiction Treatment Guide

Key components for delivering community-based medication for opioid use disorders in Alaska.

June 2025
Third Edition

Forward

The most recent wave of opioid-related fatalities has spread across Alaska. The statistics found in Chapter 1 of this guide tell the story of this deadly plague's expansion: First, it enters the state, impacting individuals, families, and neighborhoods. Then it spreads through one community after another. In such a crisis, no one is left untouched.

If you were to read off the names of every person who died in Alaska last year from a preventable cause, at least one out of ten of the names would be someone who died of an overdose. Seventy-five percent of those overdose fatalities involved fentanyl. Emergency departments are seeing overdose victims daily. In Alaska's correctional facilities, trained officers and health professionals are rescuing inmates from opiate overdoses on a near daily basis. Recognizing the risk in community settings, legislation is now in place to strategically place naloxone for overdose reversal on school campuses.

The news is alarming, but we are not without hope. In Alaska, there is a growing recognition that successful interventions are being implemented in organizations, departments, practices, and agencies across the state. These efforts fall into five broad categories, or cords, of intervention: interdiction, prevention, harm reduction, treatment, and recovery. The collaborative work being done by Alaskan community organizations is weaving these five cords of intervention together. The credit for implementing a successful opioid crisis response will not fall to any one agency or organization. Our efforts will be ineffective if done by groups working in isolation from each other. Successful interventions come from weaving together the threads of many organizations and individuals who work in collaboration with each other.

You will recognize that Medications for Addiction Treatment (MAT) is a thread found within many of the cords of intervention. MAT has an obvious role in treatment, but the medications and therapies used in treating an opioid use disorder are also an important part of harm reduction strategies and vital during recovery. There are also good examples of MAT being used as a component of prevention strategies.

Because MAT is such a vital thread, it is important for health professionals to have access to reliable guidance on how to integrate MAT — and, specifically, Medication for Opioid Use Disorder (MOUD) — into practice.

The updated Medications for Addiction Treatment Guide is like a trusted colleague who has gathered a excellent collection of resources to address what our state needs to take care of the individuals in our communities. Here you will find updated details on available medications, guidance on how to integrate MOUD into your practice, information on where patients can receive treatment, an overview of barriers your patients may face, and links to trustworthy references and education. Like time spent with any trusted friend, I hope you will find that sitting with this guide is time well spent.

Robert Lawrence, MD
Chief Medical Officer, Alaska Department of Health

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Contents

Introduction

In 2021, the 2nd Edition of the Medication for Addiction Treatment (MAT) Guide was released at the height of the COVID-19 pandemic, a time when health care providers were overwhelmed with the dual challenge of keeping their patients and themselves safe. The difficulties of that period made it hard to recognize any positive developments. However, with the release of the 3rd Edition in 2024, the lessons learned (and rapid changes implemented) during the pandemic have become clear, offering a renewed sense of hope in reducing overdose deaths and improving the quality of life for millions.

The COVID-19 pandemic — coupled with the rising overdose death rates and the slow uptake of buprenorphine prescribing across the country — has led to significant changes in regulations. Section I of the MAT Guide addresses these statistics, identifies barriers to MAT, and highlights the regulatory changes that have occurred over the past three years. Federal and state agencies responded to the pandemic with new flexibilities in telehealth, opioid treatment programs, and buprenorphine prescribing, greatly improving MAT access for individuals with opioid use disorder (OUD). These changes have alleviated many concerns about the risks of diversion and overdose death associated with medications for opioid use disorder (MOUD).

Despite the growing prevalence of integrated health care, a substantial gap remains in the integration of MAT into primary care and behavioral health practices. Section II of the guide aims to bridge this gap by supporting the treatment of individuals with OUD in a holistic, person-centered manner. It provides guidance on initial screening processes, assessments, withdrawal management, MAT initiation, and supporting clients who may wish to discontinue their MAT.

Section III delves into the medications used for OUD, focusing on the three available options, including the various formulations of buprenorphine and naltrexone. The guide emphasizes the importance of tailoring treatment to every individual's needs, especially given different formulations of these medications. It also introduces the new buprenorphine formulation, Brixadi, and underscores the critical role of methadone in addressing fentanyl addiction.

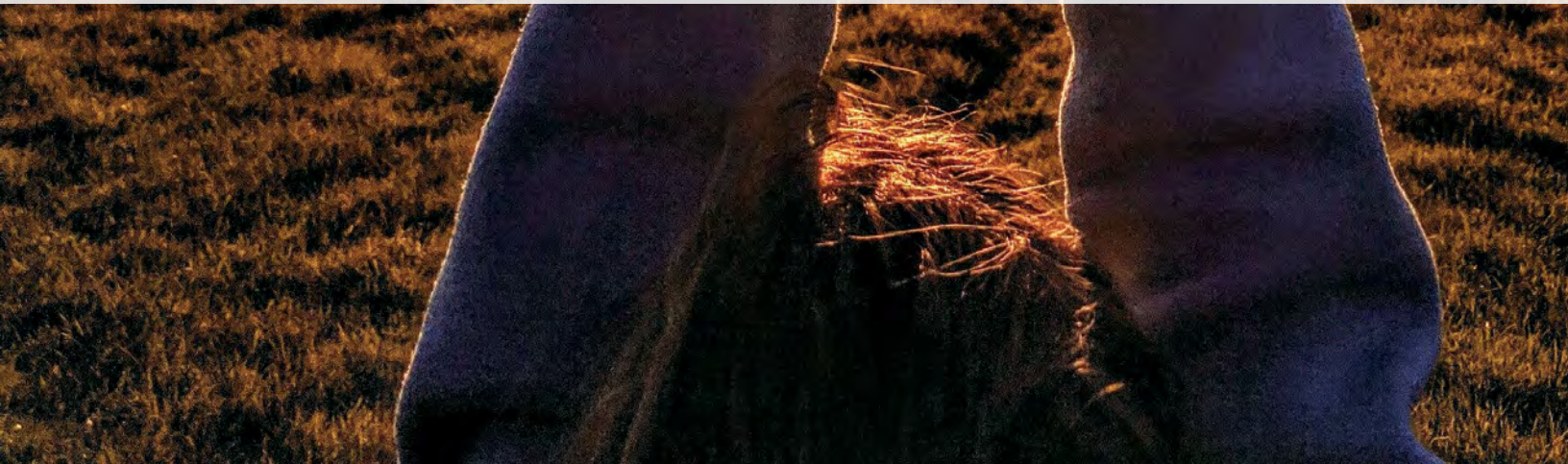
While MOUD is the primary focus of this guide, Section IV highlights the medications available for other substance use disorders, such as tobacco and alcohol use disorders. It also discusses the challenges of treating stimulant use disorder, emphasizing the value of contingency management. Given that many individuals use more than one substance, this section is essential for understanding how to treat polysubstance use effectively.

Substance use disorder affects all demographics, but certain populations are disproportionately impacted. Section V explores the specific considerations for supporting these vulnerable groups, including the importance of understanding the Alaska Tribal Health System, providing postpartum care for women, and offering trauma-informed care for gender and sexual minorities.

Despite significant progress in regulations, medications, and treatment approaches, Alaska experienced the nation's fastest-growing rate of overdose deaths in 2023. This alarming trend highlights the ongoing need to improve accessibility to MAT. The 3rd Edition of the MAT Guide includes numerous examples of how agencies across Alaska are working to address this issue. Overall, this guide is intended to empower providers to begin or continue offering life-saving medications to our most vulnerable populations.

SECTION I:

The Framework for a Medication for Opioid Use Disorder Program



Chapter 1: Overview of Substance Use Disorder Medications for Addiction Treatment

Overview of Substance use disorder

Substance use disorder (SUD) is a complex condition characterized by the uncontrolled use of substances despite harmful consequences. These substances can include alcohol, prescription medications, and illegal substances. SUD is marked by a range of physical, psychological, and behavioral symptoms that interfere with an individual's daily life and functioning.

Key features of SUD include:

- **Increased Tolerance**: Over time, individuals may need larger amounts of the substance to achieve the desired effect, indicating a reduced response to the same dose.
- **Withdrawal Symptoms**: When the substance use is reduced or stopped, individuals may experience physical and psychological withdrawal symptoms, such as anxiety, irritability, nausea, and tremors.
- **Compulsive Use**: Individuals often continue using the substance despite knowing the significant problems it causes in their lives, such as health issues, relationship problems, or legal troubles.
- **Loss of Control**: There is a persistent desire or unsuccessful attempts to cut down or control substance use, with the individual often using more than intended or for longer periods.
- **Neglect of Responsibilities**: SUD can lead to the neglect of important responsibilities at home, work, or school, and a reduction in social, occupational, or recreational activities.
- **Risky Behavior**: Individuals may engage in risky behaviors while using substances, such as driving under the influence or using dirty needles, increasing the risk of accidents, injuries, or diseases.

What increases risks for addiction

Many factors increase a person's risk for addiction. Some factors that can influence a person's risk for addiction:

- Genetic predisposition accounts for about half of a person's addiction risk.
- Environmental influences, such as family, friends, economic status, quality of life, stress, and parental support.
- Some stages of development are particularly vulnerable to decision-making that can involve risky behaviors, such as trying substances.[1]
- Adverse Childhood Experiences (ACEs), such as traumatic events or abuse, increase a person's risk.[2]

About Opioids

Opioids are a class of drugs that include heroin, synthetic opioids, such as illegally manufactured fentanyl (IMF), and pain relievers available legally by prescription such as oxycodone, hydrocodone, codeine, and morphine. Opioids are prescribed as medicines because they contain chemicals that relax the body and can relieve pain. Prescription opioids are used mostly to treat moderate to severe pain, though some opioids can be used to treat coughing and diarrhea.[3]

Patients may misuse prescription opioids. Misuse is taking the medicine in a way or dose other than prescribed, taking someone else's prescription medicine, and/or taking the medicine for the effect it causes (to get high). When misused, opioids increase the risk of certain infections, accidents and death. Misuse of prescribed opioids is often linked to use of illegal opioids; however, patients may become dependent on, or addicted to, prescription opioids.[4]

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[1] National Institute on Drug Abuse. 2018. "*Understanding Drug Use and Addiction DrugFacts* | National Institute on Drug Abuse (NIDA)." nida.nih.gov. June 6, 2018. https://nida.nih.gov/publications/drugfacts/understanding-drug-use-addiction#:~:text=Biology.

[2] Broekhof, Rosalie, Hans M Nordahl, Lars Tanum, and Sara G Selvik. 2023. "*Adverse Childhood Experiences and Their Association with Substance Use Disorders in Adulthood: A General Population Study (Young-Hunt).*" Addictive Behaviour Reports 17 (June). https://doi.org/10.1016/j.abrep.2023.100488.

[3] National Institute on Drug Abuse. 2022. "*Opioids*." National Institute on Drug Abuse. 2022. https://nida.nih.gov/research-topics/opioids.

[4] MedlinePlus. 2023. "*Prescription Drug Misuse*." Prescription Drug Misuse. National Library of Medicine. December 19, 2023. https://medlineplus.gov/prescriptiondrugmisuse.html.

Dependence and addiction are frequently confused.[5] A patient taking an opioid as prescribed can become physically dependent on the medicine. Physical dependence is when the body requires a specific dose of a particular drug to prevent withdrawal symptoms. This typically happens when a patient uses an opioid daily and can happen in as little as five days, with approximately 35 percent of opioid-naïve individuals dependent on opioids a year after their first 30 days of use.[6] With physical dependence alone, the patient can manage impulses and has control over use.

An addiction occurs when the patient's brain develops an overwhelming need to continue the use of the opioid despite negative consequences. The brain's chemistry changes over time and decision-making becomes impaired. When a person becomes addicted, they begin to experience cravings for opioids as well as a loss of control over their use. Patients with both physical dependence and an addiction develop a tolerance or a diminished response to the drug, but with the addiction, the patient has an inability to control drug use, has uncontrollable cravings, compulsively uses the drug, and continues to use the drug despite harmful consequences to oneself or others.[7]

A person who has become addicted to prescription opioids may switch to heroin/fentanyl or supplement with heroin/fentanyl because it can be readily obtained, costs less, and is easier to prepare for injection. Opioids produced on the black market can be especially dangerous and have varying and unpredictable potency. Taking a too much of an opioid, or taking it in ways other than prescribed, increases the risks of addiction and lead to overdose and death.

According to the American Society of Addiction Medicine (ASAM), addiction is defined as:

a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.[8]

What is Opioid use disorder, and what are the different types of Opioid use disorder?

Opioid use disorder (OUD) is "the chronic use of opioids that causes clinically significant distress or impairment."[9] OUD encompasses a range of physical, psychological, and behavioral symptoms, making it a complex and multifaceted disorder. The following are the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for an OUD:

- Opioids are often taken in larger amounts or over a longer period of time than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire to use opioids
- Recurrent opioid use resulting in failure to fulfill major role obligations at work, school, or home
- Continued opioid use, despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
- Important social, occupational, or recreational activities are given up or reduced because of opioid use
- Recurrent opioid use in situations in which it is physically hazardous
- Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids
- Tolerance, as defined by either of the following: (a) 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[10]

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[5] Szalavitz, Maia, Khary K. Rigg, and Sarah E. Wakeman. 2021. "*Drug Dependence Is Not Addiction—and It Matters*." Annals of Medicine 53 (1): 1989–92. https://www.tandfonline.com/doi/full/10.1080/07853890.2021.1995623.

[6] Shah, Anuj, Corey J. Hayes, and Bradley C. Martin. 2017. "*Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*." MMWR. Morbidity and Mortality Weekly Report 66 (10): 265–69. https://doi.org/10.15585/mmwr.mm6610a1.

[7] National Institute on Drug Abuse. 2020. "*Drug Misuse and Addiction.*" National Institute on Drug Abuse. National Institutes of Health. 2020. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction.

[8] *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, Volume 1: Adults. 4th ed. Hazelden Publishing; 2023

[9] Dydyk, Alexander M, Nitesh K Jain, and Mohit Gupta. 2024. "*Opioid Use Disorder.*" Nih.gov. StatPearls Publishing. January 17, 2024. https://www.ncbi.nlm.nih.gov/books/NBK553166/

[10] Lu, T., S. D. Whitley, T. J. Wiegand, et al. *Treatment of Opioid Use Disorder.* Baltimore, MD: Johns Hopkins University, February 2024. https://www.ncbi.nlm.nih.gov/books/NBK558319/

- Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

OUD is classified into three categories—mild, moderate, and severe—based on the number and intensity of diagnostic criteria met. These criteria, outlined in the DSM-5, help health care providers determine the severity of the disorder and guide appropriate treatment strategies.

- **Mild Opioid Use Disorder**: Individuals with mild OUD exhibit two to three of the DSM-5 criteria. These may include using opioids in larger amounts or for longer periods than intended, persistent desire or unsuccessful efforts to cut down or control use, and spending a significant amount of time obtaining, using, or recovering from opioid use. People with mild OUD might begin to notice negative impacts on their personal and professional lives, but these effects are often less severe and pervasive than in more advanced stages of the disorder.
- **Moderate Opioid Use Disorder**: Moderate OUD is characterized by the presence of four to five DSM-5 criteria. In addition to the symptoms seen in mild OUD, individuals may experience increased tolerance, requiring larger doses to achieve the desired effect, and withdrawal symptoms when not using opioids. There is a noticeable deterioration in social, occupational, or recreational activities, and the person may continue using opioids despite being aware of the significant problems caused by their use. The impacts on health, relationships, and daily functioning become more apparent and concerning.
- **Severe Opioid Use Disorder**: Severe OUD is identified when six or more of the DSM-5 criteria are met. Individuals with severe OUD exhibit a compulsive need to use opioids, often losing control over their use. They may abandon important social, occupational, or recreational activities due to their opioid use. The disorder severely disrupts their daily lives, causing major health issues, relationship breakdowns, and significant legal or financial problems. Tolerance and withdrawal are typically pronounced, and the risk of overdose and other life-threatening consequences is high. Severe OUD requires intensive, comprehensive treatment to address the deep-rooted physical and psychological aspects of the disorder.

The Role of Fentanyl

Fentanyl is a synthetic opioid that has become ubiquitous in the illicit opioid supply. It is up to fifty times stronger than heroin and 100 times stronger than morphine. IMF is available on the street drug market in different forms, including pressed pills and powder. Powdered fentanyl looks just like many other drugs. It is commonly mixed with drugs like heroin, cocaine, and methamphetamine and made into pills resembling other prescription medications. Fentanyl-laced drugs are extremely dangerous, and many people may be unaware that their drugs are contaminated with fentanyl. It should be assumed that all non-prescribed opioids contain fentanyl in varying concentrations.[11]

Laboratory analysis of counterfeit pills has shown that seven out of every ten pills seized by the Drug Enforcement Administration (DEA) contain a potentially lethal dose of fentanyl. Individuals who have lost their opioids tolerance are at greatest risk for overdose. Although smoking is often perceived as a "safe" mode of use for people using opioids, even a single inhalation of smoked fentanyl can result in overdose.

Due to the potency of fentanyl, regular users may develop very high levels of opioid tolerance and dependance. Fentanyl is also lipophilic, meaning it is stored in body fat, similar to cannabinoids. Renal clearance of fentanyl may take several weeks for persons who are exposed to fentanyl daily. Fentanyl withdrawal can start sooner, last longer, and be more difficult to treat than heroin. withdrawal.[12]

ASAM recently published a document ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids, provides guidance for treating patients using IMF, such as alternative buprenorphine initiation strategies, precipitated withdrawal avoidance and treatment, buprenorphine dosing, and formulation considerations and polysubstance use.[13]

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[11] National Institute on Drug Abuse. 2021. "*Fentanyl Drug Facts." National Institute on Drug Abuse. National Institute of Health.* June 2021. Retrieved 10 Dec 2024. https://nida.nih.gov/publications/drugfacts/fentanyl.

[12] H. Elizabeth Bird, Andrew S Huhn, and Kelly E Dunn. 2023. "*Fentanyl Absorption, Distribution, Metabolism, and Excretion: Narrative Review and Clinical Significance Related to Illicitly Manufactured Fentanyl.*" Journal of Addiction Medicine 17 (5): 503–8. https://doi.org/10.1097/adm.0000000000001185.

[13] Weimer, Melissa, Andrew A Herring, Kawasaki S, Marjorie Meyer, Bethea A Kleykamp, and Kelly S Ramsey. 2023. "*ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-Potency Synthetic Opioids.*" Journal of Addiction Medicine 17 (6): 632–39. https://doi.org/10.1097/adm.0000000000001202.

Medication for Addiction Treatment

Medications for Addiction Treatment (MAT) use Food and Drug administration (FDA) approved medications that are prescribed and supervised by a health care provider. MAT supports individuals on their recovery journey by blocking cravings and reducing or eliminating withdrawal symptoms and improving overall health and well-being. MAT along with social services and support, foster health and resilience to help people with SUD improve their quality of life. Medications for Opioid Use Disorder (MOUD) are the gold standard for treatment of OUD..[14][15]; [16] The medications approved for use with MOUD are:

- Buprenorphine/Buprenorphine-naloxone products: Buprenorphine Mono-product (BUP), Suboxone, Zubsolv, Sublocade, Brixadi
- Methadone: Methadose®, Dolophine
- Naltrexone: Vivitrol®[17]

More information regarding these medications are in Section III. This guide is focused mostly on MOUD, but there are additional types of MAT available for alcohol use disorder and tobacco use disorder. That information is available in Section IV.

Effectiveness of Medications for Opioid Use Disorder

MOUD is an effective treatment that provides several benefits for individuals struggling with opioid addiction. MOUD:

- Reduces withdrawal symptoms, making it easier for individuals to manage the initial phase of recovery. Limits cravings, helping to prevent relapse and supporting long-term sobriety.
- Blocks some of the euphoric and sedating effects of opioids, reducing the incentive to use these substances.
- Reduces opioid use and overdoses, thereby lowering the risk of fatal outcomes.
- Helps reduce the incidence of infectious diseases associated with opioid use, such as HIV and hepatitis, due to decreased needle sharing.
- Assist patients with higher retention rates in treatment programs, contributing to better overall recovery outcomes.[18]

Why use medications for opioid use disorder?

The high prevalence of substance dependence and addiction warrants an approach that involves everyone.

According to National Survey on Drug Use and Health (NSDUH) data, the annual averages of SUD in Alaska between 2022 and 2023 were notable. The overall SUD rate in Alaska was in past year was 21%, significantly higher than the national average of 17%. This placed Alaska 7th for the highest SUD rate in the United States, including Washington DC). in the past year. Specific substance use disorder rates in Alaska included:

- An alcohol use disorder rate of 10%, similar to the United States overall.
- The opioid use disorder rate was 2% similar to the United States overall.[19]

In 2023, approximately 2% of traditional school YRBS survey respondents reported ever using methamphetamines, 4% reported using cocaine, and 2% reported using heroin. These rates were significantly higher among respondents from alternative schools.

According to provisional data from the Centers for Disease Control and Prevention (CDC), Alaska faced its highest overdose death rate on record in 2023 with at least 364 overdose deaths.[20] Alaska's spike in overdose deaths between 2022 and 2023 was the highest year-to-year increase in the nation, and the vast majority were due to fentanyl. Of the drugs evaluated in the 2023 Alaska Drug

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[14] Mattick, Richard P., Carmen Breen, John Kimber, and Marica Davoli. "*Methadone Maintenance Therapy versus No Opioid Replacement Therapy for Opioid Dependence.*" Cochrane Database of Systematic Reviews, no. 3 (2009). https://doi.org/10.1002/14651858.cd002209.

[15] Mattick RP, Breen C, Kimber J, Davoli M. *Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence.* Cochrane Database Syst Rev. 2014;2014(2). https://doi.org/10.1002/14651858.CD002207.PUB4.

[16] Nielsen S, Tse WC, Larance B. *Opioid agonist treatment for people who are dependent on pharmaceutical opioids.* Cochrane Database Syst Rev. 2022;2022(9). https://doi.org/10.1002/14651858.CD011117.PUB3.

[17] Center for Drug Evaluation and Research. 2024. "*Information about Medications for Opioid Use Disorder (MOUD).*" FDA. https://www.fda.gov/drugs/information-drug-class/information-about-medications-opioid-use-disorder-moud.

[18] Dydyk, "*Opioid Use Disorder.*"

[19] Substance Abuse and Mental Health Services Administration (SAMHSA). 2024. "*National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).*" 2021-2022 NSDUH: Model-Based Estimated Prevalence for States. https://www.samhsa.gov/data/sites/default/files/reports/rpt44484/2022-nsduh-sae-tables-percent-CSVs/2022-nsduh-sae-tables-percent.pdf.

[20] CDC. 2024. "*Provisional Drug Overdose Data.*" CDC. August 14, 2024. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

Overdose Mortality report, notable increases were seen in the number of overdose deaths involving fentanyl (a synthetic opioid) and methamphetamine (a stimulant), increasing between 2019 and 2023 by approximately 1700% and 227%, respectively. Few declines in rates have occurred since 2019; however, heroin-involved overdose deaths have decreased by 64%.[21]

There is an overdose epidemic happening right now, and medications for opioid use disorder can reduce the number of overdoses.

In 2023, Alaska experienced its highest overdose death rate recorded, and the greatest increase in overdose death rates nationwide. MOUD is a significant tool in reducing overdose and overdose death. In a systematic review of 30 studies involving 370,611 participants, those who did not receive MOUD were 2.5 times more likely to die from any cause as compared to those who were on MOUD, and 8 times more likely to die from overdose than those who were on MOUD.[22]

Substance dependence and addiction affects everyone and will take everyone to address it

Statistically, males represent 65% of Alaska's overdose fatalities. 28% ages 35-44, 23% ages 25-34, 18% ages 45-54, 17% ages 55-64, and 6.4% both for age ranges 15-24 and 65+. Opioid related emergency department visits were highest in Anchorage, at 50.4 per 10,000. The rates in the other public health regions were: Southeast, 38.7 per 10,000, Matanuska Susitna Valley, 34.0 per 10,000, Southwest, 21.3 per 10,000, Gulf Coast, 17.0 per 10,000, Interior, 12.5 per 10,000, and Northern, 9.9 per 10,000. Twice as many opioid-related emergency department visits were by males, at 50 per 10,000, with females at 24 per 10,000, according to the latest reported figures.

Economically, SUD takes a significant toll on Alaskans. A 2020 report focused on the economic costs of SUDs in Alaska found that the estimated annual substance misuse-related costs to the state in 2018 amounted to $3.5 billion. This staggering figure includes the combined costs of productivity loss, health care expenses, criminal justice and protective services, traffic collisions, and public assistance and social services.[23] The economic burden highlights the urgent need for comprehensive measures to address SUD, not only to alleviate the financial strain but also to improve the overall quality of life for Alaskans.

Addressing SUD, including providing respectful and effective medical treatment for individuals, can significantly enhance public safety by reducing crime rates. Additionally, the death of a person due to overdose or addiction has profound ripple effects across a community. It is estimated that each death leaves an average of five people grieving[24], and studies demonstrate that bereavement itself can lead to depression and substance use as a coping mechanism[25]. By tackling addiction head-on, we can mitigate these adverse outcomes and disrupt the cyclical and generational nature of SUD, fostering healthier and more resilient communities.

Prescribers are pivotal at responding to treating addiction for several reasons:

SUD is a chronic, multifactorial disease affecting the brain. SUD should be treated just as we treat people living with diabetes, heart disease, and HIV: without regard to any environmental or genetic predispositions resulting in the chronic disease. Often, the first contacts for individuals struggling with SUD are health care providers, placing them in a unique position to respond. Providers have the opportunity to reduce harm and stigma by creating a safe space where patients can be heard and seen, and by treating them with respect and dignity within a patient-centered medical home. Health care providers working on the front lines, such as those in primary care and urgent care, are better positioned than most specialists to

[21] Alaska Department of Health, Division of Public Health, Health Analytics and Vital Records: "*Alaska Facts and Figures*" https://health.alaska.gov/media/kzvbebor/drugoverdosemortalityupdate_2022.pdf.

[22] Ma, Jun, Yan-Ping Bao, Ru-Jia Wang, Meng-Fan Su, Mo-Xuan Liu, Jin-Qiao Li, Louisa Degenhardt, et al. 2018. "*Effects of Medication-Assisted Treatment on Mortality among Opioids Users: A Systematic Review and Meta-Analysis*." Molecular Psychiatry 24 (12): 1868–83. https://doi.org/10.1038/s41380-018-0094-5.

[23] McDowell Group. 2020. "*THE ECONOMIC COSTS of DRUG MISUSE in ALASKA 2019 UPDATE PREPARED FOR*." https://alaskamentalhealthtrust.org/wp-content/uploads/2020/01/McDowell-Group-Drug-Impacts-Report-Final-1.21.2020.pdf.

[24] Shear, K., E. Frank, P. R. Houck, and C. F. Reynolds. "*Treatment of Complicated Grief: A Randomized Controlled Study*." Journal of the American Medical Association 293, no. 21 (2005): 2601–2608. https://doi.org/10.1001/jama.293.21.2601.

[25] Parisi, Anna, Anjalee Sharma, Matthew O. Howard, and Amy Blank Wilson. 2019. "*The Relationship between Substance Misuse and Complicated Grief: A Systematic Review*." Journal of Substance Abuse Treatment 103 (103): 43–57. https://doi.org/10.1016/j.jsat.2019.05.012.

diagnose SUD sooner. Therefore, they have the opportunity and duty to take the first step toward treatment by providing MOUD when indicated and supportive care referrals as needed. Providers can use readily available screening and assessment tools to link people to the most appropriate services.

Health care professionals have an ethical and professional obligation to support patients with SUD. This responsibility begins with the first prescriptions of opioids. Studies indicate at least 75% of people who began to misuse opioids started with a legitimate opioid prescription.[26] Whereas much of the start of the opioid epidemic was attributable to prescriptions, health care professionals now can (and should) play a pivotal, proactive role in curtailing harms.

Stigma is one harm that stands in the way of overcoming the overdose epidemic. No one chooses to become dependent or addicted; many individuals currently addicted to fentanyl or heroin started when they received prolonged opioid prescriptions after injury or surgery – some as teenagers. Between 2000 and 2016, these practices were common and widely endorsed by the medical community.[27] We now know that those who receive thirty-day prescriptions of opioids are 30% more likely to be dependent one year later.

A large percentage of people struggling with substance use disorders also have a physical comorbidity.

Continuity of care can be supported if SUDs are addressed simultaneously with physical comorbidities. Some frequent physical comorbidities include chronic pain, hepatitis, cancer, and heart disease.[28] Substance use can cause a variety of physical symptoms, including: changes in coordination; blood pressure and heart rate changes; feelings of being more awake or sleepy; improved sociability; pain relief; and changes in appearance.[29] Physical impacts may further result in: conditions like liver disease from alcohol use disorder; severe dental problems as a result of methamphetamine use; and injection-related infections, such as endocarditis. Moreover, a large percentage of people struggling with physical disorders and mental illness can develop a substance use disorder.[30] Therefore, it is key that the whole person is addressed to address overall health.

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[26] National Institute on Drug Abuse. 2015. "*Prescription Opioid Use Is a Risk Factor for Heroin Use*." National Institute on Drug Abuse. October 1, 2015. https://nida.nih.gov/publications/research-reports/prescription-opioids-heroin/prescription-opioid-use-risk-factor-heroin-use.

[27] Guy, G. P., Jr., K. Zhang, M. K. Bohm, et al. 2017. "*Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015*." MMWR Morbidity and Mortality Weekly Report 66: 697–704. https://doi.org/10.15585/mmwr.mm6626a4.

[28] Hser, Yih-Ing, Larissa J. Mooney, Andrew J. Saxon, Karen Miotto, Douglas S. Bell, and David Huang. 2017. "*Chronic Pain among Patients with Opioid Use Disorder: Results from Electronic Health Records Data*." Journal of Substance Abuse Treatment 77 (June): 26–30. https://doi.org/10.1016/j.jsat.2017.03.006.

[29] Eske, Jamie. 2020. "*Effects of Drug Abuse: Physical and Psychological*." Medical News Today. June 18, 2020. https://www.medicalnewstoday.com/articles/effects-of-drug-abuse.

[30] National Institute on Drug Abuse. 2020. "*The Connection between Substance Use Disorders and Mental Illness*." National Institute on Drug Abuse. 2020. https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness.

Chapter 2: Adding Medications for Opioid Use Disorder into Your Practice

Clinic Staffing: The Core Team

Establishing a core team dedicated to patient care and service coordination is fundamental to support medications for opioid use disorder (MOUD) services. The core team comprises interested and qualified staff who embrace the attitudes, values, and competencies associated with treating patients with substance use disorders. The team may also partner with other agencies to provide comprehensive treatment services to meet an individual patient's needs.

The core team ideally contains a provider, a care coordinator, nonclinical administrative staff, and, where available, a qualified addiction professional. If the clinic does not have behavioral health treatment services onsite, it is recommended that formal referral agreements be established with substance use disorder (SUD) services to further support a patient's recovery.

Provider

The provider is a Drug Enforcement Administration (DEA) licensed prescriber (MD/DO/NP/PA) authorized to prescribe Schedule III controlled substances. Their duties consist of diagnosing opioid use disorder and comorbid conditions, reviewing an intake history, performing physical exams and prescribing medications. The provider works with the patient to choose the most appropriate medications for addiction treatment, develops a treatment plan with the patient, and supervises the initiation onto MOUD. The provider performs routine follow-up visits, monitors treatment progress and reevaluates the treatment plan.

Care Coordinator (Optional)

The care coordinator facilitates communication between the provider and the patient. Duties include routine support to patients outside of office visits; arranging drug testing; pill/film counts; communicating with patients at risk for dropping out of treatment; identifying barriers to care access; and linking the patient to recovery support services. Additionally, the care coordinator monitors SUD treatment attendance and routinely provides and obtains updates from external providers. Depending on the structure and capacities of the clinical setting, a case manager, medical assistant, physician's assistant, nurse, peer support specialist, behavioral health aid, or another staff member may assume the role of care coordinator.

Qualified Addiction Professional (Optional)

Psychosocial treatment can be supportive for individuals receiving MOUD.[31] An onsite qualified addiction profession (QAP) will help promote and support behavior change. QAP is "the Alaska Medicaid specialty designation for an individual providing substance use disorder (SUD) services. The minimum qualifications for full QAP approval are the designation as a Chemical Dependency Counselor 1 (CDC 1) by meeting the requirements of the Alaska Commission for Behavioral Health Certification or a comparable program. A QAP issued a provisional approval must obtain a full QAP designation within four years from the date of their provisional approval letter."[32]

Although providing onsite behavioral health support services is ideal, it is not realistic in many communities, due to lack of available staffing or funding. The inability to provide integrated behavioral health services should not be considered a barrier to prescribing MOUD.

Administrative Staff

Administrative staff are frequently responsible for obtaining patient intake information and consents, handling the billing, and other accounting procedures. Most importantly, as the first people the patient meets, they can establish a welcoming and non-stigmatizing tone for the patient's experience of their MOUD treatment.

People with Lived Experience

People in recovery with lived experience of substance use disorders can be a valuable asset to the clinic treatment team in any position (medical/behavioral health/administration). Additionally, soliciting feedback from people in recovery and in active addition about program design and expansion of services can ensure the program is meeting the needs of patients and the greater community.

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[31] Dugosh, Karen, Amanda Abraham, Brittany Seymour, Keli McLoyd, Mady Chalk, and David Festinger. 2016. "*A Systematic Review on the Use of Psychosocial Interventions in Conjunction with Medications for the Treatment of Opioid Addiction*." Journal of Addiction Medicine 10 (2): 93–103. https://doi.org/10.1097/adm.0000000000000193.

[32] Alaska Department of Health, Policy and System *Action Map for Substance Use Disorder Services*, accessed [December 19, 2024], https://health.alaska.gov/media/o5bhf4iy/psam_sud.pdf.

Feedback from people with lived experience can help to:

- Identify community needs, goals, and objectives
- Identify innovative approaches to address those needs
- Develop budgets to submit with applications/grant proposals.

See this Substance Abuse and Mental Health Services Administration (SAMHSA) guide, Participation Guidelines for Individuals with Lived Experience and Family.

In 2020, State of Alaska Division of Behavioral Health (DBH) and Alaska Commission on Behavioral Health Certification (ACBHC) began the Peer Support Professional certification program. The ACBHC Peer Support Program requires one year of recovery for certification as a Peer Support Professional I, Peer Support Professional II, Peer Support Professional III or Traditional Peer Associate. When considering people with lived experience, this is a program that has integrated a supportive approach to enhancing the workforce with those who have lived experience.

Educational Resources

It's recommended that core team members have basic training about addiction being a treatable, chronic medical disease, as well as about available pharmacotherapy and addressing stigma around SUD. Staff also need ongoing confidentiality training. Free resources for training staff and developing the core team can be found at Care Innovations and Providers' Clinical Support Systems' SUD 101 Training.

The Opioid Response Network provides staff education and technical assistance in program development free of charge to individuals and organizations nationwide.

Project ECHO (Extension for Community Healthcare Outcomes):

"Moving Knowledge, Not People"

Project ECHO (Extension for Community Healthcare Outcomes) trains and mentors primary care providers (PCPs) in the care of patients with complex conditions. ECHO is a distance education model that connects specialists with numerous PCPs via simultaneous video link for the purpose of facilitating case-based learning.

There are a number of ECHO programs in Alaska that address caring for people with substance use and co-occurring disorders, Including:

AK ID ECHO aims to increase provider knowledge about prevention strategies, screening, diagnosing, treatment, and management of hepatitis C (HCV), HIV, PrEP, and common STIs.

LiverConnect ECHO is a comprehensive program to assist Tribal Healthcare Providers to provide better care to Alaska Native/American Indian patients with liver disease.

Addressing Substance Use in Alaska (ASUA) ECHO. is a virtual learning network focused on the establishment of a multi-disciplinary community of practice. This series seeks to establish a comprehensive understanding of current data and best practices in the treatment of substance use disorders, focusing on alcohol, opioid, and stimulant use, including the integration of ASAM 4th edition updates.

The Pain & Opioid Management ECHO is a virtual learning network intended to enhance knowledge on evidence-based pain management and addiction, and the treatment of opioid use disorder for primary care providers across Alaska.

The Peer Support ECHO is a virtual learning network that develops a community of practice amongst peer support providers in Alaska and provide them a platform where they can learn from experts and their peers on best practices for peer support of mental health and/or substance use disorders.

Updated lists of active ECHO programs are available from UAA, ANTHC and worldwide at iECHO

Mentoring: Individualized support for providers

"Treatment with medications for OUD can be provided effectively in primary care settings, 6 and primary care represents one of the biggest opportunities to improve MOUD access. However, many practices perceive OUD treatment as difficult, time-consuming, and overwhelming, indicating that support for clinics and systems aiming to integrate MOUD into primary care is needed."

The ANTHC behavioral health program offers access to free one-on-one addiction medicine consultation support for providers working with native beneficiaries with OUD. Many providers are apprehensive about adding OUD treatment to their practice without the support of American Indian and Alaska Native (AI/AN) beneficiaries to help manage complex situations. Mentorship provides individuals with the guidance and support needed for career development and may alleviate some of the alienation associated with burnout. Although mentoring does not provide direct patient care, it supports providers by providing education and connection to resources needed to expand their knowledge base and comfort with managing complex cases. Email behavioralhealth@anthc.org for more information about connection to addiction consultation, availability subject to grant project cycles. Providers outside of the tribal health system can access free mentoring through the PCSS mentoring program online, and the University of Washington offers a Psychiatric Consultation phone line to call for free clinical advice from UW psychiatrists regarding your adult patients with mental health or substance use conditions.

Medications for Opioid Use Disorder Models of Care

Prescribing MOUD can occur in a variety of settings depending on the medication. The following is a list of different types of settings in which MOUD occurs:

- **Primary Care:** Primary care providers can incorporate MOUD by using methods such as low-dose buprenorphine induction (LDBI). LDBI "decreases the risk of precipitated withdrawal, does not require that the patient already be in withdrawal to start buprenorphine, and may thus provide better treatment outcomes for patients, especially those using fentanyl."[33] The multitude of administration methods for buprenorphine allow for a patient-centered approach that range from daily doses to monthly injections.
- **Behavioral Health Care:** Integrating MOUD such as buprenorphine and/or naltrexone prescribing into American Society of Addiction Medicine (ASAM) Levels of Care can significantly improve one's treatment success. This includes intensive outpatient, residential, and outpatient treatments.[34] It's a way to stabilize the individual while supporting the individual with other clinical therapeutic care.
- **Establishing and/or maintaining an Opioid Treatment Program (OTP)**: OTPs are practices that have received accreditation by an approved accrediting body, DEA approval, State approval, and SAMHSA approval, to prescribe, administer, and dispense methadone.
- **Colocation of services**: This is a practice that offers a comprehensive array of services that support an integrated care approach to MOUD. Services would include primary care in addition to behavioral health services, and infectious disease services.

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[33] Ahmed, Saeed, Siddhi Bhivandkar, Brady B. Lonergan, and Joji Suzuki. 2020. "*Microinduction of Buprenorphine/Naloxone: A Review of the Literature*." The American Journal on Addictions 30 (4): 305–15. https://doi.org/10.1111/ajad.13135.

[34] Stahler, Gerald J., and Jeremy Mennis. "*The Effect of Medications for Opioid Use Disorder (MOUD) on Residential Treatment Completion and Retention in the US*." Drug and Alcohol Dependence 212 (2020): 108067. https://doi.org/10.1016/j.drugalcdep.2020.108067.

Incorporating crisis response services into integrated SUD care

True North Recovery Services and Programs (in Wasilla and Fairbanks) offers wrap-around services in an integrated care model that includes a mobile crisis response team, a 24 hour crisis stabilization (at The Day One Center), Integrated behavioral health assessments, withdrawal management services, residential, IOP and outpatient SUD treatment program, sober living and reentry services. To provide wrap around care coordination, they collaborate with the Lazarus Collaborative, a collaboration of providers dedicated to providing timely access to care, including those providing withdrawal management services, primary care, MOUD and community-based mental health support and peer navigation. The integration of these services allows for rapid access to the needed level of care and smooth transitions between levels of care.

A variety of methods to expand access can be conducted across these settings:

Hub and Spoke: in this model, the hub is the central location, with more intensive wrap-around services, in addition to MOUD. The hub is the specialty treatment center to provide intake, induction, and stabilization. The spokes are locations where an individual can get less-intensive services and their MOUD. An example of this would be a medication unit of an OTP and Other methods:

- Collaborative Opioid Prescribing (Co-OP)
- Massachusetts Nurse Care Manager Model
- Buprenorphine HIV Evaluation and Support (BHIVES) Collaborative Model
- Medicaid Health Home Model for Those with Opioid Use Disorder
- Southern Oregon Model

Program initiation and community engagement

Eastern Aleutian Tribes (EAT) serves the remote tribal villages of Sand Point, King Cove, Adak, Akutan, False Pass, Nelson Lagoon, and Cold Bay through permanent and itinerant Advanced Practice Providers and Community Health Aides overseen by a Medical Director. In 2019 they decided to add MOUD to their clinic services. In addition to buprenorphine prescribing training for their medical providers, the Tribal Health Organization sought technical assistance to help them implement their MOUD program. With the help of an addiction medicine specialist, they arranged a half day training for their clinic staff that included medical, behavioral health and administrative personnel. In addition, they arranged a public event that included a potlatch and invited community members to listen to an educational talk about OUD treatment, ask questions and discuss their concerns. EAT has since been operating a successful MOUD program offering both sublingual and long-acting buprenorphine through in-person and telemedicine care. Organizations can request free technical assistance to implement and expand their treatment programs through the Opioid Response Network, and through ANTHC Behavioral Health

Developing Program Policies and Procedures

Treatment agreements

A Treatment Plan is educational and informational, promotes treatment engagement and identifies:

- Treatment goals
- Conditions for changing or stopping treatment
- Therapeutic contingencies for non-adherence and failure to meet initial goals
- Expectations for patients and providers

A treatment plan or agreement can be a helpful tool to

document and clarify MOUD treatment expectations and promote treatment engagement. Because opioid use disorder (OUD) is often a chronic and relapsing illness, patients may have different types and durations of treatment over their lifetimes.

Because every clinic is unique in its location, resources, strengths, challenges, and philosophies of care, there is no "one-size-fits-all" set of policies and procedures. It is important to customize policy and procedures (P&P) to address local challenges and outline an agreed-upon framework so that clinicians and support staff have consistency when addressing commonly encountered challenges. It is also important that P&P allow flexibility in developing patient-centered treatment plans that meet patients where they are and help them reach their personal goals.

Common challenges that present during MOUD treatment include:

- No-shows/late arrivals
- Requests for early refills
- Refusal to provide drug testing or unexpected results on drug test
- Polysubstance use
- Medication non-adherence
- Lack of behavioral health participation
- Criminal justice/child welfare involvement
- Billing/collection concerns

Considerations when formulating clinic policies

No-shows/late arrivals

Patients with SUDs may struggle with keeping their scheduled medical appointment and arriving on-time. It is important to remember that these behaviors can be consistent with the diagnostic criteria for SUDs: "failure to fulfill major obligations," and "having persistent and recurring social and interpersonal problems" related to their drug use.[35] No-show rates for first appointments may approach 50% in some populations; however, appointments scheduled less than 48 hours in advance have much lower no-show rates.[36]

Offering intake visits via telemedicine many also help to reduce no-show rates.[37] If possible, schedule blocks of appointment time each week designated for MOUD patients, to allow for more open access scheduling. These set blocks of time can also function as walk-in hours for patients who need urgent appointments or fail to attend their scheduled appointments.

Group visits that occur at the same time every week can allow for consistency that may simplify attendance for some patients and be more time efficient for busy providers.[38] Afternoon appointment times are better suited to many patients, especially those struggling with sleep disturbances.

Intensive case management for patients with severe SUD is often required, such as frequent reminder calls and assistance to reschedule appointments and arrange transportation. Patients who face transportation or other home obligation challenges may benefit from the use of telemedicine when possible.

Patients who repeatedly miss appointments resulting in lapses of medication and frequent cycles of drug use and abstinence may benefit from a switch to monthly long-acting formulations of medications.

Policies must clearly outline expectations for schedule adherence and consequences for non-adherence. Policies must prioritize keeping the patient on uninterrupted MOUD whenever possible, as overdose death is greatly increased when patients stop taking their medications.[39]

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[35] SAMHSA. 2024. "*Exhibit 2-6, DSM-IV-TR Criteria for Substance Abuse and Substance Dependence.*" NIH.gov. Substance Abuse and Mental Health Services Administration (US). 2024. https://www.ncbi.nlm.nih.gov/books/NBK92053/table/ch2.t5/

[36] Turkcan, A., L. Nuti, P. C. DeLaurentis, et al. "*No-Show Modeling for Adult Ambulatory Clinics.*" In Handbook of Healthcare Operations Management: Methods and Applications, edited by Brian Denton, 251–288. New York: Springer, 2013.

[37] Sumarsono, A., M. Case, S. Kassa, and B. Moran. "*Telehealth as a Tool to Improve Access and Reduce No-Show Rates in a Large Safety-Net Population in the USA.*" Journal of Urban Health: Bulletin of the New York Academy of Medicine 100, no. 2 (2023): 398–407. https://doi.org/10.1007/s11524-023-00721-2.

[38] Cunningham, S. D., R. A. Sutherland, C. W. Yee, J. L. Thomas, J. K. Monin, J. R. Ickovics, and J. B. Lewis. "*Group Medical Care: A Systematic Review of Health Service Performance.*" International Journal of Environmental Research and Public Health 18, no. 23 (2021): 12726. https://doi.org/10.3390/ijerph182312726.

[39] Sordo, L., G. Barrio, M. J. Bravo, B. I. Indave, L. Degenhardt, L. Wiessing, M. Ferri, and R. Pastor-Barriuso. "*Mortality Risk during and after Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies.*" BMJ 357 (2017): j1550.

Requests for early refills and trouble with medication compliance

Most treatment agreements include a clause that early refills will not be issued. When a patient requests an early refill, it is important to ask why. Considerations include:

- If uncontrolled cravings lead to taking more medication than prescribed, it is important to re-evaluate the patient frequently to adjust the dose as needed. Inquire about what triggered the cravings. Stressful events, insomnia, depression, anxiety, and pain are common triggers of increased cravings. Treating these comorbid conditions may reduce medication overuse. Increased outreach by, and engagement in, behavioral health or peer support services may help manage psychosocial stressors.
- Keeping prescriptions short early in treatment can reduce the amount of medication a patient needs to manage and reduce the number of days of withdrawal a patient might endure if they run out early.
- Inquire if a patient is sharing their medication with a friend, family member, or partner. If so, working to recruit their loved one into treatment can be helpful. If medication is reported stolen, providing basic lockboxes to patients can improve medication security.
- If a patient still has some medication left, help them to make a plan to ration it to reduce withdrawal symptoms (cutting the dose in half for the last few days before fill is due). If the patient is completely out of medication for three days or more before their refill date, providers may choose to refill as a "one-time emergency," while simultaneously increasing the level of support a patient is receiving.
- Multiple episodes of running out of medication early despite dose increases, short prescriptions, and adequate management of comorbid conditions may mean that the patient would benefit from directly observed dosing of their medications (typically done via video chat or via secure apps).
- Failure to reach successful medication adherence with the above tactics may mean that the patient would benefit from switching to a long-acting injectable form of MOUD. All patients should be offered a referral to higher level of care when appropriate, and patients should always be offered comfort medications for withdrawal symptoms as demonstrated in Table 1.[40]

Table 1. Treatment strategies for withdrawal symptoms

Medication	Dose	Treatment Considerations
Clonidine	0.2 mg q4h PRN; hold for SBP < 90, DBP < 60; Total: < 0.8 mg daily	Dysautonomia/orthostatic hypotension, especially with dehydration
Lofexidine	0.2–0.4 mg q6–12h PRN	Dysautonomia, possibly less hypotension; FDA-approved for opioid withdrawal; expensive
Loperamide	2 mg q2h PRN, NTE 16 mg/day	Diarrhea; QTc prolongation
Ondansetron	4–8 mg q4–6h PRN	Nausea; QTc prolongation
Dicyclomine	20 mg q6h PRN	Stomach cramps
Tizanidine	4-8 mg q6h PRN	Muscle cramps
Ibuprofen	400–600 mg q8h PRN	Pain; caution in renal impairment
Gabapentin	100–300 mg TID	Pain, anxiety; Caution in renal impairment
Chlordiazepoxide (or other benzos)	10–25 mg q6h PRN	Anxiety, agitation; for ED/hospital use only
Hydroxyzine	12.5–50 mg TID PRN	Anxiety, agitation
Trazodone	50–200 mg qHS PRN	Insomnia

Sources: Carlat Publishing, "A Carlat Psychiatry Reference Table: Treatment Strategies for Opioid Withdrawal," The Carlat Report. March/April 2021.Rehan Aziz, MD, "Management of Opioid Withdrawal in the Emergency Setting," The Carlat Addiction Treatment Report 9, no.2 (Newburyport, MA: Carlat Publishing, 2021), Table: Treatment Strategies for Opioid Withdrawal, Symptomatic Treatment.

See also Section II, Chapter 7: Psychosocial Treatment and Determining the Appropriate Level of Care.

[40] Aziz, Rehan. 2021. "*Management of Opioid Withdrawal in the Emergency Setting*." The Carlat Addiction Treatment Report 9, no. 2 (March/April): Carlat Publishing. https://www.thecarlatreport.com/articles/3408-management-of-opioid-withdrawal-in-the-emergency-setting

Drug test refusal or unexpected results

Medical visits for MOUD monitoring and prescribing commonly include obtaining a urine or oral fluid drug test. Drug testing may also be performed randomly, especially for patients that have drug-related legal or Office of Children's Services (OCS) cases. Inability or refusal to give a drug testing sample, tampering with a sample, and unexpected results on a drug test are common problems that providers encounter in everyday practice. Even long-term, stable patients may occasionally show aberrance in test results, and this may be one of the first indicators of return to use. Clinics should create treatment agreements that clearly outline expectations for drug testing compliance and what changes might be made in their treatment plan if they refuse to give a sample or tamper with their sample. Witnessed urine collection is invasive and embarrassing for patients, can be uncomfortable for staff, and may not be possible if same-gender staff is not present to witness. It is best reserved for patients with legal issues who are likely to have medical records subpoenaed and is best performed in a laboratory that has staff trained to perform the procedure. A simpler alternative to witnessed urine collection is oral fluid testing, which may be performed in the clinic or at home via video chat. Treatment agreements should emphasize the importance of honesty about drug use and the use of testing as a therapeutic tool. When illicit drug use is revealed by testing, this is an indication that increased patient support and monitoring is required, such as increasing frequency of visits and shorter prescriptions, adjusting medication dose or formulation, offering more behavioral health support, and addressing underlying comorbid conditions and stressors that are triggering use. Aberrancy in a drug test result should almost never be a trigger to withhold medication from a patient but may guide decisions to change dose, formulation, or type of medication utilized. Drug testing policy should always prioritize keeping patients on MOUD whenever possible. See Section II, Chapter 9: Drug Testing for more information on interpreting and responding to drug tests.

Polysubstance use

Polysubstance use is common in patients with OUD. However, even patients who continue to use other substances can still be successful in stopping or reducing opioid use, reducing their risk of overdose death, and improving their quality of life. It is important to remember that MOUD does not treat other substance use disorders, so treatment specifically directed at the comorbid SUD is required. It is not recommended to withhold buprenorphine from patients that are using alcohol or other sedatives,[41], [42] but it is important to warn them of the risk of overdose and to provide naloxone rescue kits. In patients who continue to use other illicit drugs, the provider may consider continuing to prescribe sublingual buprenorphine with weekly visits and close monitoring, or to require a switch to long-acting injectable buprenorphine if diversion and medication adherence are a concern.

Lack of behavioral health participation

MOUD can be effective to reduce drug use and associated morbidity and mortality even without psychosocial supports, so MOUD should never be withheld due to lack of participation in behavioral health care.[43] A wide variety of psychosocial supports should be continually offered to patients to find an option that best suits their needs. Many modalities of psychosocial support may be helpful outside of the traditional individual and group counseling, including mutual support groups (Narcotics Anonymous (NA)/Alcoholics Anonymous (AA)) which can be attended virtually, tele-behavioral health, peer support, motivational interviewing, and digital therapeutics. Rather than punish a patient for not engaging in behavioral health, participation should be incentivized through rewards/contingency management.[44] Motivational interviewing should be offered at every patient interaction and can be provided by medical staff, behavioral health aides (BHA) and case managers. It may take several months in treatment before a patient is receptive to engaging in psychosocial support. Group visits, where a patient receives their medical check-in

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[41] AATOD. 2017. "*Addressing Benzodiazepine Use in OTPs – AATOD.*" Aatod.org. 2024. https://www.aatod.org/advocacy/policy-statements/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-otps-april-6-2017/.

[42] Center for Drug Evaluation and Research. 2019. "*FDA Drug Safety Communication: FDA Urges Caution about Withholding Opioid Addiction Medications from Patients Taking Benzodiazepines or CNS Depressants: Careful Medication Management Can Reduce Risks | FDA.*" U.S. Food and Drug Administration. 2019. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications

[43] Wakeman, Sarah E., Marc R. Larochelle, Omid Ameli, et al. "*Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder.*" JAMA Network Open 3, no. 2 (2020): e1920622. https://doi.org/10.1001/jamanetworkopen.2019.20622.

[44] Bolívar, H. A., E. M. Klemperer, S. R. M. Coleman, M. DeSarno, J. M. Skelly, and S. T. Higgins. "*Contingency Management for Patients Receiving Medication for Opioid Use Disorder: A Systematic Review and Meta-Analysis.*" JAMA Psychiatry 78, no. 10 (2021): 1092–1102. https://doi.org/10.1001/jamapsychiatry.2021.1969.

and prescription during a mutual support group meeting can increase engagement, as can scheduling a medical and behavioral health visit back-to-back if co-located or available via tele-medicine. Peer support workers and BHAs can also meet briefly with patients before or after their medical appointment to provide support.

Billing and collection concerns

Treatment agreements should clearly outline plans should patients fail to pay their bill at the clinic. All possible social service assistance should be offered to assist patients in obtaining insurance and to enroll in grants that can help to cover the cost of medical and behavioral health services. Withholding medication increases risk of overdose death and is not recommended.

Some other considerations for ongoing treatment agreement/plan challenges:

- Reassess the treatment agreement and what the patient wants out of treatment, if there appears to be a lack of interest in following through on various recommended strategies.
- Determine if any modified strategies can be accomplished in the current level of care, or a different level of care in the continuum of MOUD services or different adjunctive services available.
- It may be a matter of the patient needing a better program "fit" (not even necessarily a change in overall level of care) to a program that better suits their needs/preferences, such as one that has walk-in appointments, mostly does harm reduction, extended clinic hours/days, etc.
- If it becomes clear that the patient is mandated and "doing time" rather than "doing treatment and change," explore what Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment and developing internal motivation for change.

Fostering Community Support and Collaboration

Coalitions

A coalition is an alliance of stakeholders from various fields working together toward a specific goal. For addressing opioid use, a coalition might involve stakeholders from public health, hospitals, social services agencies, school district faculty and staff (i.e., teachers, school principals), public safety (municipal safety officers, state troopers), Tribal offices, city offices, retail store management, and faith organizations (i.e., local pastors, faith leadership). To establish an interdisciplinary network means everybody can offer input and add their voice to the conversation. Additionally, coalitions allow people to develop the same knowledge and language around the topic to be disseminated more widely. Therefore, everyone is aware about what treatment options are available locally and can coordinate how warm handoffs can be made between service agencies.

Community partnerships: joining forces to expand services

Partnerships between community organizations can help to better serve the needs of patients without duplication of services. In Homer, the local syringe access program Megan's Place has collaborated with Kachemak Bay Family Planning to provide STI testing and reproductive health services, and the Ninilchik Community Clinic to provide rapid access to hepatitis C treatment, MOUD and BH assessments. These collaborations can benefit all partners by providing seamless flow between community services and efficient utilization of resources, while also opening doors for future grant funding opportunities. Participating in community coalitions can be a great way to break down silos and spark partnerships between service providers.

Listening sessions

Listening sessions provide members of the public an opportunity to offer valuable input on the issues of OUD treatment and to learn about public concerns. Listening sessions can play a valuable role in shaping educational and program materials. They can also be integrated into the program itself as a way to demonstrate a genuine commitment to understanding and addressing the needs of patients and the public. To offer a space for the public to voice their concerns and needs might improve openness to the implementation in MOUD in rural communities.

Education

Community education is key to addressing barriers, such as stigma, around MOUD. Education can occur through community presentations, community panel discussions and promotional materials (handouts, flyers).

Community Readiness

Communities vary in readiness for expanding access to MOUD. It is important to meet communities where they are at. Readiness can be measured through readiness assessments and should take into consideration cultural factors.

Community readiness can be influenced by education around MOUD. Many people are cautious or skeptical of something they know little to nothing about.

Establish Partnerships with Systems

Establishing and strengthening relationships within communities, such as emergency medical services, OCS, domestic violence (DV) and sexual violence (SV) service agencies, housing services, law enforcement, and others, can support the success of MOUD programs, if you have capacity and outreach resources. When partners are familiar with the efficacy and local availability of MOUD, they can be an important referral and entry point into treatment programs for their clients and help make more personal connections that can motivate clients to stay in treatment.

- **Office of Children's Services (OCS)**: Pregnant women, parents, and guardians may have engaged with child protective services while struggling with SUD. Overall outcomes can be improved when OCS staff understand essential services that clients are receiving and the correlation between engagement in MOUD services and the improvement of child welfare and safety. Promotional materials such as brochures with MOUD information can be distributed through these partnerships and providers can meet with local offices to provide personal academic detailing to promote de-stigmatizing language and provide additional education.
- **Domestic Violence and Sexual Violence Service Agencies**. Studies demonstrate a connection between substance misuse and intimate partner violence.[45] DV and SV agencies and professionals can be a resource in providing information to clients about availability of MOUD providers and programs and DV and SV professionals can inform services according to the issues and perspectives they see. Access a list of DV/SV services in Alaska.
- **Shelters and Food Banks**: It is estimated that one in four deaths among unhoused individuals are a result of a drug overdose.[46] Shelters, food banks, and other sites that serve vulnerable populations can offer venues to share information about MOUD services and therapeutic residential opportunities for clients needing services. Providers and case managers can also become more familiar with the housing assistance programs available in their communities to better assist patients facing housing insecurity.
- **Criminal Justice**: 85% of the prison population have an active substance use disorder or were incarcerated for a crime involving drugs or drug use.[47] Providing education to the local justice systems about OUD and treatment services can provide the context to maladaptive and disruptive behaviors of untreated SUD and can highlight the benefits of MOUD in reducing recidivism. Developing relationships with judges, therapeutic courts, probation officers and other law enforcement professionals can increase the likelihood that they will refer individuals to MOUD providers when appropriate. Partnerships with therapeutic courts can help increase the utilization of these services by increasing treatment availability. The Alaska Department of Corrections is working towards expanding availability of MOUD to incarcerated individuals; however, not all patients will have access to MOUD while incarcerated. It is critical to provide information to jails, prisons and re-entry programs on how to provide a warm handoff to MOUD programs upon release, as overdose rates in the first 2 weeks following release from incarceration are 12.7 times higher for patients not on MOUD.[48] See Section IV,

[45] Stone, R., and E. F. Rothman. "*Opioid Use and Intimate Partner Violence: A Systematic Review.*" Current Epidemiology Reports 6 (2019): 215–230. https://doi.org/10.1007/s40471-019-00197-2.

[46] Stone, R., and E. F. Rothman. "*Opioid Use and Intimate Partner Violence: A Systematic Review.*" Current Epidemiology Reports 6 (2019): 215–230. c

[47] Fine, Danielle R., Kirsten A. Dickins, Logan D. Adams, Denise De Las Nueces, Karen Weinstock, Joseph Wright, Jessie M. Gaeta, and Travis P. Baggett. 2022. "*Drug Overdose Mortality among People Experiencing Homelessness, 2003 to 2018.*" JAMA Network Open 5 (1): e2142676–76. https://doi.org/10.1001/jamanetworkopen.2021.42676.

[48] Binswanger, Ingrid A., Marc F. Stern, Talia E. Yamashita, Susan R. Mueller, Travis P. Baggett, and Patrick J. Blatchford. "*Clinical Risk Factors for Death after Release from Prison in Washington State: A Nested Case-Control Study.*" Addiction 111, no. 3 (2016): 499–510. https://doi.org/10.1111/add.13200.

Chapter 25: Criminal Justice for more information.

- **Law enforcement**: Law enforcement professionals often are first responders to crisis situations that might involve SUD, such as an opioid overdose. When officers respond to drug related crisis situations, they can provide information about recommended services for people experiencing drug related problems. For example, information about naloxone access or flyers about how to access SUD treatment locally and peer support specialists that can help intervene in crisis situations.
- **Community Medical and Behavioral Health Service Providers**: Outreach to local medical providers, hospitals, emergency departments and BH professionals can strengthen critical relationships that can improve transitions of care for patients. Many medical and behavioral health professionals address complex cases involving patients with SUDs and comorbid conditions, and many report not feeling adequately informed about substance use treatment. Many of these professionals are interested in receiving education about addiction and evidence-based interventions to improve their practice. Collaborate with medical staff and administration to offer addiction medicine educational opportunities to their staff, or to connect them to resources such as the latest clinical guidelines and treatment algorithms. Providing your practice contact information (including after-hours contact and peer support if available) to the hospital to post with the specialty call list in the emergency department or provider offices can assist them with reaching you when they have a referral or clinical question.
- **Pharmacists**: Pharmacists can get involved in MOUD teams through collaborative practice agreements. Under state statute AS 08.80.337: "A pharmacist may, under a collaborative practice agreement with a written protocol approved by a practitioner, provide patient care services." This regulation was recently updated to remove restrictions on dispensing and administering controlled substances. For example, pharmacists could assist with administering long-acting injectable MOUD or by directly observed therapy or oral MOUD dosing. Pharmacists can also provide training on using naloxone to reverse an overdose. For more information about how pharmacists can support access to MOUD, the National Association of Boards of Pharmacy's guide: The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARMOUD) Guideline

Where to begin?

Establishing a partnership with any recommended agencies can happen in several ways. You can offer to attend an organizational training session to provide education about SUD treatment or overdose response training. You can also invite them to participate in a community coalition to meet regularly about any community needs and issues around addiction or invite them to be on stakeholder committees for program development. Memorandums of understanding (MOU) can help to solidify a partnership between agencies and can help to clarify expectations and roles in the partnership. If you are already collaborating with another agency, you can request letters of support from them when applying for grant funding and offer them the same service.

Asset Mapping: Developing a Roadmap to Treatment

In South Peninsula Hospital's 2017 Community Health Needs Assessment Implementation Strategy, substance misuse, and uncertainty of how to access treatment, was ranked the factor most negatively affecting the community. In 2018 South Peninsula Hospital partnered with the Mobilizing for Action through Planning and Partnerships (MAPP) coalition of the Southern Kenai Peninsula (SKP) to help identify resources and gaps in the local pathway to recovery. The Southern Kenai Peninsula Roadmap for Success in Treatment and Recovery from Substance Use Disorder was created that outlines the levels of care available in the hospital service area to demystify the availability of treatment options, in a one-page, user friendly document available to the general community.

Technology to support practice management and quality improvement

There are a variety of technologies to assist with practice management and patient monitoring and support.

Case Management Software

Case management software is a digital system enabling organizations to track and store information in a centralized location and report on their data. Case information is accessible to a variety of users for stakeholder collaboration on cases and to share information in a secure environment. A case management software system streamlines intake, case tracking, and reporting. It consolidates all case information into a central repository to provide a single

source of up-to-date information on ongoing cases. The most sophisticated case management software also provides a tool for reporting on all the accumulated data for risk management and prevention.

Psychiatric data registries and tools

PsychPRO is the Mental Health Registry operated by the American Psychiatric Association.

This is a Centers for Medicare & Medicaid (CMS)-Qualified Clinical Data Registry for all behavioral mental health providers, and can assist with measuring, tracking and benchmarking care, at the provider, practice and system levels. Clinical effectiveness is monitored and addressed, including the impact of interventions and treatment. It also streamlines data submissions to CMS for their Merit-based Incentive Payment System (MIPS) reporting as well as to giving providers a simple method of submitting Performance-in-Practice data and readily obtain American Board of Preventative Medicine (ABPM) Maintenance of Certification (MOC) credits. Users may also have the opportunity to contribute to research collaborations that pool data from many practices nationwide.

The Alaska Prescription Drug Monitoring Program (PDMP) allows providers to access their prescribing reports for patients on buprenorphine. This access can assist with patient tracking, evaluating length of medication therapy and monitoring for lapses in medication continuity, and for quality improvement projects.

Electronic Medical Record Flowsheets

Many electronic medical records (EMRs) have built in flowsheets for monitoring patient progress and quality measures. For example, an organization can track scores over time for mental health screenings like the GAD-7 or PHQ-9, as well as track special population health testing, such as hepatitis screening.

Alaska Native Tribal Health Consortium/Indian Health Service Provider Opioid Dashboard

The Indian Health Service (IHS) opioid surveillance dashboard is a graphical display of de-identified prescription drug data extracted from the IHS National Data Warehouse. This prescription data is received through periodic uploads, at least monthly, from IHS sites. The opioid surveillance dashboard is a tool that can be used to support opioid stewardship initiatives at your site. The dashboard is an interactive web-based tool that provides recent, as well as historical information, related to opioid prescribing. Alaska Native Tribal Health Consortium (ANTHC) has expanded on this dashboard by also tracking quality of care measures for patients with OUD, tracking rates of treatment engagement, rates of MOUD usage and retention in treatment on MOUD. Providers who work in the ANTHC/IHS system can reach out to their supervisors to obtain access to these dashboards

HoloLens

ANTHC's Telehealth Technology Assessment Center, a leader in telehealth technology, has been developing and improving the HoloLens virtual reality learning experience to provide education to providers and patients about opioid use disorder. The augmented reality learning experience incorporates culturally appropriate images and references with straightforward explanations of neurophysiology. When clients or clinicians put on a pair of mixed reality glasses, they are transported to a campfire, complete with the sound of crackling firewood. Information is presented in a narrative format that is more accessible to users. Users can select chapters ranging from the epidemiology of opioid use in Alaska, to different brain functions, to the effects of opioids on the brain. 3D images provide immersive sensory experiences throughout each chapter of this new curriculum. ANTHC staff worked with local language experts to translate materials into the Yup'ik language, which makes the education even more accessible to patients. Contact ANTHC's behavioral health substance use prevention department to get information about accessing HoloLens training in your community.

Innovation and Alaska Native Cultural Awareness

Southcentral Foundation's Four Directions MAT program offers a unique learning tool for individuals to better understand their opioid use disorder – the HoloLens Augmented Reality experience. Utilizing this tool, which has incorporated Alaska Native cultural elements and is offered in native Yupik and English, allows for a different learning medium which overwhelmingly has been a positive experience for most users. Soon a new HoloLens curriculum will be available to help train providers on offering MOUD.

Digital Patient Communications

HIPAA compliant secure medical texting services can allow for more seamless patient communication with patients that prefer that mode of communication. Telemedicine video platforms can also be used by case managers to perform tasks remotely such as medication counts, directly observed dosing or observed collection of an oral fluid drug test.

Virtual Directly Observed Therapy

There are many software companies that offer remote applications for directly observed dosing of medications via video. Created mainly for monitoring tuberculosis treatment, some of these applications have added MOUD dosing monitoring to their services offered.

Virtual Directly Observed Therapy: a new approach to support medication monitoring

SEARHC utilized the platform Sonara for virtual dosing program for their opioid treatment. Sonara is a HIPAA compliant, digital health solution that uses a web-based application to support patients who administer methadone at home. Patients scan a patented tamper aware label and are prompted to record a video of themselves taking their medication at home, versus requiring daily travel to a treatment center. The asynchronous video is available for the care team to review, helping providers assess how effectively patients are using their take-home medications. Remote observation provides a daily touchpoint for

our Opioid Treatment Programs to enhance trust with patients, engage in more timely interventions and retain patients in treatment.

The Ninilchik Community Clinic utilizes the platform Scene (formerly E-mocha) to help monitor dosing of sublingual buprenorphine, disulfiram and benzodiazepines. They have also used the platform to perform observed oral fluid collection for mail-out drug testing. This has been a useful addition to telemedicine services for patients that benefit from additional systems of accountability and also to help document dosing a people with court ordered treatment.

Breathalyzers for home alcohol use monitoring

There are companies that make breathalyzers designed to use at home for monitoring alcohol use disorder. These devices may connect to the internet via Wi-Fi or cellular data and can be set up for testing multiple times a day and transmit the data securely to the clinic for review.

Remote patient monitoring

There are multiple companies developing remote tracking of patient vital signs through wearable devices. The enhanced interest in wearable devices and digital health is a promising opportunity. Wearable devices can collect information and compute values even when the user is asleep, thereby reducing any manipulation by the user. Most commercial wearable devices use photoplethysmography that measures at a single point of contact like the wrist or fingers. Devices are in development to monitor and prevent lethal outcomes of overdoses and prevent patients from misusing opioids. There are also devices in development that can monitor withdrawal symptoms and signs of intoxication. Companies developing these devices may offer treatment programs opportunities to participate in research and development free of charge to their patients.

Prescription digital therapeutics for substance use and mental health

According to a SAMHSA factsheet Digital therapeutics (DTx) are part of a spectrum of digital health interventions currently available in behavioral health care. DTx are:

- Currently used to treat or manage mental health conditions or substance use disorders (SUDs)
- Designed and tested rigorously with sufficient scientific and clinical evidence that demonstrate improvement in outcomes in the management and treatment of mental health conditions and SUDs
- Able to extend the reach of evidence-based behavioral health treatments (e.g., Cognitive Behavioral Therapy (CBT) and contingency management) and improve health equity through enabling easier access to patients in their preferred environments
- Accessible via smartphones, tablets, virtual reality headsets, or other devices
- Driven by software that can be used independently or in conjunction with direct clinical care but are not intended to replace provider-led clinical services
- Designed to maintain client privacy and security protections
- Generally considered medical devices subject to FDA oversight; when cleared or approved for prescription use (depending on the classification and corresponding risks), they can be referred to as prescription digital

therapeutics (PDTs)In behavioral health, six DTx currently meet the Food & Drug Administration's (FDA) criteria for PDTs

Certain DTx have been shown to increase abstinence rates when offered as part of SUD treatment,[49] greatly increase SUD treatment retention[50], and reduce costly emergency department visits and inpatient hospitalizations.[51] DTx have also been created to treat anxiety and depression among persons receiving treatment for OUD (demonstrating a significant reduction in anxiety, depression, and opioid use). Efficacy has also been demonstrated for cannabis use and co-occurring use disorders among sexual and gender minority young adults. Additionally, increased percent of days abstinent and social connectedness occurred when a digital therapeutic for substance use disorders was used among American Indians/Alaska Natives.[52] This guide provides health care providers and DTx developers with a framework to assess digital therapeutics products and their impact in real-world settings.

[49] Maricich, Yuri A., Xiaorui Xiong, Robert Gerwien, Alice Kuo, Fulton Velez, Bruce Imbert, Keely Boyer, Hilary F. Luderer, Stephen Braun, and Karren Williams. 2020. "*Real-World Evidence for a Prescription Digital Therapeutic to Treat Opioid Use Disorder.*" Current Medical Research and Opinion 37 (2): 175–83. https://doi.org/10.1080/03007995.2020.1846023.

[50] Xiong, Xiaorui, Stephen Braun, Maxine Stitzer, Hilary Luderer, Gigi Shafai, Brendan Hare, Michael Stevenson, and Yuri Maricich. 2022. "*Evaluation of Real-World Outcomes Associated with Use of a Prescription Digital Therapeutic to Treat Substance Use Disorders.*" The American Journal on Addictions 32 (1): 24–31. https://doi.org/10.1111/ajad.13346.

[51] Shah, Neel, Fulton Velez, Samuel Colman, Laura Kauffman, Charles Ruetsch, Kathryn Anastassopoulos, and Yuri Maricich. 2022. "*Real-World Reductions in Healthcare Resource Utilization over 6 Months in Patients with Substance Use Disorders Treated with a Prescription Digital Therapeutic.*" Advances in Therapy 39 (9): 4146–56. https://doi.org/10.1007/s12325-022-02215-0.

[52] A. N. C. Campbell, E. Turrigiano, M. Moore, et al., "*Acceptability of a Web-Based Community Reinforcement Approach for Substance Use Disorders with Treatment-Seeking American Indians/Alaska Natives*," Community Mental Health Journal 51 (2015): 393–403, https://doi.org/10.1007/s10597-014-9764-1.

Chapter 3: Addressing Barriers to Medications for Opioid Use Disorder Practice Integration

Although medications for opioid use disorder (MOUD) have been available for over a decade with substantial evidence, continual resistance has occurred across administrators, clinicians, and people with lived experience to utilizing life-saving buprenorphine and methadone. A June 2024 Centers for Disease Control (CDC) Morbidity and Mortality Weekly Report (MMWR) reviewed 2022 National Survey on Drug Use and Health (NSDUH) data to identify estimated number of individuals who need OUD treatment, perceived a need for opioid use disorder (OUD) treatment, received any OUD treatment, and received medications for OUD in the past year. The authors found that of the 3.7% of their sample size of 56,610 adults needed treatment, but just a little over half received treatment, and only a quarter received medications for opioid use disorder (MOUD). The report found that 42% of adults who needed treatment perceived they did not need treatment or received treatment that did not include MOUD. [53] This chapter focuses on typical barriers noted to using buprenorphine and/or methadone, and how to address each one.

Availability of Opioid Treatment Program/ Methadone in area

The advent of asynchronous dosing as well as flexibilities regarding take-home dosing in addition to expansion of medication units fosters a great geographic range of available methadone in areas. Providers working in the Southcentral, Southeastern, and Fairbanks areas now have expanded reach to support their clients with methadone. Find a list of available Opioid Treatment Programs in your geographic region.

Insufficient resources for ongoing education, mentoring, and consultation

Several studies have documented that providers do not prescribe MOUD because they feel ill-prepared to do so. [54] Fortunately, at an international, federal, and state level, there are significant resources to supporting education and mentorship for prescribers. The following are key resources to obtain this support:

Nationally

- Provider Clinical Support System-Medications for OUD,
- CDC Linking People with Opioid Use Disorder to Medication Treatment,
- Agency for Health Care Research & Quality (AHRQ) Medication-Assisted Treatment for Opioid Use Disorder Playbook,
- Substance Abuse and Mental Health Services Administration (SAMHSA) Medications for Opioid Use Disorder,

State

- University of Alaska, Anchorage's (UAA) Center for Human Development (CHD) Project ECHO: These virtual learning communities provide educators, service providers, case managers, administrators, families, and others access to expert advice from professionals throughout the state and country, building capacity in home communities to implement best practices and improve outcomes.
- Medications for Addiction Treatment (MAT) Conference: This annual conference aims to unite professionals from diverse sectors to share knowledge, exchange ideas, and build robust networks that support and enhance MAT services in Alaska.
- State of Alaska, Division of Behavioral Health Evidence-Based Medication for Addiction Treatment Guides: This website offers a few different guides of how to incorporate MOUD into different settings such as emergency departments and residential settings.

Insufficient time in the day to address people living with opioid use disorders

Several studies have documented providers and administrators feeling hesitant to incorporate MOUD into their practice because of the extra time it might take to support this patient load. However, there are several ways to address this hesitancy. AHRQ has identified the following specific strategies to reduce this burden:

[53] Dowell, Deborah, Sarah Brown, Sarojini Gyawali, et al. "*Treatment for Opioid Use Disorder: Population Estimates — United States, 2022.*" MMWR Morbidity and Mortality Weekly Report 73 (2024): 567–574. https://doi.org/10.15585/mmwr.mm7325a1.

[54] Cioe, Kristen, Brittany E. Biondi, Rebecca Easly, Amanda Simard, Xuan Zheng, and Sandra A. Springer. "*A Systematic Review of Patients' and Providers' Perspectives of Medications for Treatment of Opioid Use Disorder.*" Journal of Substance Abuse Treatment 119 (2020): 108146. https://doi.org/10.1016/j.jsat.2020.108146.

"Consider postponing paperwork or assessments that can wait until after the patient has started on medication. This approach will help reduce the number of patients lost to treatment initiation and follow up."

"Brainstorm how staff roles and responsibilities can be shifted to maximize efficiency of provider time."

"Think about which other staff can be trained to perform certain steps of the intake and induction process, to take some of the burden off the prescribers. For example, a behavioral health provider or nurse care manager can collect most of the patient information and assessment data during intake before the patient sees the prescriber. Or a health care navigator can help collect relevant information and conduct outreach or follow up with patients."

"Consider workload requirements for providers in the few weeks immediately after the first visit. Overscheduling providers to accommodate subsequent weekly visits after the first visit will lead to provider burnout." [55]

Insufficient wrap-around services/behavioral health support

Medication first models to opioid use disorder treatment have been seen as effective as MOUD with wrap-around services; and therefore, insufficient behavioral health support should not be a barrier to initiating MOUD for an individual living with opioid use disorder. To secure wrap-around services, several strategies can be incorporated. The following positions can be incorporated into a practice to support MOUD:

- Peer support professional
- Behavioral health aides (BHAs)
- Chemical dependency counselors
- Patient Navigator (specifically peer)
- Co-located psychiatrists

Other initiatives to support wraparound services can be partnerships with other agencies that integrate behavioral health services into the agency, or partnerships that allow for co-location of services.

Insufficient financial viability

MAT can be a cost-effective intervention within both primary and behavioral health care. Fried and colleagues (2020) evaluated four approaches to creating financial viability with buprenorphine in a primary care practice. They found that using one of the following four approaches resulted in $18,000 to $70,000 net revenue for each full-time physician in the first year:

- Physician-led visits with nurse-led logistical support: Nurse care managers perform logistics such as patient intake and telephone outreach, while physicians conduct the regular in-person visits and concentrate on patients' medication management.
- Nurse-led visits with physician oversight: Nurse care managers perform the duties in the previous model and bill the patient and "take the lead during in-person visits," Basu said, while the physician meets with the patient every 3 months for medication management.
- Shared visits: Prescribers lead weekly group visits with a mental health professional and nurse care manager, when patients receive addiction-focused medical evaluation and management, buprenorphine prescription and group psychotherapy. Prior to the group psychotherapy, the patient has a one-on-one visit with the provider, nurse care manager and mental health professional and receives a bridging prescription.
- Prescribing by physician alone: According to Basu, this approach allows physicians to "manage everything from intake through discharge, without additional support from others".

To ensure positive net revenues with any of the four approaches to care, providers would need to maintain at least nine patients in treatment, with a no-show rate of less than 34%, the researchers said.[56]

Fears of diversion and misuse

Diversion and misuse of buprenorphine/naloxone and methadone are legitimate concerns. According to research, diversion and misuse is frequently related to management of physical pain, withdrawal management and supporting others as a bridge to treatment due to current insufficient

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[55] Agency for Healthcare Research and Quality (AHRQ). "*Engaging Patients in OUD Treatment.*" Opioid Use Disorder Playbook. Accessed September 4, 2024. https://integrationacademy.ahrq.gov/products/playbooks/opioid-use-disorder/implement-mat-for-oud/engaging-patients-oud-treatment

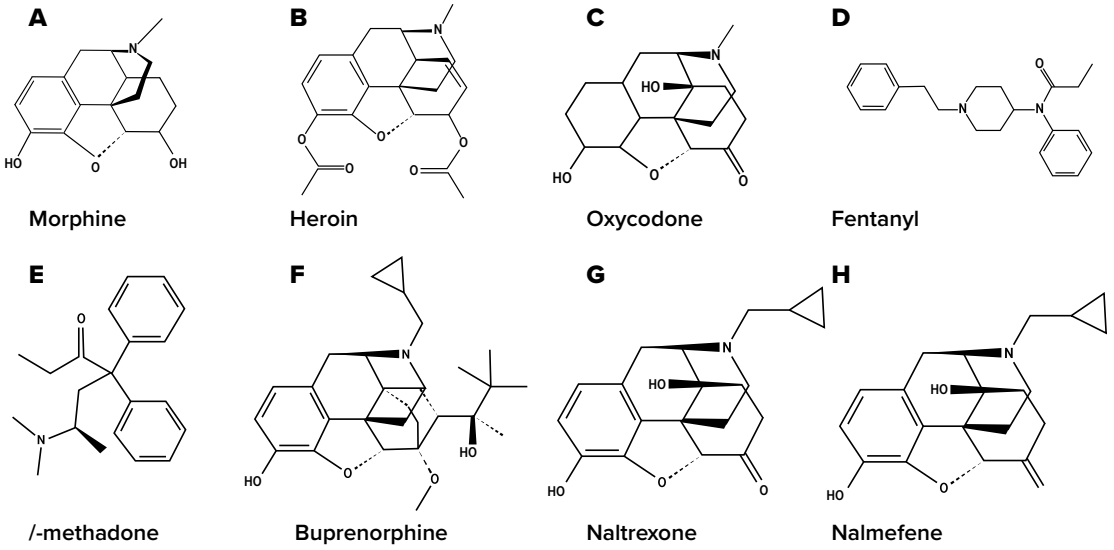
[56] Healio. "Four Ways PCPs Can Provide Financially Sustainable Buprenorphine-Based Treatment." Accessed September 4, 2024. https://www.healio.com/news/primary-care/20201201/four-ways-pcps-can-provide-financially-sustainable-buprenorphinebased-treatment.

treatment.[57] Diverted buprenorphine is almost always utilized by the end user for its medically intended purposes, and recreational use is rare.[58] However, diversion and misuse should be looked at as an opportunity to build relationship with the client and understand reasons for this in a non-judgmental way.

Fear of substituting one opioid for another

The opioids for medications for opioid use disorder and their chemical structures work differently on the brain than the synthetic opioid oxycodone, tramadol, or fentanyl as demonstrated by the figure below.[59] When a person is addicted to opioids the use of the drug escalates out of their control and they are unable to stop despite the harm the substance is causing them. Opioid agonist medications for opioid use disorder provide long-acting, stable medication levels that help patients to improve their health and quality of life by stabilizing their opioid dependence and balancing the brain chemistry while greatly reducing the patient's risk of overdose death. Patients who are stable on MOUD should not experience intoxication or cognitive impairment from their medication and can focus on rebuilding their life in recovery.

Figure 1. Opioid Use Disorder and their Chemical Structures



Difficulty with stigma

All people hold beliefs that form the basis of attitudes and judgments, which in turn, have an impact on how people react and interact with others. Sometimes the foundation of beliefs may be faulty due to misinformation or false narratives. Stigma represents the negative attitudes and behaviors demonstrated toward a circumstance or person. Stigma is a primary barrier to effective prevention, treatment, and recovery efforts at individual, family, community, and societal levels. It prevents many people from getting the help they need[i]

Stigma experienced by people with substance use disorders (SUDs) can contribute to a host of adverse outcomes, including:

- Poor mental and physical health
- Non-completion of substance use treatment
- Delayed recovery and integration process
- Increased involvement in risky behavior (i.e. needle sharing) [60]

Research shows that clinicians tend to hold more negative attitudes toward individuals with substance use disorders

[57] Han, B., C. M. Jones, E. B. Einstein, and W. M. Compton. "Trends in and Characteristics of Buprenorphine Misuse Among Adults in the US." JAMA Network Open 4, no. 10 (2021): e2129409. https://doi.org/10.1001/jamanetworkopen.2021.29409.

[58] Chilcoat, Howard D., Halle R. Amick, Molly R. Sherwood, and Kelly E. Dunn. 2019. "Buprenorphine in the United States: Motives for Abuse, Misuse, and Diversion." Journal of Substance Abuse Treatment 104 (September): 148–57. https://doi.org/10.1016/j.jsat.2019.07.005.

[59] Kreek, M. J., B. Reed, and E. R. Butelman. 2019. "Current Status of Opioid Addiction Treatment and Related Preclinical Research." Science Advances 5 (10): eaax9140. https://doi.org/10.1126/sciadv.aax9140.

[60] "Stigma and Discrimination." National Institute on Drug Abuse, 21 Dec. 2021, nida.nih.gov/research-topics/stigma-discrimination#affect.

compared to those with other medical conditions.[61] Clinician-held stigma is reflected in reduced empathy, minimal patient engagement, compromised or interrupted care, refusal of treatment, and inadequate competency in managing addiction as a medical condition.[62] Collectively, these challenges increase the risk of patient harm by limiting access to essential addiction treatment, reducing patient empowerment, decreasing adherence to treatment plans, and negatively impacting treatment outcomes.[63]

Stigma may be reinforced by previous traumatic experiences when seeking medical care, thus making patients cautious about trusting and having open communication with their provider. Patient mistrust and reluctance can be decreased by recognizing that addiction is a chronic medical disease while providing an empathetic and trauma informed approach in judgment free clinical space that fosters a healthy therapeutic relationship. Providers can reinforce that the patient's SUD can be treated with medication much like diabetes, hypertension or other chronic conditions, with individualized treatment plans focused on patient goals.

Understanding stigma can be key in overcoming it. It occurs across a variety of levels not just at the provider level. By exploring this, strategies can be developed to support changing the attitudes and beliefs around the stigma. The figure, "The Seven Types of Stigma", demonstrates the varying levels of stigma and how they manifest[64]. As a provider, try to identify how this occurs within your practice and community, and incorporate tactics to implement access to MOUD through addressing these levels of stigma.

Figure 2. The Seven Types of Stigma

Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	Type 7
Public Stigma This happens when the public endorses negative stereotypes and prejudices, resulting in discrimination against people with mental health conditions.	**Self Stigma** Self-stigma happens when a person with mental illness or substance-use disorder internalizes public stigma.	**Perceived Stigma** Perceived stigma is the belief that others have negative beliefs about people with mental illness.	**Label Avoidance** This is when a person chooses not to seek mental health treatment to avoid being assigned a stigmatizing label. Label avoidance is one of the most harmful forms of stigma.	**Stigma by Association** Stigma by association occurs when the effects of stigma are extended to someone linked to a person with mental health difficulties. This type of stigma is also known as "courtesy stigma" and "associative stigma".	**Structural Stigma** Institutional policies or other societal structures that result in decreased opportunities for people with mental illness are considered structural stigma.	**Health Practitioner Stigma** This takes place at any time a health professional allows stereotypes and prejudices about mental illness to negatively affect a patient's care.

Words Matter

[61] Van Boekel, L.C., Brouwers, E.P., van Weeghel, J., and Garretsen, H.F. 2013. "*Stigma Among Health Professionals Towards Patients with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review.*" Drug and Alcohol Dependence 131, no. 1–2: 23–35. https://doi.org/10.1016/j.drugalcdep.2013.02.018.

[62] Nyblade, Laura, Melissa A. Stockton, Kurt Giger, Virginia Bond, Maria L. Ekstrand, Rose M. Lean, Emily M.H. Mitchell, Robert E. Nelson, Jaime C. Sapag, Thanprasert Siraprapasiri, Janet Turan, and Edwin Wouters. 2019. "*Stigma in Health Facilities: Why It Matters and How We Can Change It.*" BMC Medicine 17, no. 1: 25. https://doi.org/10.1186/s12916-019-1256-2.

[63] Atkins, Jessica, Amy L. Dopp, and Emily B. Temaner. 2020. "*Combatting the Stigma of Addiction: The Need for a Comprehensive Health System Approach.*" NAM Perspectives, 2020. https://doi.org/10.31478/202011d.

[64] National Alliance on Mental Illness (NAMI), "*Overcoming Stigma*", accessed [December 18, 2024], https://www.nami.org/depression-disorders/overcoming-stigma/.

Addiction is a condition, not an identity. Language matters. Avoid labels like “addict” or “drug user.” Instead use people-first language, for example, “a person with an opioid use disorder.” Table 2 offers word/term alternatives that may reduce stigma overall.

Words Matter Table 2

Language that may be stigmatizing	Objective, Person-first language
Addict, drug abuser	A person with a substance use disorder
Clean/dirty drug test	A test that is positive/negative for a substance, a test result is expected/unexpected, consistent/inconsistent with patient report
Alcoholic	A person with and alcohol use disorder
Medication assisted treatment, opioid replacement therapy	Medication for opioid use disorder, medication for addiction treatment, pharmacotherapy, opioid agonist therapy
Relapse	Return to use
Former addict, clean	A person in long term recovery, abstinent from drugs
Addicted baby	Newborn exposed to substances, a baby with neonatal abstinence syndrome
Abuse	Use, misuse
	Words Matter: How Language Choice can Reduce Stigma.

Stigma Surrounding Opioid Treatment Programs

Although methadone is one of the most effective medications available for the treatment of OUD[65], it is also the treatment with the heaviest burden of associated stigma[66]. Stigma surrounding opioid treatment programs (OTPs) can be a barrier to expanding services and can prevent patients from initiating or continuing effective therapy.

As noted in the 2017 A Qualitative Study of Methadone Patients’ Experiences of Stigma, a total of 78% of participants reported having experienced stigma surrounding methadone treatment. Common stereotypes associated with patients taking methadone included that people use methadone “to get high, or that they are incompetent, untrustworthy, lack willpower or are otherwise of poor moral character. Participants reported that stigma resulted in lower self-esteem; relationship conflicts; reluctance to initiate, access, or continue methadone; and distrust toward the health care system. Public awareness campaigns, education of health care workers, family therapy, and community meetings were cited as potential stigma-reduction strategies.”[67]

Please refer to this resource for more information on addressing stigma in your workplace or situation: A Movement to End Addiction Stigma.

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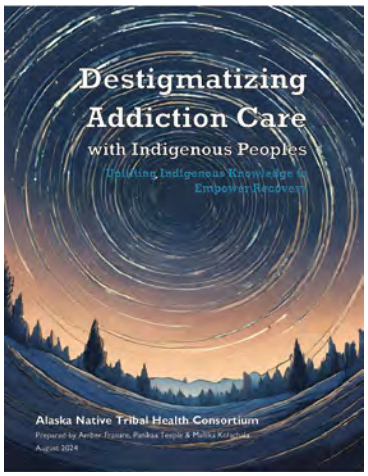
[65] National Institute on Drug Abuse (NIDA). "*How Effective Are Medications to Treat Opioid Use Disorder?*" Last modified December 3, 2021. https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder. Accessed September 10, 2024.

[66] National Academies of Sciences, Engineering, and Medicine; *Action Collaborative on Countering the U.S. Opioid Epidemic; Health and Medicine Division; Board on Healthcare Services; Board on Health Sciences Policy. Methadone Treatment for Opioid Use Disorder: Improving Access Through Regulatory and Legal Change: Proceedings of a Workshop.* Edited by Clare Stroud, Sarah M. Posey Norris, and Laurie Bain. Washington, DC: National Academies Press, 2022. Chapter 3, "The History of Methadone and Barriers to Access for Different Populations." https://www.ncbi.nlm.nih.gov/books/NBK585210/.

[67] Woo, J., A. Bhalerao, M. Bawor, M. Bhatt, B. Dennis, N. Mouravska, L. Zielinski, and Z. Samaan. "'Don't Judge a Book by Its Cover': A Qualitative Study of Methadone Patients' Experiences of Stigma." Substance Abuse: Research and Treatment 11 (2017): 1178221816685087. https://doi.org/10.1177/1178221816685087.

Resources to Address and Reduce Stigma



- Destigmatizing Addiction Care with Indigenous Peoples: Uplifting Indigenous Knowledge to Empower Recovery: This guide came out in August 2024, and "hopes to: improve addiction care for Indigenous Peoples; increase awareness of how stigma affects people, communities and systems; and honor Indigenous Peoples that Tribal Health Organizations work with."
- Undoing Stigma. Fact sheet from the Harm reduction Coalition
- Decreasing Stigma Involving Addiction Begins with the Medical Profession, a short one-minute video by PCSS
- SAMHSA's Reducing Discriminatory Practices in Clinical Settings, a hour-long video addressing stigma and discrimination.
- SAMHSA's Digital Storytelling Guide, provides tools to assist patients in recovery to share their experiences
- Episode 2: Breaking Bad Stigma: Changing the Spoken and Unspoken Bias in Treating Substance Use, a 20 min podcast episode by AAAP
- Stop Stigma Now, offers patient and provider flyers and other educational material to reduce stigma surrounding MOUD.
- Dickson et al, Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids, Substance Abuse: Research and Treatment. 2022
- 1.5-hour Panel Discussion: Stigma Around Opioid Use Disorder Presents Challenges to Treatment, by Pew Charitable Trusts
- Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma, Central East ATTC Network

Disease vs. moral weakness:

Understanding that substance use disorders are a medical illness and are related to changes in the brain chemistry combats the common misconception that substance use is a willful choice or a moral weakness.

"We must all confront the intangible and often devastating effects of stigma," according to Patrice A. Harris, MD, the AMA's president-elect and chair of the AMA Opioid Task Force. "The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment."[68]

[68] American Medical Association. "*4 Factors That Add to the Stigma Surrounding Opioid Use Disorder.*" Accessed September 10, 2024. https://www.ama-assn.org/delivering-care/overdose-epidemic/4-factors-add-stigma-surrounding-opioid-use-disorder.

Chapter 4: Regulatory and Administrative Considerations

The COVID-19 pandemic prompted significant regulatory changes in the administration of medication for opioid use disorder (MOUD). Between 2020 and 2024, substantial amendments were made to federal regulations, including 42 CFR Part 2 and 42 CFR Part 8. The Consolidated Appropriations Act of 2022 was passed, Department of Justice issued Americans with Disabilities Act (ADA) Guidance for those receiving MOUD, and the American Society of Addiction Medicine (ASAM) released its 4th Edition guidelines.

Due to the need for isolation to curb the spread of COVID-19, new flexibilities were introduced for methadone and buprenorphine, allowing for telehealth consultations and increased take-home doses. Historically, there were concerns about the risk of overdose and a preference for keeping patients closely connected to treatment services. However, research on these flexibilities revealed that take-home doses did not lead to an increase in overdoses[69], and telehealth improved clinic attendance rates and treatment retention[70] and reduced barriers such as stigma for those with opioid use disorder (OUD).[71]

Additionally, the ongoing fentanyl overdose epidemic has heightened the recognition of the importance of MOUD. The new regulatory framework aims to enhance access to methadone and buprenorphine. It is expected that further changes to increase access to MOUD will be implemented in the coming years. For now, the following outlines the updated regulatory and administrative considerations.

Figure 3. Timeline of MOUD Regulation Change

2021	2022	2023	2024	2025
Registration Requirements for Narcotic Treatment Programs with Mobile Components Methadone Take-Home Flexibilities Extension Guidance Easy Medication Access and Treatment (Easy MAT) for Opioid Addiction Act	MAT Act MATE Act	Methadone Take-Home Flexibilities Extension Guidance Dispensing of Narcotic Drugs to Relieve Acute Withdrawal Symptoms of Opioid Use Disorder 2nd Temporary Extension of COVID-19 Flexibilities for Prescription of Controlled Medicines	42 CFR Part 8 Changes take place 42 CFR 2 Changes take place ASAM 4th Edition finalized 3rd Temporary Extension of COVID-19 Flexibilities for Prescription of Controlled Medicines	DEA Finalizes: Expansion of Buprenorphine Treatment via Telemedicine Encounter

Treatment for OUD in Alaska most typically includes a prescription for the buprenorphine or naltrexone with other medical and psychosocial interventions to achieve and sustain remission. Opioid Treatment programs (OTPs) provide methadone dispensing as well as psychosocial supports. Various components may be involved in the development, implementation and integration for an office based opioid treatment (OBOT). Formal structuring of office systems facilitates efficient patient care, and the information in this guide can assist programs in accessing the information needed to improve their services.

[69] Krawczyk, Noa, Brian D. Rivera, Emily Levin, and Brendan C. E. Dooling. "*Synthesising Evidence of the Effects of COVID-19 Regulatory Changes on Methadone Treatment for Opioid Use Disorder: Implications for Policy.*" The Lancet Public Health 8, no. 3 (2023): e238–e246. https://doi.org/10.1016/S2468-2667(23)00023-3.

[70] Avalone, Lynsey, Carla King, Dennis Popeo, Charles Perkel, Chidinma J. Abara, Rebecca Linn-Walton, Vladimir Gasca, Laurie Vitagliano, Charles Barron, and Omar Fattal. 2022. "*Increased Attendance During Rapid Implementation of Telehealth for Substance Use Disorders During COVID-19 at the Largest Public Hospital System in the United States.*" Substance Use & Misuse 57 (8): 1322–27. doi:10.1080/10826084.2022.2079140

[71] Couch, J.V., et al. "*Patient Perceptions of and Experiences with Stigma Using Telehealth for Opioid Use Disorder Treatment: A Qualitative Analysis.*" Harm Reduction Journal (2024). https://doi.org/10.1186/s12954-024-01043-5.

"Easy MAT for Opioid Addiction Act" and "Dispensing of Narcotic Drugs to Relieve Acute Withdrawal Symptoms of Opioid Use Disorder" (72-hour rule)

The Easy Medication Access and Treatment for Opioid Addiction Act (Easy MAT) for Opioid Addiction Act required the Drug Enforcement Administration (DEA) to revise regulations to allow a practitioner to administer or dispense (but not prescribe) up to a three-day supply of methadone to an individual at one time for purposes of relieving acute withdrawal symptoms while the individual awaits arrangements for MOUD treatment.

- The previous three-day waiver for emergency physicians was helpful but patients had to come back every 24 hours within the 72-hour window while they awaited arrangements for long-term MOUD treatment.
- Because many patients have difficulty coming back to the emergency department each day for a variety of reasons, this becomes a barrier to patient care and providers could be less likely to initiate treatment. With the ability to give 3 days of treatment at one time, patient care is improved.

Hence, the "Easy MAT for Opioid Addiction Act" gave way to the "Dispensing of Narcotic Drugs to Relieve Acute Withdrawal Symptoms of Opioid Use Disorder". The DEA revised regulations to expand access to medications for the treatment of opioid use disorder. The changes allow practitioners to dispense not more than a three-day supply of methadone to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both).[72] Hospital emergency room and inpatient settings can utilize this key rule to support the bridging of treatment into an opioid treatment program.

Consolidated Appropriations Act of 2023[73]

The Consolidated Appropriations Act of 2023 was passed in December 2022 and paved the way for increased availability of medication for opioid use disorder as well a variety of other treatment.

- The Consolidated Appropriations Act of 2023 reauthorized major funding sources for substance use prevention, treatment, and recovery services and includes three bills that help facilitate the integration of behavioral health and primary care.
- The Medication Access and Training Expansion (MATE) Act (H.R. 2067 / S. 2235) passed that requires all prescribers of federally controlled substances to complete eight hours of training on treating and managing patients with opioid use disorder (OUD) and substance use disorder (SUD).
- The Mainstreaming Addiction Treatment (MAT) Act (H.R. 1384 / S. 445) passed that eliminated the need for a separate waiver to dispense buprenorphine to treat OUD.
- The Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) passed providing grants and technical assistance for using the Collaborative Care Model to integrate behavioral health into primary care.

The Federal Mainstreaming Addiction Treatment Act (MAT Act)

This act enacted the following:

- A waiver (or "x-number") is no longer required to prescribe buprenorphine
- All medical providers with a DEA license to prescribe schedule 3 controlled substances may prescribe buprenorphine, subject to state laws.
- There are no longer limits on numbers of patients a provider can prescribe buprenorphine to
- There is no requirement to maintain a list of patients prescribed buprenorphine
- There is no longer a requirement to attest to the capacity to refer for counseling[74]

[72] "*Dispensing of Narcotic Drugs to Relieve Acute Withdrawal Symptoms of Opioid Use Disorder.*" Federal Register 88, no. 151 (August 8, 2023): 53458-53463. https://www.federalregister.gov/documents/2023/08/08/2023-16892/dispensing-of-narcotic-drugs-to-relieve-acute-withdrawal-symptoms-of-opioid-use-disorder.

[73] *U.S. Congress. House. Consolidated Appropriations Act, 2023. H.R. 2617, 117th Cong.* Introduced April 16, 2021. https://www.congress.gov/bill/117th-congress/house-bill/2617.

[74] U.S. Congress. Senate. Methamphetamine Response Act of 2021. S. 445, 117th Cong. Introduced February 16, 2021. https://www.congress.gov/bill/117th-congress/senate-bill/445.

The Medication Access and Training Expansion (MATE) Act[75]

The MATE Act requires all medical practitioners to attest to completing 8 hours of training in addiction treatment to renew their DEA registration as of July 2023. This is a one-time requirement and does not need to be repeated with future DEA renewals. This educational requirement needs to be met to renew DEA registration but does not need to be completed prior to starting to prescribe buprenorphine.

The following outlines the requirements to satisfy this training requirement:

- First, the following groups of practitioners are deemed to have satisfied this training:
  - Group 1: All practitioners that are board-certified in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, the American Board of Addiction Medicine, or the American Osteopathic Association
  - Group 2: All practitioners that graduated in good standing from a medical (allopathic or osteopathic), dental, physician assistant, or advanced practice nursing school in the United States within five years of June 27, 2023, and successfully completed a comprehensive curriculum that included at least eight hours of training on addiction medicine
- Second, practitioners can satisfy this training by engaging in a total of eight hours of training on treatment and management of patients with opioid or other substance use disorders from authorized organizations. A few key points related to this training:
  - The training does not have to occur in one session. It can be cumulative across multiple sessions that equal eight hours of training
  - Past trainings on the treatment and management of patients with opioid or other substance use disorders can count towards a practitioner meeting this requirement. In other words, if you received a relevant training from one of the groups listed below—prior to the enactment of this new training obligation on December 29, 2022—that training counts towards the eight-hour requirement
  - Past DATA-Waived trainings count towards a DEA registrant's 8-hour training requirement
  - Trainings can occur in a variety of formats, including classroom settings, seminars at professional society meetings, or virtual offerings

See Substance Abuse and Mental Health Services Administration's (SAMHSA) website for more information and for links to free educational resources to meet this requirement

Telemedicine in Alaska

Telemedicine is "the delivery of health care services using the transfer of medical data through audio, visual, or data communications that are performed over two or more locations by a provider who is physically separated from the recipient of the health care services."[76] For information about state telemedicine regulations see the state Telehealth Information page.

What are the standards for telehealth delivery?

A provider may deliver health care services via telehealth without an initial in-person exam if the provider holds an Alaska license. For these visits:

- The provider must only provide services within their authorized scope of practice
- Fees for telehealth services must be reasonable and consistent with ordinary fees for the same in-person service
- There is no requirement to document the barrier to in-person health care delivery
- There is no limitation to the physical setting from which telehealth may be delivered
- Neither the patient nor the provider is required to use telehealth to deliver health care services

A physician or physician assistant may not prescribe, dispense, or administer a prescription drug in response to an Internet questionnaire or electronic mail message to a person with whom the physician or physician assistant does not have a prior physician-patient relationship.

Alaska-licensed physicians and physician assistants may prescribe a controlled substance via telehealth without an in-person exam if the provider complies with AS.08.64.364

[75] U.S. Congress. House. *Substance Use Disorder Workforce Expansion Act. H.R. 2067*, 117th Cong. Introduced March 23, 2021. https://www.congress.gov/bill/117th-congress/house-bill/2067.

[76] Alaska Administrative Code. "*7 AAC 110.639. Medication-Assisted Treatment Programs*." Accessed September 10, 2024. https://www.akleg.gov/basis/aac.asp#7.110.639.

and federal law. Alaska-licensed Advanced Practice Registered Nurses (APRNs) may prescribe a controlled substance via telehealth if the provider complies with AS.08.68.710 and federal law, as well as Sec. AS.08.64.362 regarding the maximum days supply for opioid prescriptions.

There is no longer a requirement to document an emergency to prescribe buprenorphine without an in-person visit, or to perform urine drug testing.

Before providing telemedicine services to a patient located in Alaska, the business providing telemedicine services must register on the telemedicine business registry (individual providers do not need to register) and have a valid Alaska business license.

Federal telemedicine regulations related to buprenorphine prescribing

In November 2024, DEA and The Department of Health and Human Services (HHS) announced its plan to extend COVID telemedicine flexibilities through December 2025, including waiving the in-person examination requirements for new patients being prescribed buprenorphine. A final set of telemedicine regulations was released in January 2025 including the Expansion of Buprenorphine Treatment via Telemedicine Encounter. "This rule provides patients with remote access to buprenorphine, the medicine used to treat opioid use disorder. This change allows a patient to receive a 6-month supply of buprenorphine through a telephone consultation with a provider. Further prescriptions of buprenorphine will require an in-person visit to a medical provider.[77]

42 CFR Part 8: Medications for the Treatment of Opioid Use Disorder

In most cases, agencies that wish to prescribe, administer, and dispense methadone must be registered as an OTP. OTPs are regulated by the federal rule, 42 CFR Part 8. Historically, the authority for these regulations stems from the Comprehensive Drug Abuse Prevention (CDAP) and Control Act of 1970 and the Narcotic Addict Treatment Act of 1974, which tightly regulated administration and dispensing of methadone. On February 2, 2024, HHS issued a final rule revising its 42 CFR Part 8 regulations, Medications for the Treatment of Opioid Use Disorder. The rule went into effect April 2, 2024, with a compliance date of October 2, 2024. The final rule is the first substantial update to OTP standards in over 20 years. The changes aim to expand access to evidence-based treatment, reduce stigma, and improve patient-centered care in OTPs. Key changes implemented in the final rule include:

a. Making flexibilities implemented during the COVID-19 Public Health Emergency permanent, such as allowing for extended take-home doses of methadone and the use of telehealth for initiating buprenorphine treatment, and methadone treatment.Clarifying OTP accreditation and certification standards to reflect an evolving treatment environment and evidence-based practices.
b. Expanding access to care by removing the requirement for a one-year history of opioid use disorder before admission to an OTP and updating admission criteria for youth.
c. Promoting patient-centered care and a system of care more grounded in clinical education, experience, and judgment.
d. Aligning Title 42 CFR Part 8 with Federal law changes that eliminated the Drug Addiction Treatment Act (DATA) Waiver.

The final rule reduces barriers to get individuals into treatment and maintain therapeutic relationships over time. The rule reduces exclusionary criteria like the one-year rule of documented OUD before starting treatment, directly addresses the expectation of a patient-centered care approach and other evidence-based approaches through OTPs and makes permanent some of the flexibilities that arose during the public health emergency including broader use of telehealth.

The final rule updates elements of admissions, periodic examinations and assessments, modalities like telehealth, and treatment standards that have already shifted through federal guidance, the public health emergency, and accreditation standards. Accreditation standards closely align with treatment criteria published by ASAM.[78]

In Alaska, shifts in OTP policy and procedure will be monitored largely through the accreditation process with the Commission on Accreditation of Rehabilitation Facilities (CARF) or other accreditors. Title 42 CFR Part 8

[77] U.S. Drug Enforcement Administration. “DEA Announces Three New Telemedicine Rules to Continue Open Access While Implementing Safeguards to Keep Patients Safe.” DEA, January 16, 2025. https://www.dea.gov/press-releases/2025/01/16/dea-announces-three-new-telemedicine-rules-continue-open-access

[78] Electronic Code of Federal Regulations (eCFR). "42 CFR Part 8—Treatment for Opioid Use Disorder." Accessed September 10, 2024. https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8

and ASAM criteria are adopted into regulation by reference and accreditation is a requirement described under 7 AAC 70, Behavioral Health Services Provider Accreditation. In Alaska, OTPs must follow 7 AAC 70.125 to provide services. The State Opioid Treatment Authority (SOTA) serves to ensure compliance with 7 AAC 70.125, with SAMHSA partly relying on SOTA and DEA approvals to move forward with approving new and/or specific changes (i.e. relocation) to existing OTPs.

Other important standards and guidelines for OTPs are as follows:

- "Narcotic Treatment Program Manual: A Guide to DEA Narcotic Treatment Program Regulations". DEA Diversion Control Division.
- "Federal Guidelines for Opioid Treatment Programs". SAMHSA.
- "Tip 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs". SAMHSA.

Prescription Drug Monitoring Program

The Alaska PDMP grants access to practitioners and approved delegates to access and review controlled substance dispensing information for their patients. Per Alaska law:

1. Prescribers must review data prior to prescribing, administering or directly dispensing a schedule II or III controlled substance to ensure appropriate treatment according to established safe standards of practice. Per federal standards 85 FR 42015, OTPs may (but are not required to) enter data in the PDMP.
2. Each dispenser is required to submit information into the PDMP regarding every prescription dispensed for a Schedule II, III, or IV controlled substance. In accordance with transmission methods, information is submitted daily by the close of business on the next business day from the date the prescription was dispensed.

Medications administered or dispensed at a hospital or emergency department are not reported to the PDMP.

We know accessing the PDMP takes time, which is in short supply for providers. Investigate if your electronic medical record (EMR) can integrate with the PDMP to improve your workflow.

Register with the Alaska Prescription Drug Monitoring Program

Visit the Alaska Department of Commerce, Community and Economic Development's website for detailed instructions on how to sign up and use Alaska's PDMP.

Long-acting injectable Buprenorphine and the Prescription Drug Monitoring Program

Specialty pharmacies that dispense long-acting injectable buprenorphine (LAIB) report to the PDMP when they dispense a medication dose to clinic; however, there is no place in the PDMP where a user can see if or when that dose was administered. Providers who administer LAIB in their office are not required to submit this administration information to the PDMP and "buy-and bill" medication doses are not reported to the PDMP.

Opioid Treatment Programs and the Prescription Drug Monitoring Program

OTPs are now allowed under 42 CFR Part 2 to report methadone dispensing information in the PDMP; however, currently there are no OTPs in Alaska that are submitting data to the PDMP. Records verifying methadone administered at an OTP can be obtained directly from the OTP with release from the patient.

Additional tools and resources offered by the Prescription Drug Monitoring Program

In addition to offering patient prescription records, the PDMP offers various tools and resources to assist in improving patient care:

- The Overdose Risk Score (ORS) provides an indicator, along with other patient centric factors, of the likelihood of an unintentional overdose death.
- Prescribers are issued quarterly prescriber report cards, which are intended to give prescribers insight into their controlled substance prescribing patterns. Alaska PDMP Prescriber Report Card User Guide
- The "My Rx" feature allows prescribers to create drug specific prescribing reports which can provide data that can be utilized in quality improvement initiatives such as evaluating length of buprenorphine therapy in their patient population.

- The Resources tab on the "Other Health Information" tab of each patient report that links to a search for local buprenorphine waivered providers (this list is archived and is not maintained), along with patient education resources including the CDC Opioid Prescribing Resources

Medicaid

Buprenorphine Coverage

Alaska Medicaid currently covers all forms of buprenorphine, although quantity limits apply, and sublingual mono-buprenorphine is covered only for pregnant and lactating females. **No prior authorization is required for prescriptions of LAIB or sublingual buprenorphine/naloxone at doses of up to 24 mg/day.** Providers need to complete a prior authorization form and meet criteria for approval if prescribing more than 24 mg/day of sublingual buprenorphine or when prescribing mono-buprenorphine products (to non-pregnant/lactating females). Prior authorizations may require review of patient records or peer-to-peer specialty consultation. Prior authorization may also be initiated over the phone by calling Comagine Health at 877-200-9046. A provider may be granted a waiver for completing certain prior authorizations for buprenorphine by completing an Alaskan MAT Provider Standards of Care Attestation.

LAIB (Sublocade/Brixadi) prescriptions should be sent to a specialty pharmacy authorized to dispense these medications. Medicaid will pay the pharmacy directly for the patient's medication which will then be shipped directly to the clinic where the patient will get their injection, for use only for that designated patient.

- Sublocade distributors
- Brixadi Distributors

Coverage of other medications for addiction treatment

Alaska Medicaid covers Food & Drug Administration (FDA) approved medications for alcohol use disorder (AUD) including both oral and injectable naltrexone, disulfiram, and acamprosate, all without prior authorization. Other medications commonly used off-label for treating AUD are also on formulary including gabapentin, topiramate, and baclofen.

Most medications for tobacco dependence are on formulary including varenicline, bupropion, and nicotine patches lozenges, and gum (although nicotine inhalers are not covered).

Most medications that are used off label to treat stimulant withdrawal and cravings are on formulary, including bupropion, naltrexone, topiramate and mirtazapine.

As formularies may change over time, check the Alaska Preferred drug list program overview website for current medications covered.

Coverage of behavioral health services for substance use disorders

Alaska Medicaid covers a broad range of outpatient counseling for substance use disorders and co-occurring mental health diagnoses across both its State Plan and 1115 Demonstration Waiver service arrays. See the Division of Behavioral Health's Medicaid website for more information about Behavioral Health Medicaid program provider enrollment requirements, service recipient eligibility criteria and behavioral health services reimbursement rates. Behavioral Health Medicaid provider billing manuals may also be found on the Alaska Medicaid fiscal agent provider portal, listed under the Professional Services section.

Most Behavioral Health Medicaid outpatient services, including residential substance use disorder (SUD) treatment, are covered without prior authorization up to the state fiscal year allowance for each Medicaid client. For clients needing extended episodes of care beyond the stipulated state fiscal year allowance, providers may submit a service authorization request. Service authorization requests must be supported by an individualized plan of care and demonstrate medical necessity for a client remaining at the prescribed level of care. Information about state fiscal year service allowances and service authorization can be found on the Division of Behavioral Health's Medicaid website; in the Behavioral Health Medicaid provider billing manuals; in the Alaska Medicaid fiscal agent provider portal, listed under the Professional Services section; or by contacting the Division of Behavioral Health's Medicaid Provider Assistance Services Section at doh.dbh.mpassunit@alaska.gov.

Drug Testing Coverage

Alaska Medicaid covers drug testing with limitations on quantities. Currently Medicaid covers 20 presumptive (rapid screening) tests and 20 definitive (send-out confirmatory) tests per calendar year.

Coverage of Telemedicine

In 2022, Alaska HB 265 clarified Medicaid coverage of telehealth. Medicaid covers:

> all services covered by the medical assistance program provided through telehealth in the same manner as if the services had been provided in person… provided through audio, visual, or data communications, alone or in any combination, or through communications over the Internet or by telephone, including a telephone that is not part of a dedicated audio conference system, electronic mail, text message, or two-way radio. … The department may not decrease the rate of payment for a telehealth service based on the location of the person providing the service, the location of the eligible recipient of the service, the communication method used, or whether the service was provided synchronously or asynchronously. … The department may set a rate of payment for a service provided through telehealth that is different from the rate of payment for the same service provided in person. Regulations calculating the rate of payment for a rural health clinic or federally qualified health center must treat services provided through telehealth in the same manner as if the services had been provided in person.[79]

Updates to Medicare coverage of telehealth made in Section 4113 of the Consolidated Appropriations Act of 2023 extended many of these flexibilities initiated during the COVID emergency through December 31, 2024, and made some of them permanent. Center for Medicare and Medicaid Services (CMS) has a Telehealth Factsheet that explains many of these coverage changes.

Practicing During a Public Health Emergency

The anxiety and stress associated with the COVID-19 pandemic exacerbated symptoms of SUD for many people.[80] The societal response to COVID-19 resulted in an increase in isolation and difficulties for those needing MOUD. Abrupt discontinuation of MOUD can lead to withdrawal as well as return to pretreatment substance use, overdose and overdose death.[81]

According to the American Society of Addiction Medicine: "Every effort should be made to ensure that patients currently taking buprenorphine have timely access to refills of this medication and that any new patients in need of treatment for opioid use disorder can initiate treatment in a timely manner."[82]

Consider offering longer prescription quantities and refilling medications without an in-person visit, especially for stable patients.

ASAM recommendations for providing care for patients with OUD during a public health emergency include:

- Maximize the use of telemedicine to reduce in-person interactions, especially for patients at risk of complications from an epidemic, or when PPE supply is limited
- Consider deferring in-person drug screening, especially for stable patients, and consider the use of at-home testing options such as virtually observed oral fluid collection.
- For patients in early treatment, or for those with polysubstance use, unstable housing or other risk factors for return to use, overdose or diversion, consider increasing the frequency of contact with patients via telemedicine and implementing shorter, more frequent medication refills. Telehealth technologies can also be used for observed medication dosing and medication counts in high-risk patients.
- Consider switching patients from monthly injectable MOUD to daily sublingual dosing, if local pandemic conditions or PPE availability make in-person visits inaccessible. Consider changing from daily dosing to monthly injection, if the risk of a monthly in-person visit

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[79] Alaska State Legislature, *House Bill 265: An Act Relating to the Controlled Substance Prescription Database, 32nd Legislature*, 2021-2022, accessed [Month Day, Year], https://www.akleg.gov/basis/Bill/Text/32?Hsid=HB0265Z.

[80] Czeisler, Mark É., Robert I. Lane, Elizabeth Petrosky, et al. "*Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020.*" MMWR Morbidity and Mortality Weekly Report 69 (2020): 1049–1057. https://doi.org/10.15585/mmwr.mm6932a1.

[81] Zweben, J. E., J. L. Sorensen, M. Shingle, and C. K. Blazes. "*Discontinuing Methadone and Buprenorphine: A Review and Clinical Challenges.*" Journal of Addiction Medicine 15, no. 6 (2021): 454–460. https://doi.org/10.1097/ADM.0000000000000789.

[82] American Society of Addiction Medicine (ASAM). "*Access to Buprenorphine in Office-Based Settings.*" Accessed September 10, 2024. https://www.asam.org/quality-care/clinical-recommendations/covid/access-to-buprenorphine-in-office-based-settings.

outweighs the risk of more frequent visits for patients who are unstable or do not have access to a local pharmacy for frequent refills. The decision to change medication formulations in a patient who is currently stable should include the patient in a discussion of risks and benefits that these changes pose.

- Patients should have increased access to telemedicine psychosocial supports, such as counseling, peer support and mutual support groups, especially as the increased stressors associated with public health emergencies may put people at risk for exacerbations of behavioral health problems.[83]

The Americans with Disabilities Act Protections for Patients with OUD

The Department of Justice published guidance in April 2022 on how the ADA protects people with OUD who are in treatment or recovery, including those who take medication to treat their OUD. The publication, "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery," is intended to help people with OUD who are in treatment or recovery understand their rights under federal law and to provide guidance to entities covered by the ADA about how to comply with the law.[84] The guidance document explains how the ADA protects people with OUD who are in treatment or recovery from discrimination in a number of settings, including carceral settings, housing, employment, health care and participation in state or local government services and programs.[85] The ADA National Network published a fact sheet to provide examples of scenarios where patient's rights are protected.[86]

Some examples of protections include:

- Individuals have a right to continue MOUD while incarcerated, in residential SUD treatment, recovery homes, and skilled nursing facilities
- Individuals cannot be denied access to treatment at a health care facility due to current diagnosis of OUD or due to taking MOUD
- Individuals cannot be discriminated against for employment or housing due to current of past diagnosis of OUD
- Parents cannot be denied visitation rights on the basis of receiving MAT for OUD nor can a child be removed from a parent receiving MAT based on unfounded determinations related to the risk of relapse or assumptions about the illegal use of drugs.

Filing an ADA Complaint

- Complaints may be filed at the Department of Justice
- Complaints related to state agencies can be filed at the State of Alaska, Americans with Disabilities Act (ADA) Compliance Program
- Complaints related to incarcerated individuals can be filed at the United States District Course, District of Alaska, Civil Rights Complaint Form for Prisoners section

The Disability Law Center of Alaska is an independent non-profit law firm providing legal advocacy for people with disabilities anywhere in Alaska.

Confidentiality and 42 CFR Part 2

SUD treatment confidentiality is regulated by state statutes (AS.47.30.590), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and by 42 CFR Part 2. 42 CFR Part 2 are federal substance use disorder confidentiality regulations issued by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). They were developed to protect patients from unintended bias associated with SUDs. The 42 CFR Part 2 non-disclosure requirements are stricter than HIPAA. Thus, SUD providers must handle treatment information about SUD patients with heightened confidentiality.

Effective and timely communication among the prescriber and other providers and the patient is critical. The communication must be documented and confidential, consistent with SAMHSA confidentiality regulation Title 42 Part 2 of the Code of Federal Regulations (42 CFR Part 2). It is recommended that policies and practices be established for each level of communication to ensure that care is well coordinated and aligned with patient needs.

Not all clinics that provide MOUD are subject to 42 CFR

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[83] American Society of Addiction Medicine (ASAM). "*Clinical Recommendations for COVID-19*." Accessed September 10, 2024. https://www.asam.org/quality-care/clinical-recommendations/covid.

[84] U.S. Department of Justice, Civil Rights Division, "*The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery*," January 2022, accessed [December 18, 2024], https://archive.ada.gov/opioid_guidance.pdf.

[85] U.S. Department of Justice. *Opioid Prescribing: A Guide for Practitioners*. Accessed September 10, 2024. https://archive.ada.gov/opioid_guidance.pdf.

[86] ADA National Network, *ADA, Addiction, and Recovery: Ensuring Nondiscrimination in Government Programs and Services*, accessed [December 18, 2024], https://adata.org/factsheet/ada-addiction-and-recovery-and-government.

Part 2, only those that are federally assisted (accepting Medicare/Medicaid payments) that hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment or referral for treatment.

To learn more about 42 CFR requirements:

- Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule
- Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?
- SAMHSA FAQ about Confidentiality Regulations

Voluntary Non-Opioid Directive

Under direction of Alaska Statute 13.55.010, the Alaska Department of Health (DOH) has developed a Voluntary Non-Opioid Directive (VNOD) form. The VNOD aims to prevent providers from inadvertently offering certain controlled substances to those who could be adversely affected. It also empowers patients to proactively inform their provider that they do not wish to receive opioids for any reason.

DOH encourages patients to complete the VNOD in consultation with their primary care provider or behavioral health treatment provider. A signed VNOD should be given to a health care provider and recorded in the patient's medical record.

The existence of a signed VNOD:

- Does not alter an advance health care directive
- Does not limit the prescribing, dispensing, or administering of an opioid overdose drug
- Does not prohibit offering, prescribing, or administering opioid medications for the purpose of medications for addiction treatment, as approved by the FDA

SECTION II:
Clinical Considerations

Chapter 5: Screening, Assessment, and SBIRT

When meeting with a patient, it is essential to determine the presence and severity of a substance use disorder (SUD). After a diagnosis is determined through an assessment, a course of treatment is developed based on the patient's individual needs in collaboration with the provider's clinical expertise. If the patient has co-occurring disorders and/or comorbid medical conditions, referrals to psychosocial and/or medical services are recommended. While in treatment, the provider and patient continually assess treatment progress and adjustments to pharmacotherapy as indicated. The majority of this section is based on SAMHSA's TIP 63: Medications for Opioid Use Disorder and on the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.

Overview of Screen, Assess, Treatment/Referral

Screen

- Use validated screening tools to screen for alcohol, tobacco, and substance misuse (including opioids)
- If individual screens positive for risk of harm from substance use, then assess

Assess

- Determination of SUD diagnosis and severity, including intoxication or withdrawal
- Include patient medical, social, psychiatric, SUD and family histories
- Laboratory and drug testing if available
- Query the Prescription Drug Monitoring Program (PDMP)

Treatment/Referral

- Determine treatment plan
- Offer or refer for psychosocial treatment based on individual need

Screening

DEFINITION

"Screening entails asking patients brief questions (or a single question) about substance use and can quickly identify patients with potentially unhealthy substance use. Many of these patients will not have substance use-related clinical signs or symptoms [Saitz(b), et al. 2014; Gordon, et al. 2013[87]

Screening is the first step to identifying if an individual may be at risk for opioid misuse, dependence, and/or substance use disorder. The following are benefits to screening:

- Identifies potential substances an individual might be receiving to consider contraindications with prescriptions
- If prescribing opioids for pain management, it can act as a preventative measure to supporting an individual who may be at risk of opioid misuse, dependence, or SUD
- Takes only a few minutes
- Reimbursed by Medicaid, Medicare, and most private insurers
- It's required when conducting a Medicare Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit
- Federal agencies recommend it: U.S. Preventive Services Task Force recommends screening adults ages 18 years and older for unhealthy drug use.[88] SAMHSA recommends that health care professionals screen patients for alcohol, tobacco, prescription drug, and illicit drug use at least annually.
- The screening tool of choice can be integrated into existing clinical workflows in a variety of settings, per preference of provider and specialty. Screening can be incorporated into existing clinical procedures to support staff to administration of the screening.

Identifying a screening tool to incorporate into your clinical practice depends on several factors including:

- preference for an oral, verbal, or written tool
- type of substance being screened for
- self-administered or provider administered
- adolescent and/or adult appropriate
- sensitivity and specificity of the screening tool;

[87] Jennifer McNeely, Lisa K. Hamilton, S. Darius Whitley, et al., Substance Use Screening, Risk Assessment, and Use Disorder Diagnosis in Adults (Baltimore, MD: Johns Hopkins University, May 2024), accessed [December 18, 2024],

[88] U.S. Preventive Services Task Force. "*USPSTF A and B Recommendations*." Accessed September 10, 2024. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations#:~:text=The%20USPSTF%20recommends%20screening%20by,can%20be%20offered%20or%20referred.

- ease of administration
- cost
- patient acceptance

Here are examples of evidence-based screening tools available for use in practice:

- AUDIT-C (for alcohol use disorder)
- Tobacco, Alcohol, Prescription Medication and Other Substance Use (TAPS)
- Opioid Risk Tool (ORT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

In many cases, the practitioner may not have sufficient time to conduct a comprehensive assessment. In these cases, the provider can conduct the validated, public health intervention of SBIRT. SBIRT is an evidence-based intervention to identify risk of SUD using the screening tools discussed above. SBIRT also includes a brief intervention and referral to treatment piece. [89]

A screened individual may not have a substance use disorder but may have unhealthy substance use patterns. In this case, referral to treatment may not be needed but a brief intervention is needed. A brief intervention is a short (five to ten minute) discussion with the patient, using motivational interviewing skills, to work with the patient on meeting them where they're at and identifying possible ways to address the substance use.

If after conducting an assessment, the individual is determined to possibly have a SUD then referral to treatment is indicated. Referral to treatment then can occur to a particular level of treatment or to a certified professional for specific level of care treatment to use. Getting someone into a specific level of treatment should not be a barrier to initiating a treatment plan for medications for opioid use disorder (MOUD) and MOUD itself. **Starting pharmacotherapy should not be delayed.**

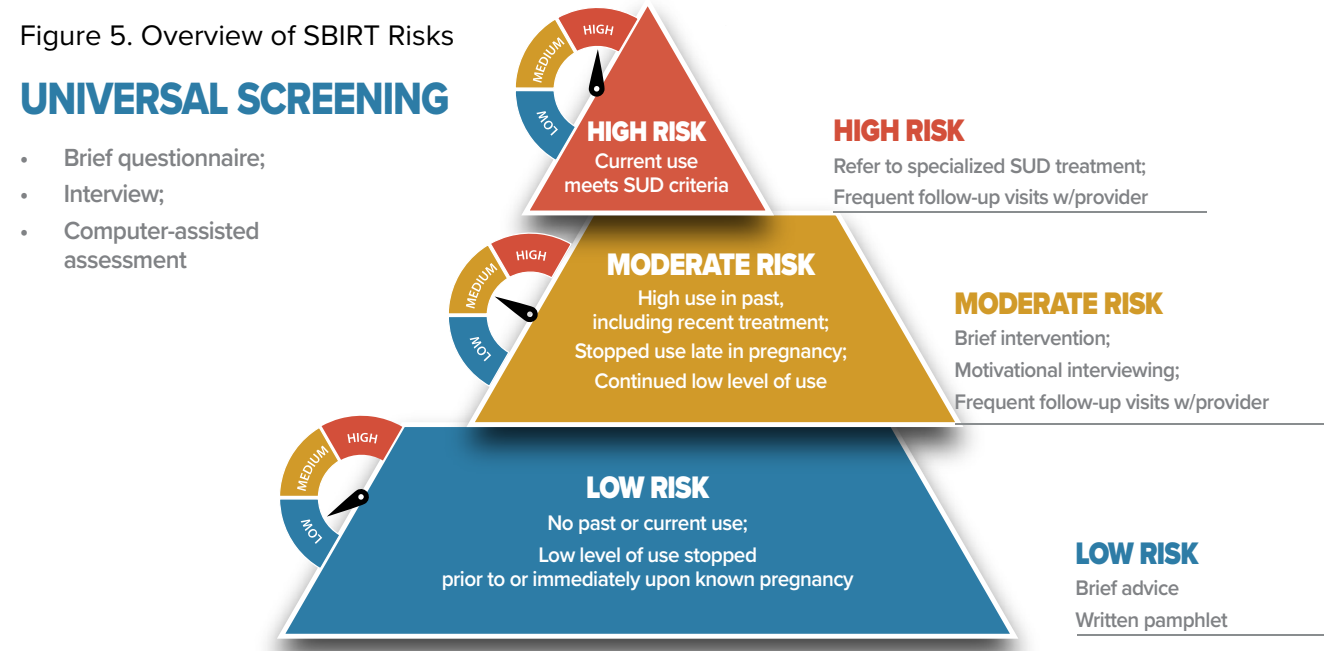
Resources

- PCSS course for screening, assessment and treatment initiation for SUD
- SAMHSA's Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment

Screening can identify substance misuse or indicate a possible substance use disorder.

- For substance misuse with low risk of harm:
  - Brief counseling and monitoring/follow up may be indicated.
- For a possible SUD:
  - Conduct an assessment to determine if the patient meets criteria for an SUD.
  - Brief counseling/treatment referral and consideration for pharmacotherapy may be indicated.

Figure 5. Overview of SBIRT Risks



[89] Substance Abuse and Mental Health Services Administration (SAMHSA). "*SBIRT: Screening, Brief Intervention, and Referral to Treatment*." Accessed September 10, 2024. https://www.samhsa.gov/sbirt.

Assessment

DEFINITION

"Assessment: An ongoing process used to determine the medical, psychological, and social needs of individuals with substance- related conditions and problems. It can take the form of biological assays (e.g., blood or urine samples), as well as clinical diagnostic interviewing and the completion of self-report measures to determine the presence of a SUD or other mental health condition, and other symptoms and challenges with the ultimate goal of developing a fully informed and helpful treatment and recovery plan."[90]

Depending on the capacity of the provider who conducts the screening, an individual can be referred for an assessment and/or the assessment can be conducted by the provider. An assessment is conducted if any of these conditions are present:

- Patient screens positive for substance misuse
- Patient discloses substance misuse
- Signs and symptoms of substance misuse are present
- Patient asks for an assessment or for treatment[91].

A comprehensive assessment includes:

- Determination of SUD diagnosis and severity
- Obtaining the patient's medical history
- Obtaining a substance use history
    - Identification of co-occurring mental health disorders
    - Identification of medications that may affect treatment
    - Identification of psychosocial issues.
- Physical examination
- Laboratory and drug testing.
- Querying the Prescription Drug Monitoring Program (PDMP)

IMPORTANT NOTE:

Completion of a comprehensive assessment should not delay or preclude initiating pharmacotherapy for opioid use disorder (OUD). The benefits of initiating pharmacotherapy in decreasing morbidity and mortality are indications to start an appropriate medication for substance use disorder in coordination with the patient as soon as possible, even if an assessment is pending or not yet completed.

Determination of Opioid Use Disorder Diagnosis and Severity

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-V) uses eleven criteria to determine substance use disorders. At least two of these criteria should be observed within a twelve-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use
8. Recurrent opioid use in situations in which it is physically hazardous
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
10. Exhibits tolerance*
11. Exhibits withdrawal*[92]

[90] Addiction Recovery. "*Addiction-Ary.*" Accessed September 10, 2024. https://www.recoveryanswers.org/addiction-ary/.

[91] Substance Abuse and Mental Health Services Administration (SAMHSA). *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Rockville, MD: SAMHSA, 2009. Treatment Improvement Protocol (TIP) Series, No. 51. 4 Screening and Assessment. Accessed September 10, 2024. https://www.ncbi.nlm.nih.gov/books/NBK83253/.

[92] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5).* Arlington, VA: American Psychiatric Publishing, 2013.

IMPORTANT NOTE:
The diagnostic criterion is NOT considered to be met for those individuals taking opioids solely as prescribed under appropriate medical supervision

The severity of OUD diagnosis is based on how many of these criteria are met:

Mild OUD: 2 to 3 criteria are met

Moderate OUD: 4 to 5 criteria are met

Severe OUD: 6 to 11 criteria are met

OUD diagnosis is primarily based on patient history. Validated clinical scales to measure withdrawal symptoms and drug testing may also be utilized. The provider must confirm the OUD diagnosis before pharmacotherapy starts.[93] The use of cannabis, stimulants, sedatives, alcohol and/or other addictive drugs should not be a reason to withhold or suspend MOUD. [94]

Withdrawal Signs and Symptoms

A patient experiencing severe withdrawal symptoms may be unable to participate to complete the comprehensive assessment process. To manage and treat withdrawal symptoms for OUD or alcohol use disorder (AUD), the patient may require administration of buprenorphine or methadone for opioid withdrawal symptoms[95][96] and/or treatment of alcohol withdrawal. See Section III for more information on withdrawal management.[97] Alcohol withdrawal syndrome can be severe and potentially fatal, so it is particularly important to assess the need for medically managed withdrawal. Patients who need medically supervised withdrawal management may need to be referred to a SUD specialist or addiction treatment program that can provide that service.

Table 3. Withdrawal Management Levels of Care

LEVEL	Withdrawal Management- Adults	Description
1-WM	**Ambulatory Withdrawal Management W/P Extended On-Site Monitoring**	Mild withdrawal with daily or less than daily OP supervision; likely to complete withdrawal management and to continue treatment or recovery
2-WM	**Abulatory Withdrawal Management with Extended On-Site Monitoring**	Moderate withdrawal with all withdrawal management support and supervision; at night, has supportive family or living situation, likely to complete withdrawal management
3.2-WM	**Clinical Managed Residential Withdrawal Management**	Moderate withdrawal, but each 24 hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery
3.7-WM	**Medically Monitored Inpatient Withdrawal Management**	Severe withdrawal and needs 24 hour nursing care and physician visits as necessary, unlikely to complete withdrawal management without medical, nursing monitoring
4-WM	**Medically Managed Intensive Inpatient Withdrawal Management**	Severe, unstable withdrawal and needs 24 hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical stability

- Use medically accruate, person-first non-stigmatizing language
- Be aware of one's own anxieties, feelings and non-verbal communication.

[93] American Society of Addiction Medicine.*The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*. www.asam.org/Quality-Science/quality/2020-national-practice-guideline. Published March 2020

[94] ASAM National Practice Guide

[95] Gowing, Linda, Reza Ali, Jason M. White, and Dickson Mbewe. "*Buprenorphine for Managing Opioid Withdrawal*." The Cochrane Database of Systematic Reviews 2, no. 2 (2017): CD002025. https://doi.org/10.1002/14651858.CD002025.pub5.

[96] World Health Organization. *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings. Geneva: World Health Organization, 2009. 4, Withdrawal Management*. Accessed September 10, 2024. https://www.ncbi.nlm.nih.gov/books/NBK310652/.

[97] U.S. Substance Abuse and Mental Health Services Administration. *Detoxification and Substance Abuse Treatment (Treatment Improvement Protocol Series, No. 45.)* https://library.samhsa.gov/product/tip-45-detoxification-and-substance-abuse-treatment/sma15-4131. Published October2015. Accessed January 5,2021.

- Convey warmth and care for a patient's well-being.
- Ask permission to discuss sensitative topics.
- Reflect on treatment progress thoughtfully, using language that demonstrates respect.
- Use open-ended questions.
- Engage with the patient as a partner in treatment planning.

Patient History

Collecting a patient history is arguably the most important part of the assessment. The history includes:

- Medical history, including sequela of substance use such as injection related infections, such as endocarditis and hepatitis
- Mental health history
- Substance use history, including type, route, quantity, frequency and treatment history
- Social history, including family and psychosocial supports, children, living situation, employment, transportation, criminal justice or child welfare involvement, and assessment of available recovery resources ("recovery capital")
- Preventative health screening history, including general health screening, immunizations, and screening for infections such as Hepatitis, HIV, Hepatitis C, sexually transmitted infections, and others as indicated
- Gynecological history, including need for contraception

An intake questionnaire can assist with collecting social information and intake history and physical templates can assist providers with their documentation.

Physical Examination

The initial examination can be focused on signs and symptoms of substance use and related conditions, with follow up comprehensive exam after patient has been stabilized.

- Infectious diseases (tuberculosis, hepatitis B and C, HIV)
- Pregnancy
- Signs and symptoms of SUD withdrawal or intoxication
- Any acute trauma
- Any medical consequences of misuse (track marks, skin infections and wounds, heart murmurs, dental disease)

Laboratory Testing

If possible, pregnancy and drug urine tests should be performed before starting pharmacotherapy. Additional lab testing may be collected in the following few weeks of initiation and stabilization. Depending on the results of these tests, follow up may be required. **Pharmacotherapy should not be delayed pending test results, or if laboratory testing is not accessible**

Chapter 6: Initiating Medications for Opioid Use Disorder and Providing Stabilizing Care

Providers should review data, such as the Prescription Drug Monitoring Program (PDMP), prior to prescribing, administering, and directly dispensing scheduled medications to evaluate for the co-prescribing of other medications (such as benzodiazepines) that may interact with treatment so that patients can be properly counseled regarding risk.

The Medications for Opioid Use Disorder Treatment Plan

Following screening and assessment, a treatment plan for use of medications for opioid use disorder (MOUD) can be developed in conjunction with the goals and wishes of the patient. Providers should consider the patient's preferences and experience when deciding which medication to prescribe, including preference for medications, past treatment history, current state of health and comorbidities, and treatment setting.[98] See Section III for more information. Discussing the risks, benefits, and accessibility of each medication can assist in determining the most appropriate course of treatment. Informing the patient of what to expect in treatment is also important. A MOUD treatment plan or agreement can be a helpful tool to document and clarify treatment expectations and promote treatment engagement. The plan can identify the length and frequency of office visits, the length of time between prescriptions or injections, the frequency of drug testing, and recommended psychosocial/medical treatment and referrals. [99]MOUD treatment plans should be reviewed and amended with the patients periodically as patients progress, face challenges, and new goals emerge.

A treatment plan is educational and informational, promotes treatment engagement and identifies:

- Treatment goals
- Conditions for changing or stopping treatment.
- Therapeutic contingencies for non-adherence and failure to meet initial goals
- Expectations

Treating the whole person will improve the likelihood of substance use disorder (SUD) recovery and remission. Integrated medical and behavioral health care delivery can effectively provide patient-focused, comprehensive treatments that address the full range of symptoms and service needs that patients with opioid use disorder (OUD) frequently have.[100] Ideally, treatment comprises a comprehensive approach to directly address co-occurring mental health disorders and/or comorbid medical concerns. If the provider refers the patient to outside mental health and/or SUD treatment, the following are suggested:

- Establish strong working relationships or formal agreements with providers offering different levels of care and recovery support services
- Review psychosocial treatment options with the patient.
- Obtain signed releases of information from the patient for open communication
- Routinely provide and obtain updates from the other providers to consistently monitor treatment progress and help coordinate care

See Section III for more information.

Because OUD is often a chronic and relapsing illness, patients may have different types and durations of treatment over their lifetime.

Referral to psychosocial services and SUD treatment are covered in more detail in Psychosocial Treatment and Recovery Support Services in chapter 7 and 8. For more information about SUD treatment services in Alaska, the appendix has a resource page on Finding SUD Treatment in Alaska.

Monitoring Treatment Progress

Per the American Society of Addiction Medicine (ASAM) "National Practice Guideline for the Treatment of Opioid Use Disorder", there is no recommended time limit for pharmacological treatment. The best results occur when a patient receives medication for as long as it provides a benefit. This approach is called "maintenance

[98] American Society of Addiction Medicine (ASAM). *National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update.* Chevy Chase, MD: American Society of Addiction Medicine, 2020

[99] U.S. Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder (Treatment Improvement Protocol Series, No. 63).* Published June 1, 2019. Accessed September 12, 2024. https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002

[100] Chou R, Korthuis PT, Weimer M, et al. *Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings*. Rockville (MD): Agency for Healthcare Research and Quality(US);2016 Dec. (Technical Briefs, No.28.) https://www.ncbi.nlm.nih.gov/books/NBK402352/

treatment", similar to chronic treatment of diabetes or hypertension.[101][102]

Office visit frequency should not depend solely on dosing schedule for medications. It is recommended that patients be seen approximately once a week until they demonstrate significant reductions in or abstinence from illicit substance use. After a patient regularly demonstrates treatment adherence to therapeutic doses of MOUD and decreases in substance use, the provider can consider less frequent visits. As visits become less frequent, the provider can consider implementing random drug testing, medication counts, and involvement of additional recovery supports if available, and if indicated. [103]

When in maintenance treatment, the provider:

- Assesses medication effectiveness and side effects
- Assesses severity and frequency of drug cravings and investigates their triggers
- Assesses medication adherence, which may include drug testing, medication counts and checking the PDMP
- Assesses functional status (home, work, school).
- Discusses use of alcohol, prescriptions (including benzodiazepines), and illicit substances
- Provides brief supportive counseling/motivational interviewing
- Refers/follows up on recovery support services
- Refers/follows up on mental health disorder, substance use disorder and medical treatment
- Adjusts the frequency of visits based on individual need.
- Engages and educates family members with patient's permission

Consider offering laboratory testing as indicated, including:

- Liver function tests
- Complete blood counts
- Bloodborne Infectious disease (tuberculosis, hepatitis B and C, HIV) and offering hepatitis A/B vaccines as needed
- Sexually transmitted diseases (syphilis, GC/chlamydia)
- Pregnancy test

Talking to Patients about Medications for Opioid Use Disorder

Decreasing substance use disorder stigma begins with the medical profession. Many patients seek treatment through their primary care providers, who have an ethical and professional duty to create opportunities to educate and guide patients about MOUD and the chronic medical disease of SUD. Although sometimes these discussions may be challenging, they are critical to assisting a patient and to supporting them to start (or continue) their recovery journey. Below are some suggestions from the Provider Clinical Support System (PCSS) on how to approach talking to patients about MOUD.

Addressing common myths and misconceptions about MOUD can assist with motivating patients to engage in treatment and staying on their medications. This factsheet from PCSS discusses common patient concerns.

Family members often have questions about medications for SUD treatment and want to know how to support their loved one in recovery. Family members may also want some support and resources for themselves while their loved one is in treatment. Below are links for resources for families.

- MAT Handouts for Patients and Family Members
- Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends
- Recovery Research Institute's Guide for Family Members
- SAMHSA's Decisions in Recovery: Treatment for Opioid Use Disorder
- ASAM's Opioid Addiction Treatment: A Guide for Patients, Families and Friends
- Community Reinforcement and Family Therapy (CRAFT)

Family members can and should be, with the permission of the patient, included in the treatment process. For example, with the patient's consent, providers can invite family members to office visits to discuss strategies to support patients. Also, providers can engage and educate family members who are reluctant to accept the role of medications in treatment. For a short overview about family involvement, watch "Addiction Impacts the Entire Family: Pearls for Providers".

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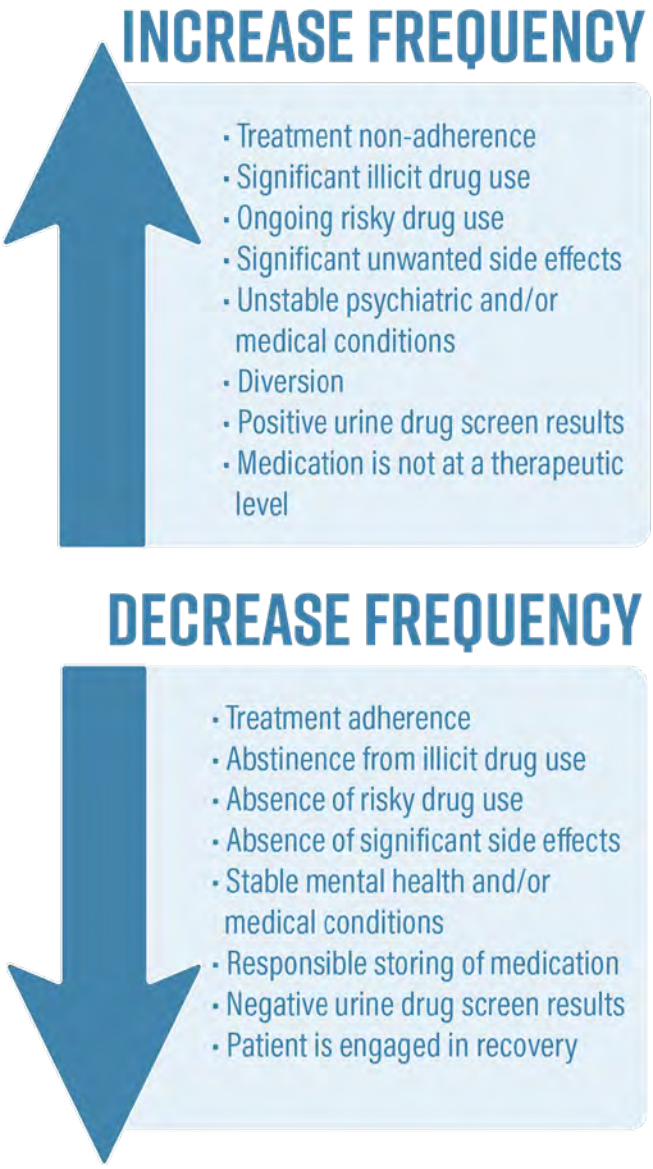
[101] Mattick, Richard P., Caitlin Breen, Joanne Kimber, and Marina Davoli. "*Methadone Maintenance Therapy versus No Opioid Replacement Therapy for Opioid Dependence.*" Cochrane Database of Systematic Reviews, no. 3 (2009): 1–19. https://doi.org/10.1002/14651858.CD002209.pub2.

[102] Mattick, Richard P., Caitlin Breen, Joanne Kimber, and Marina Davoli. "*Buprenorphine Maintenance versus Placebo or Methadone Maintenance for Opioid Dependence.*" Cochrane Database of Systematic Reviews, no. 2 (2014): 1–84. https://doi.org/10.1002/14651858.CD002207.pub4.

[103] Substance Abuse and Mental Health Services Administration (SAMHSA). *TIP 63: Medications for Opioid Use Disorder.* PEP21-02-01-002, July 2021. https://store.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002.

Figure 6. Typical Indicators of Decreasing or Increasing Frequency of Office Visits



Monitoring Progress Indicator

The chart illustrates typical indicators to increase or decrease the frequency of office visits.

Before increasing the frequency of office visits with a patient due to substance use or other concerning behaviors, it is important to have an open and nonjudgemental conversation with the patient to explore the underlying reasons they may be engaging in a behavior. For example, a patient may miss appointments due to a transportation or childcare issues. This is very different than a patient missing appointments because they are experiencing a return to opioid use due to uncontrolled pain or because they have been using substances illicitly and are afraid of legal ramifications. Having an open and honest discussion to discover a patient's motivation for treatment nonadherence or illicit substance use can increase the likelihood for patient re-engagement.

In addition to increasing the frequency of office visits with a patient, the provider may employ other strategies to support treatment engagement and medication adherence in a patient who is struggling:

- Adjust medication dosage for best therapeutic effect
- Switch to extended-release injectable medication
- Shorten prescriptions if patients are having difficulty with managing their medication
- Longer prescriptions may help address transportation barriers
- Increased drug testing and medication counts may help some patients with accountability (consider offering remote monitoring options)
- Increase recovery support service.
- Increase family/primary support involvement
- Refer patient to a more intensive level of care
- Initiate contingency management

Offer harm reduction services and low-threshold care to patients who continue to use drugs. See Harm Reduction Chapter. Pregnancy, surgery, and increase in life stressors are all examples of events that may indicate the need for increased support and medication adjustment. Providers should be sensitive to these life issues by discussing them with their patients.

Medications for Opioid Use Disorder Discontinuation

A patient may request to stop pharmacotherapy for many reasons, and it is essential that providers discuss the risks and benefits of discontinuing treatment. Providers should work to counsel patients AGAINST discontinuation of MOUD during the following high-risk situations:

- Abstinent from illicit substance use less than a year
- Taking pharmacotherapy less than a year
- During pregnancy or first year postpartum
- Pending incarceration
- During times of high stress
- During surgery/hospitalization
- Due to pressure from family and/or friends

The provider should especially work to discourage patients that have been on MOUD less than a year from discontinuing treatment because of high rates of return to illicit opioid use (>90% return to use within the year) and increased chance of overdose death.[104] If the patient is unstable, consider offering another form of MOUD as an alternative prior to discontinuing pharmacotherapy altogether. If the patient still wishes to discontinue pharmacotherapy for OUD:

- Taper the medication as appropriate
- Encourage the patient to attend psychosocial treatment and recovery support services
- Give information about overdose prevention
- Prescribe naloxone

Providers are encouraged to 'keep the door open' if the patient changes their mind and decides to restart pharmacotherapy in the future. See Section III, Chapter 11, for information on tapering and discontinuation strategies.

[104] Gibson, Amy, Louisa Degenhardt, Richard P. Mattick, Riaz Ali, Jennifer White, and Shane O'Brien. "*Exposure to Opioid Maintenance Treatment Reduces Long-Term Mortality.*" Addiction 103, no. 3 (2008): 462–68. https://doi.org/10.1111/j.1360-0443.2007.02090.x.

Chapter 7: Psychosocial Treatment and Determining the Appropriate Level of Care

The use of Medications for opioid use disorder without behavioral health intervention results in reduced mortality and opioid-related morbidity[105]

Most reviews of the evidence have shown that the addition of behavioral health supports have little impact on opioid abstinence or retention in treatment.[106] However, often, the person receiving medication for opioid use disorder (OUD) may desire additional services to support their physical, mental, and emotional health. Research is nuanced when it comes to counseling supports when receiving medications for OUD. When looking at 12-month retention with receiving MOUD, for those receiving methadone, there is higher 12-month retention in a contingency management take-home condition dosing (74%) than in a daily supervision of dosing (58%).[107] Concurrent therapy services may help to address premature buprenorphine discontinuation, particularly for patients with high-risk clinical profile.[108] Studies remain mixed on the effects of peer support on recovery for patients with OUD though seem promising for MOUD initiation and opioid abstinence.[109] A few studies have suggested that for patients experiencing homelessness and PTSD, counseling appointments were positively associated with retention at three months.[110] One study showed that twelve-step programs may be beneficial for patients taking MOUD.[111]; [112] Therefore, addressing the desire to use wraparound services can be key to supporting the individual struggling with opioid use disorder.

Based on the American Society of Addiction Medicine's (ASAM) Six Dimension Criteria, a clinician and client work together to determine what level of care may be most appropriate for them. The goal is to place patients in the least intensive and restrictive care that meets the patient's multi-dimensional needs and affords optimal treatment outcome. There is evidence of poorer treatment outcome if level of care intensity is either too high or too low.

American Society of Addiction Medicine (ASAM) Criteria for Assessment

The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with substance use disorder (SUD) and co-occurring conditions. Required in over 30 states for Medicaid coverage of certain SUD treatment services, including Alaska, the ASAM Criteria provides a nomenclature for describing the continuum of substance use disorder services. In November 2023, ASAM published a 4th edition, that altered many aspects of the previous edition. It is estimated that it may take up to three years for State of Alaska and insurance companies to reflect

[105] Wakeman, Sarah E., Marc R. Larochelle, Omid Ameli, et al. "*Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder.*" JAMA Network Open 3, no. 2 (2020): e1920622. https://doi.org/10.1001/jamanetworkopen.2019.20622.

[106] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher, Michelle, and Alan I. Leshner, eds. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: National Academies Press (US), March 30, 2019. https://www.ncbi.nlm.nih.gov/books/NBK541393/.

[107] Chan, Bonnie, Erin Gean, Irina Arkhipova-Jenkins, Jessica Gilbert, Joanna Hilgart, Chris Fiordalisi, Kate Hubbard, Isabel Brandt, Elizabeth Stoeger, Roberta Paynter, Paul T. Korthuis, and Jeanne M. Guise. "Retention Strategies for Medications for Opioid Use Disorder in Adults: A Rapid Evidence Review." Journal of Addiction Medicine 15, no. 1 (2021): 74–84.

[108] Samples, Hillary, Arthur Robin Williams, Stephen Crystal, and Mark Olfson. "*Psychosocial and Behavioral Therapy in Conjunction with Medication for Opioid Use Disorder: Patterns, Predictors, and Association with Buprenorphine Treatment Outcomes*." Journal of Substance Abuse Treatment 139 (2022): 108774. https://doi.org/10.1016/j.jsat.2022.108774.

[109] Gormley, Mirinda Ann, Irene Pericot-Valverde, Liam Diaz, Ashley Coleman, Jonathan Lancaster, Erik Ortiz, Phillip Moschella, Moonseong Heo, and Alain H. Litwin. "*Effectiveness of Peer Recovery Support Services on Stages of the Opioid Use Disorder Treatment Cascade: A Systematic Review.*" Drug and Alcohol Dependence 229, Part B (2021): 109123. https://doi.org/10.1016/j.drugalcdep.2021.109123.

[110] Berry, Alexandra R. W., Teresa L. Finlayson, Lisa M. Mellis, and Lianne A. Urada. "*Association between Participation in Counseling and Retention in a Buprenorphine-Assisted Treatment Program for People Experiencing Homelessness with Opioid Use Disorder.*" International Journal of Environmental Research and Public Health 18, no. 21 (2021): 11072. https://doi.org/10.3390/ijerph182111072.

[111] Hefner, Kathryn, Tsz Hui Choo, Dafna Shmueli-Blumberg, Martina Pavlicova, Joseph King, Marc Fishman, Michael Shulman, Allison Campbell, Melinda Greiner, Joshua Scodes, Sara Meyers-Ohki, Peter Novo, Edward Nunes, and Jeffrey Rotrosen. "*Time-Lagged Association between Counseling and/or 12-Step Attendance with Subsequent Opioid Use in a Secondary Analysis from a Randomized, Clinical Trial of Medications for Opioid Use Disorder.*" Drug and Alcohol Dependence Reports 5 (2022): 100100. https://doi.org/10.1016/j.dadr.2022.100100.

[112] Harvey, Laura M., Weihua Fan, Miguel Ángel Cano, Ellen L. Vaughan, Consuelo Arbona, Saman Essa, Helen Sanchez, and Marcel A. de Dios. "*Psychosocial Intervention Utilization and Substance Abuse Treatment Outcomes in a Multisite Sample of Individuals Who Use Opioids.*" Journal of Substance Abuse Treatment 112 (2020): 68-75. https://doi.org/10.1016/j.jsat.2020.01.016.

this updated edition in addition to the workforce being trained in this edition. However, the following reflects the 4th Edition updates.

Reasons to use the ASAM Criteria:

- It is the universal standard used by insurance companies to categorize care types and determine coverage
- It uses a holistic approach to determine individualized and outcome-driven treatment plans for patients
- It covers a service spectrum from assessment through treatment
- It provides one common language for assessing patient needs[113]

The ASAM Criteria's multidimensional assessment

accounts for a patient's needs, obstacles, and liabilities, as well as their strengths, assets, resources, and support structure.

This information is used to determine the appropriate level of care across a continuum. A qualified addiction professional (typically a licensed behavioral health clinician or certified chemical dependency counselor) will complete a SUD assessment using the ASAM Criteria. Access a free fillable assessment form based on the 4th edition.

The Six American Society of Addiction Medicine Dimensions

The ASAM explores six different dimensions to create an all- inclusive and comprehensive assessment used for service planning and treatment.

- **Dimension 1** – Intoxication, Withdrawal, and Addiction Medications
- **Dimension 2** – Biomedical Conditions
- **Dimension 3** – Psychiatric and Cognitive Conditions
- **Dimension 4** – Substance Use-Related Risks
- **Dimension 5** – Recovery Environment Interactions
- **Dimension 6** – Person-Centered Considerations

Levels of Care

- ASAM Levels of Care reflect a continuum of clinical SUD treatment services, increasing in intensity from Level 1 to Level 4. Each level of care refers to a broad category of services and treatment formats offered to clients that include outpatient, residential, and hospital services. A description of the 4th Edition Levels of Care can be found on ASAM's website.
- Alaska Behavioral Health Medicaid Program's Levels of Care are defined in the Alaska Behavioral Health Provider Service Standards and Administrative Procedures for SUD Provider Services and parallel the levels of care described in the 3rd Edition:

Level 0.5:	Early Intervention
Level 1:	Outpatient
Level 2:	Intensive Outpatient Treatment/Partial Hospitalization
Level 3:	Residential/Inpatient Treatment
Level 4:	Medically Managed Intensive Inpatient Treatment

See ASAM Criteria Continuum of Care on the following page.

Psychosocial Treatment

Psychosocial treatment encompasses non-pharmacological treatments, or "talk therapies," found in counseling and psychotherapy. Psychosocial treatment can be offered to an individual, to a group, and/or to a family. This can be done in either an outpatient setting or within a residential treatment setting. These types of treatments:

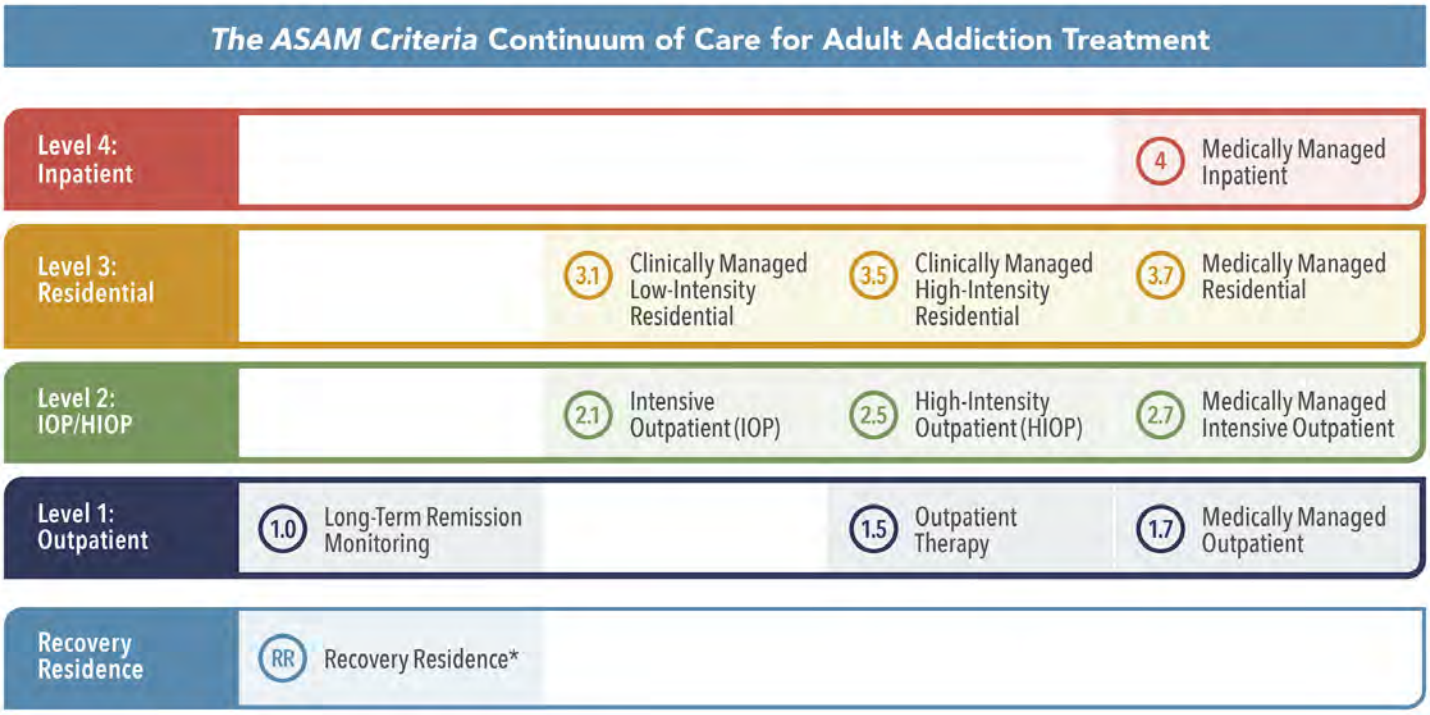
- Help people attain and maintain motivation to change addictive behaviors (e.g., motivational interviewing, motivational enhancement therapy, contingency management)
- Teach skills to help prevent recurrence of substance use (e.g., CBT)
- Link patients to community-based resources to help sustain remission and enhance recovery over time (e.g., Twelve-Step Facilitation)
- Can also involve significant others such as a significant other (e.g., behavioral couple's therapy) or one or more family members (e.g., family therapy) in an attempt to help attain and sustain remission from a substance use disorder

Cognitive behavioral therapy

Cognitive behavioral therapy (CBT) is one of the more commonly used therapy approaches for OUD. CBT focuses on recognizing negative behaviors, teaching individuals how to break patterns, cope with stressful situations, and change thinking. The Association for Behavioral and Cognitive Therapies highlights a number of specific ways

[113] American Society of Addiction Medicine. "*About the ASAM Criteria*." Accessed September 14, 2024. https://www.asam.org/asam-criteria/about-the-asam-criteria.

Figure 7. ASAM Criteria Continuum of Care for Adult Addiction Treatment



CBT might be used to address OUD, including:

- Identifying triggers for substance use
- Managing those triggers by increasing coping and problem-solving skills
- Working to identify low-risk alternatives to substance use and avoid high-risk situations

CBT can be particularly helpful in managing issues that frequently co-occur with OUD, such as chronic pain or depression.[114] Additionally, although CBT is frequently used as an individual therapy approach, it can be used in group therapy as well.

Motivational Interviewing

When patients are faced with a major life change, a normal response is to be ambivalent about the change. Motivational Interviewing is an evidence-based approach to behavior change that works well in a clinical setting. The approach has shown good applicability to individuals from a variety of cultural backgrounds and is recognized as a behavioral counseling treatment modality. It is not a counseling technique, but a way to structure conversations to engage the patient. By using motivational interviewing, the patient makes their own argument to change the behavior through weighing the advantages of the change over the disadvantages of not changing. The provider uses open-ended questions and reflective listening as a way to guide the patient through the change process and to fortify the patient's thinking towards making positive change.

The Provider's Clinical Support System has several resources to help providers become proficient at motivational interviewing, including a thirty-minute podcast, Addressing Patient Resistance to Medication-Assisted Treatment. This podcast discusses the importance of directly addressing ambivalence and offers suggestions on how to enhance treatment motivation.

The Northwest Addiction Technology Transfer Center (NW ATTC) also has free MI training courses online

Group Visits

A group visit integrates psychosocial treatment with the medical office visit. A group visit involves the provider and often a behavioral health counselor or peer support co-facilitating a group with a brief individual medical check-in preceding, during or following the group. These visits can offer mutual support to the patients as well as facilitated

[114] Sanabria-Mazo, J. P., A. Colomer-Carbonell, Ó. Fernández-Vázquez, G. Noboa-Rocamora, G. Cardona-Ros, L. M. McCracken, A. Montes-Pérez, J. R. Castaño-Asins, S. Edo, X. Borràs, A. Sanz, A. Feliu-Soler, and J. V. Luciano. "*A Systematic Review of Cognitive Behavioral Therapy-Based Interventions for Comorbid Chronic Pain and Clinically Relevant Psychological Distress.*" Frontiers in Psychology 14 (2023): 1200685. https://doi.org/10.3389/fpsyg.2023.1200685.

therapeutic discussions and education. They may also allow the provider to consolidate their appointment schedule and provide treatment services with more time efficiency. For more information about group visits, Care Innovations website check the for a section on group visits, and see also Building a Group-Based Opioid Treatment article.

Contingency Management

Research has demonstrated the effectiveness of treatment approaches using contingency management principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence.[115] Research in methadone programs and psychosocial counseling treatments shows that incentive-based interventions are highly effective at boosting treatment retention and encouraging abstinence from substance use[116]. See the section on treatment of stimulant use disorders for more information about contingency management.

Community Reinforcement and Family Training (CRAFT)

CRAFT is a system for helping friends and family members change the way that they interact with someone they love who is drinking or using drugs too much. CRAFT teaches family members how to stay connected, increase communication, and effectively encourage their loved one towards treatment, while taking care of themselves in the process. CRAFT also helps family members improve their own lives, whether their loved one ends up seeking treatment or not. See this resources page for more information on books and online supports for CRAFT.

For Alaska Native beneficiaries CRAFT is currently offered at:

- ANTHC Behavioral Health Wellness Clinic (ANTHC BHWC)
- The Aleutian Pribilof Islands Association (APIA)
- Copper River Native Association (CRNA)
- Eastern Aleutian Tribes (EAT)

See the ANTHC website for more information.

Peer Support Specialists

"Peer workers are nonclinical professionals who have lived experience with problematic substance use, behavior change, and recovery. These professionals deliver a range of recovery supports designed to improve the treatment experience of individuals who have problematic substance use and their ability to continue their chosen recovery pathways before, during, and after treatment. Peer workers fill a range of roles, such as providers of recovery support, educators, engagement facilitators, role models and mentors, resource navigators, and recovery advocates. In fulfilling these roles, peer workers serve not just individuals in or seeking recovery but also their families and the community." SAMHSA TIP 64

If your organization does not employ a peer support specialist (PSS), they should consider partnering with organizations that do employ peers to help support their clients.

Peer Support services are reimbursable under Alaska Medicaid 1115 waiver program. The Alaska Commission on Behavioral Health Certification (ACBHC) was awarded a contract by the Department of Health to develop and maintain a Certificate Program for Alaska Peer Support Staff in April 2020 to support the patient as they make the necessary changes to recover from SUD. Alaska Behavioral Health Peer Specialist Training & Support offers many training opportunities for PSS.

A few of the state grant funded peer support programs include:

- Set Free Alaska
- Central Peninsula General Hospital
- JAMHI Health and Wellness
- Interior Alaska Center for Non-Violent Living
- True North Recovery
- Cook Inlet Tribal Council
- Volunteers of America (VOA)

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[115] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. "*Contingency Management for Substance Use Disorders: A Review of the Literature*." Accessed September 14, 2024. https://aspe.hhs.gov/sites/default/files/documents/72bda5309911c29cd1ba3202c9ee0e03/contingency-management-sub-treatment.pdf.

[116] Griffith, James D., Grace A. Rowan-Szal, Ryan R. Roark, and D. Dwayne Simpson. "*Contingency Management in Outpatient Methadone Treatment: A Meta-Analysis*." Drug and Alcohol Dependence 58, no. 1–2 (2000): 55-66. https://doi.org/10.1016/S0376-8716(99)00068-X.

Peer Support: Offering sober events

Access to affordable recreation and connection to a sober recovery community is something many people in early recovery struggle to find. The recovery Coalition "All Things Recovery" on the southern Kenai Peninsula has utilized grant funding for recovery support to develop a series of free sober events in their community. Kayaking, beach bonfires, ax-throwing and snowshoeing are just a few of the well attended few events the coalition has organized. The grant funding has allowed them to provide free access to these events as well as offering refreshments and transportation assistance. These events give people a chance to make meaningful connections to others in the recovery community and to explore new kinds of recreational activities that can benefit both their physical and mental health.

Chapter 8: Recovery

DEFINITION

Recovery: A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. [117]

Recovery has many components and may mean different things to different people. In general, recovery encompasses increased management of one's physical health, connection into social opportunities that support improved life outcomes, attaining and maintaining satisfying employment, pursuing education opportunities, ensuring sustainable housing, and more. The process takes continual training, help from peers with lived experience and mutual support groups, and living in environments that promote recovery as a whole. Those who are employed may have reduced risk of depression and distress, improved general mental health, and lower psychiatric morbidity[118] People with stable housing have improved general health, mental health, and respiratory health.[119] Finally, people living with stronger social capital may have better physical health[120], quality of relationships, social cohesion, productivity[121], and better trust[122] with those around them. Recovery comes with stability, and MOUD is a first line treatment for this stabilization. The following are examples of activities that can assist an individual with recovery.

Twelve-Step Programs and mutual support groups

Another model to support recovery is a twelve-step approach, such as through Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or Medication-Assisted Recovery Anonymous (MARA). The twelve-step approach may be used alone or in conjunction with other group or individual therapy approaches, providing an additional tool for managing substance use disorders. All twelve-step programs rely on peer support, such as through group meetings and sponsors.

A word of caution on referring patients taking medications for opioid use disorder to twelve-step programs:

More traditional twelve-step recovery approaches (such as NA and AA) focus on complete abstinence, which can sometimes create an unwelcoming environment for individuals who use medication as part of their recovery efforts.

Studies suggest that negative attitudes towards opioid use disorder medications may be enacted in some twelve-step mutual-help groups in the following ways:

- Prohibiting people using MOUD from speaking at meetings
- Encouraging people to shorten the amount of time taking opioid use disorder (OUD) medications
- Describing people utilizing OUD medications as not in recovery
- Refusal to sponsor (that is, act as a recovery mentor for) people utilizing OUD medications, or prohibiting someone from utilizing OUD medications from being a sponsor[123]

To ensure patients are getting the support they need, providers should investigate which local mutual support groups are supportive of MOUD before referring patients. Medication-Assisted Recovery Anonymous (MARA) is a newer approach to the twelve-step program, developed as an alternative program to support people who utilize MOUD that addresses this specific challenge.

[117] U.S. Department of Health and Human Services. "*Recovery from Substance Use Disorder.*" Accessed September 14, 2024. https://www.hhs.gov/opioids/recovery/index.html#:~:text=Recovery%20is%20a%20process%20of,to%20reach%20their%20full%20potential

[118] van der Noordt, M., H. IJzelenberg, M. Droomers, and K. I. Proper. "*Health Effects of Employment: A Systematic Review of Prospective Studies.*" Occupational and Environmental Medicine 71, no. 10 (October 2014): 730-36. https://doi.org/10.1136/oemed-2013-101891. Epub February 20, 2014. PMID: 24556535.

[119] Thomson, H., S. Thomas, E. Sellstrom, and M. Petticrew. "*Housing Improvements for Health and Associated Socio-Economic Outcomes.*" Cochrane Database of Systematic Reviews 2013, no. 2 (February 28, 2013): CD008657. https://doi.org/10.1002/14651858.CD008657.pub2. PMID: 23450585.

[120] Rodgers, J., A. V. Valuev, Y. Hswen, and S. V. Subramanian. "*Social Capital and Physical Health: An Updated Review of the Literature for 2007-2018.*" Social Science & Medicine 236 (2019): 112360. https://doi.org/10.1016/j.socscimed.2019.112360.

[121] Wiley, Megi. "*Social capital and output per worker.*" Capstone project, University of Maryland, Baltimore County, 2020. Accessed September 14, 2024. https://economics.umbc.edu/wp-content/uploads/sites/243/2020/11/Megi-Wiley-Final-Capstone-2.pdf.

[122] Algan, Yann. "*Trust and Social Capital.*" In OECD Guidelines on Measuring Trust, Chapter 10. Paris: OECD, 2018. Accessed September 14, 2024. https://www.yann-algan.com/wp-content/uploads/2020/12/Algan-2018_Ch.-10-Trust-and-Social-Capital_OECD.pdf.

[123] Recovery Research Institute. "*Negative Attitudes Towards Medications for Opioid Use Disorder in 12-Step Groups.*" Accessed September 14, 2024. https://www.recoveryanswers.org/research-post/negative-attitudes-towards-medications-opioid-use-disorder-12-step-groups/.

In The Rooms is a global online community that provides people in recovery a place to meet and socialize when they're not in face-to-face meetings. It is a global online community with over 1,000,000 members who share their strengths and experience with one another daily through substance use disorder recovery groups. Through live meetings, discussion groups and other tools, people from around the world connect with one another and help each other along their recovery journeys.

Alaska Mutual Support Group links (not an exhaustive list)

- Alcoholics Anonymous (AA)
- 12 Step Recovery Groups in Alaska
- Alaska Women's Recovery Project
- Alaska Narcotics Anonymous

Self-Management and Recovery Training

Self-Management and Recovery Training (SMART) Recovery is an evidenced-informed[124] recovery method grounded in Rational Emotive Behavioral Therapy (REBT) and Cognitive Behavioral Therapy (CBT), that supports people with substance dependencies or problem behaviors to:

- Build and maintain motivation
- Cope with urges and cravings
- Manage thoughts, feelings and behaviors
- Live a balanced life

Online SMART recovery meetings can be accessed at their website and through their app.

Recovery Support Centers Recovery-oriented care and recovery support systems help people with mental and substance use disorders manage their conditions successfully[125] The belief that people can overcome their substance use challenges is the foundation of recovery. "Recovery addresses the whole person and their community and is supported by peers, friends and family members" identifies SAMHSA.[126] In recovery-oriented systems of care, the expectation is that contact with the patient will continue after the acute stage of treatment is completed and that recovery support services are extended to family members and to people who may not have remained in treatment.[118] Recovery support services can be accessed at community-based recovery centers or recovery community organizations like Recover Alaska (alcohol).

Alaska Community-Based Recovery Centers (not an exhaustive list)

- The Bridge Fairbanks
- Alaska Mental Health Consumer Web
- Alaska Youth and Family Network
- CHOICES Inc.
- Kachemak Bay Recovery Connection

Faith based Recovery Supports

Numerous faith-based recovery support systems/meetings are made available through various local churches/religious organizations. These may be a consideration for some individuals who feel that their faith plays a major role in their recovery and would like to get recovery support in this manner.

Recovery Residences

Recovery residences are alcohol and illicit substance free living facilities for individuals recovering from alcohol or other use disorders that serves as an interim living environment between withdrawal management experiences, residential substance use disorder (SUD) treatment or incarceration and mainstream society. These are known as sober houses or sober living homes/environments. Alaska currently has four grant funded recovery residence homes located in Fairbanks, Wasilla, Seward, and Kenai. Click on this link to find more information about sober housing in Alaska.

Virtual Recovery Supports

In addition to online mutual support groups as noted above, many SUD self-help apps can be found free of charge from any smartphone or computer.

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[124] Leventhal, Adam M., Matthew G. Kirkpatrick, Jessica L. Anderson, and Matthew W. Dormitzer. "*Incentives for Smoking Cessation in Ethnic Minority Adults: A Randomized Controlled Trial.*" American Psychologist 72, no. 2 (2017): 125-134. https://psycnet.apa.org/buy/2017-05067-001.

[125] Kaplan, L. *The Role of Recovery Support Services in Recovery-Oriented Systems of Care*. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2008.

[126] Substance Abuse and Mental Health Services Administration. "*Recovery and Recovery Support.*" Accessed September 14, 2024. https://www.samhsa.gov/find-help/recovery.

The following is a brief list of a few free digital applications that offer SUD recovery support. These apps are not evaluated for their efficacy by the FDA or by the Department of Health, and we encourage providers to explore each program's content before referring patients to an online source.

I Am Sober
iOS, Android

Sober Grid
iOS, Android

I Am
iOS, Android

SoberWorx
Android

Recovery Today Magazine
iOS, Android

Recovery Box
iOS

Nomo
iOS, Android

SoberTool
iOS, Android

A Big Book Free – For Alcoholics Anonymous
iOS, Android

Insight Timer.

Chapter 9: Drug Testing

Utility and Implications of Drug Testing

Monitors	▸ Abstinence ▸ Response to medication treatment
Detects	▸ Nonadherence ▸ Interaction with other substances
Provides	▸ Information to supplement patient's self-report ▸ Information to improve treatment plan

Drug tests are designed to measure whether a substance has been used within a particular window of time.[127] They are only one of several methods for detecting substance use or monitoring treatment. Drug testing cannot identify the timing, dose, route or frequency of substance use. Drug testing is a therapeutic tool and is not performed as a punitive measure. It is particularly important for identifying potential interactions and contraindications, with medications patients receive. Results can be utilized to enhance treatment motivation, monitor medication adherence, reinforce abstinence, and to discuss discrepancies between self-reported substance use and substances detected during testing.

Although drug testing is a common component of treatment services, evidence is limited that the use of drug testing in substance use disorder (SUD) treatment improves patient outcomes.[128] In fact, recent literature suggests that frequent drug testing may actually create a barrier to treatment retention.[129] Despite guidelines emphasizing patient-oriented care and advising that drug tests should not be used punitively, qualitative evidence demonstrates drug tests may foster distrust, damage the rapport between client and provider, and compromise treatment outcomes.[130] For some patients drug testing and its results can have serious legal implications (in criminal justice, child custody, child welfare cases, and employment issues), so obtaining informed consent for drug testing is always required.[131] Drug testing in pregnant women and parents, and newborns can be particularly fraught with unintended consequences and is discussed further in Section V, Chapter 25. If a patient is apprehensive about providing a sample for testing the provider should explore patient concerns and consider deferring testing if the results will not demonstrably alter treatment decisions. Additionally, providers must be adequately trained in interpreting test result to avoid inappropriate application of testing and results. Rapid urine drug tests have notoriously poor specificity and sensitivity, and studies have shown that most medical providers are not proficient in interpreting the results. [132] [133]

As drug testing is a complicated topic, this guide will highlight key concepts. Providers requiring more detailed information about drug testing refer to The American Society of Addiction Medicine (ASAM) Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document. (These guidelines are currently under revision and a major update is expected in early 2026.)

Testing Types

Urine samples are commonly used for drug testing due to their ease of collection, making them the most widely

[127] McNeil, S. E., R. J. Chen, and M. Cogburn. "*Drug Testing.*" Last updated July 29, 2023. In StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing, January 2024–. https://www.ncbi.nlm.nih.gov/books/NBK459334/.

[128] Patnode, C. D., L. A. Perdue, M. Rushkin, and E. A. O'Connor. "*Screening for Illicit Drug Use, Including Nonmedical Use of Prescription Drugs: An Updated Systematic Review for theU.S. Preventive Services Task Force*." Rockville, MD: Agency for Healthcare Research and Quality (2019).

[129] Guerra-Alejos, B. C., M. Kurz, J. E. Min, L. M. Dale, M. Piske, P. Bach, J. Bruneau, P. Gustafson, X. J. Hu, K. Kampman, P. T. Korthuis, T. Loughin, M. Maclure, R. W. Platt, U. Siebert, M. E. Socías, E. Wood, and B. Nosyk. "*Comparative Effectiveness of Urine Drug Screening Strategies Alongside Opioid Agonist Treatment in British Columbia, Canada: A Population-Based Observational Study Protocol.*" BMJ Open 13, no. 5 (2023): e068729. https://doi.org/10.1136/bmjopen-2022-068729.

[130] Guerra-Alejos, B. C., M. Kurz, J. E. Min, L. M. Dale, M. Piske, P. Bach, J. Bruneau, et al. 2023. "*Comparative Effectiveness of Urine Drug Screening Strategies Alongside Opioid Agonist Treatment in British Columbia, Canada: A Population-Based Observational Study Protocol.*" BMJ Open 13 (5): e068729. https://doi.org/10.1136/bmjopen-2022-068729.

[131] Penney, Stephanie R., Sonya McLaren, and Treena Wilkie. 2020. "*Urine Drug Screening in a Forensic Mental Health Population: Frequency and Clinical Utility in Risk Management.*" The Journal of Forensic Psychiatry & Psychology 32 (4): 431–48. doi:10.1080/14789949.2020.1859590.

[132] Reisfield, G. M., F. J. Webb, R. L. Bertholf, P. A. Sloan, and G. R. Wilson. "*Family Physicians' Proficiency in Urine Drug Test Interpretation.*" Journal of Opioid Management 3, no. 6 (2007): 333–337. https://doi.org/10.5055/jom.2007.0022.

[133] Chua, I., A. K. Petrides, G. D. Schiff, J. R. Ransohoff, M. Kantartjis, J. Streid, C. A. Demetriou, and S. E. F. Melanson. "*Provider Misinterpretation, Documentation, and Follow-Up of Definitive Urine Drug Testing Results.*" Journal of General Internal Medicine 35, no. 1 (2020): 283–290. https://doi.org/10.1007/s11606-019-05514-5.

utilized biological sample. However, alternative testing methods exist, including blood, hair, saliva, sweat, and nail samples. Oral fluid drug tests, while available as confirmatory send-out tests only, offer distinct advantages, especially when a patient cannot provide a urine specimen. Notably, oral fluid tests can be witnessed and collected remotely during telemedicine visits, facilitating convenient testing procedures. Patients may even receive testing supplies at home directly from some laboratories, complete with prepaid mail-back envelopes for hassle-free processing.

Table 4. Approximate Drug Testing Detection Times[134]

Substance	Urine	Saliva
Alcohol	2-5 days (ETG metabolite)	12-24 hours
Amphetamines	1-5 days	12-48 hours
Benzodiazepines (short-term use)	7 days	6-48 hours
Benzodiazepines (chronic use)	4-6 weeks	6-48 Hours
Buprenorphine (daily Sublingual)	1-2 weeks	12-48 hours
Buprenorphine (long-acting injectable)	12+ months	unknown
Cannabis (intermittent use)	2-7 days	2-24 hours
Cannabis (chronic use)	30 days	2-24 hours
Opioids (short acting)	2-4 days	1-3 days
Opioids (long acting)	3-14 days	1-3 days

Actual detection times vary depending on the limit of detection for the test used, which is affected by dose, frequency, and duration of use. The detection time for substances in oral fluid is much shorter than in the urine. In general, hair follicle testing detects most substances used in the past 90 days and tends to be used in legal setting.

Testing Categories

Presumptive (Rapid Screening) Tests

Rapid urine drug screening tests (available both in hospital settings and Clinical Laboratory Improvement Amendments (CLIA)-waived for in-office use) use immune assays to provide simple and rapid positive/negative results.

Presumptive tests are helpful to guide the discussion with a patient in the office and for routine monitoring and assessment. They provide quick results and are very inexpensive; however, they have very high rates of false positives and false negatives.[135]. Table 1 provides examples of some possible causes of a false positive result. When an unexpected positive or negative result is found on a screening test (a result that is inconsistent with the patient report) and the result impacts the treatment plan, then the sample should be sent out for confirmatory (definitive) testing. Avoid making changes in treatment plans without definitive/confirmatory results. Urine samples are shelf stable at room temperature for up to a month for drug testing purposes, so samples collected when the provider is not available for immediate interpretation should be kept, rather than disposed of, so that they can be sent out for confirmatory testing later, if indicated after review.

Table 5. Prescription drugs, over-the-counter products, and foods that could trigger a false-positive result in urine immunoassays[136]

Amphetamines	Amantadine, brompheniramine, bupropion, chlorpromazine, desipramine, ephedrine, labetalol, phentermine, phenylephrine*, promethazine, pseudoephedrine, quinolone antibiotics, ranitidine*, selegiline, thioridazine, trazodone, trimipramine
Barbiturates	Ibuprofen*, naproxen*
Benzodiazepines	Oxaprozin, sertraline

[134] American Society of Addiction Medicine. "Drug Testing." Accessed September 26, 2024. https://www.asam.org/quality-care/clinical-guidelines/drug-testing.

[135] Raouf, M., J. J. Bettinger, and J. Fudin. "*A Practical Guide to Urine Drug Monitoring*." Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS 35, no. 4 (2018): 38–44.

[136] University of Illinois Chicago. "*What Drugs Are Likely to Interfere with Urine Drug Screens?*" Drug Information Group, May 2021. Accessed September 26, 2024. https://dig.pharmacy.uic.edu/faqs/2021-2/may-2021-faqs/what-drugs-are-likely-to-interfere-with-urine-drug-screens/.

Table 5. Prescription drugs, over-the-counter products, and foods that could trigger a false-positive result in urine immunoassays	
Cannabinoids	Dronabinol, efavirenz, hemp-containing foods*, CBD products, ibuprofen*, ketoprofen, naproxen*, piroxicam, promethazine*, proton pump inhibitors*, sulindac
Cocaine	Coca leaf teas (de-cocainized)*
LSD	Amitriptyline, dicyclomine, ergotamine, promethazine, sertraline, sumatriptan
Methadone	Chlorpromazine, clomipramine, diphenhydramine*, doxylamine, ibuprofen*, quetiapine, thioridazine, verapamil
Opiates	Dextromethorphan*, diphenhydramine*, fluoroquinolones, poppy seeds and oil*, rifampin
Oxycodone	Naloxone and naltrexone
Phencyclidine	Dextroamphetamine, dextromethorphan*, diphenhydramine*, doxylamine*, ibuprofen*, imipramine, ketamine, meperidine, thioridazine, tramadol, venlafaxine
Tricyclic antidepressants	Carbamazepine, cyclobenzaprine, cyproheptadine, diphenhydramine*, ibuprofen*, hydroxyzine, quetiapine
*Can be purchased over-the-counter in some states or through internet sources	

Definitive (Confirmatory Send-Out) Testing

Confirmatory testing is generally performed at specialty labs via gas chromatography. The tests measure the exact amount of the substance and its metabolites present in the urine/oral fluid. Uses of confirmatory testing include:

- Confirming a positive or negative result that does not agree with the patient report.
- Identifying substances that are not easily identified on standard rapid tests (such as fentanyl, xylazine, kratom, tramadol, methylphenidate, clonazepam, alcohol, Nonbenzodiazepines (z-drugs), and gabapentin).
- Identifying specific medications within a larger drug class (such as differentiating alprazolam from diazepam in a patient testing positive for benzodiazepines).
- Identifying drug metabolites to monitor medication adherence (such as checking for the presence of norbuprenorphine in a patient prescribed buprenorphine).
- Monitoring drug levels during taper or after cessation (for example, when a patient has stopped using a long-acting drug such as cannabinoids or benzodiazepines). Of note, **the concentration of substance present on a confirmatory test does not correlate well with serum drug levels and can NOT be used to determine the dose of the drug taken or the timing of the last dose.** Urine drug levels can be affected by many factors including timing and dose, chronicity of use, hydration status, renal and hepatic function, and administration of other medications that effect drug metabolism.
- Building an accurate medical record for a patient with ongoing legal concerns (such as probation or Office of Children's Services cases), the provider should consider confirmatory testing more frequently if clinically indicated as the results may be critical to a patient's legal case.

Confirmatory testing takes 5-10 days to obtain results, and the test can be expensive. It is important to know if the patient's insurance covers this testing and if they impose limits on the numbers of tests allowed per year.

Medical Review Officers

Confirmatory tests are performed by outside labs that are supervised by medical review officers (MROs). MROs are physicians with special training in interpreting drug testing results, and most lab reports will include a phone number to contact the MRO. The MRO can be an excellent and greatly underutilized resource to help clarify questions about drug testing results.

Testing Considerations for Long-acting Injectable Buprenorphine

Patients who receive injections of long-acting injectable buprenorphine (Sublocade/Brixadi) can have buprenorphine metabolites present in their urine for many months after their last medication administration. The prescribing information for Sublocade notes that patients may test positive for buprenorphine in their urine for more than a year after stopping therapy. This can sometimes cause confusion when patients are being monitored by entities outside the medical system (such as probation), who may incorrectly assume that the patient is taking non-prescribed

buprenorphine. Monthly quantitative urine testing or serum drug testing can clarify by demonstrating a general downward trend of buprenorphine levels over time, when clinically indicated.

Testing for Fentanyl

Until recently, access to point-of-care CLIA waived testing for fentanyl was limited; however, a breakthrough came in November 2023 with the release of the first CLIA waived fentanyl test. It's noteworthy that fentanyl isn't consistently included in CLIA waived multi-drug tests, potentially leading to false negatives in opioid screenings. Given the proliferation of illicitly manufactured fentanyl and its numerous analogs, confirmatory testing becomes crucial for accurate detection. This is especially pertinent in identifying fentanyl use or inadvertent exposure resulting from the consumption of contaminated stimulants or counterfeit pills. Despite the availability of fentanyl test strips for harm reduction purposes, commonly distributed to patients, it's important to recognize that these strips are strictly for forensic use and are not CLIA waived, rendering them unsuitable for use in medical clinic labs, but can be useful for patient education. It is also crucial to know that with chronic use fentanyl accumulates in the fatty tissue, and fentanyl metabolites may be detected in the urine for months after cessation of use.[137]

Testing for Xylazine

Xylazine, a veterinary sedative, has increasingly been found mixed with opioids, creating a dangerous combination that significantly heightens the risk of overdose and other adverse health effects. Although most commonly encountered in the mid-Atlantic coast, xylazine has only recently been detected in Alaska. Individuals who use drugs may unknowingly consume xylazine-laced substances, and chronic exposure to xylazine can complicate withdrawal management. There are no rapid CLIA waived tests for xylazine; however, laboratory confirmation testing can detect it. Forensic grade xylazine test strips are available for harm reduction programs to offer clients for drug checking services. Providers should especially consider testing for xylazine when patients are presenting with unexplained ulcerating or necrotic skin wounds.

Poppyseed Ingestion

Poppyseeds contain varying concentrations of morphine and/or codeine in unpredictable ratios. Although a confirmatory test can measure the concentration of morphine and codeine in a urine sample, it cannot differentiate between pharmaceutical opioids and poppy seed ingestion. Counsel patients to avoid poppyseed ingestion particularly if they are subject to court mandated drug testing.

For federally regulated workplace drug testing, when there is no clinical evidence of abuse, and the concentration of morphine is less than 15,000 ng/mL, the MRO is required to report the test result as negative due to possible poppyseed ingestion. Substance Abuse and Mental Health Services Administration (SAMHSA) published a 2022 Medical Review Officer (MRO) Case Studies series that gives examples of complicated drug test interpretation.

Confirming Medication Adherence through Drug Testing

Buprenorphine undergoes metabolism to produce norbuprenorphine, both of which are consistently found in urine samples of patients taking buprenorphine. However, the presence of norbuprenorphine can only be confirmed through specialized laboratory testing (referred to as send-out testing).[138] Patients on very low doses of buprenorphine (generally 2 mg/day or less) may have false negative buprenorphine on rapid testing, and the drug concentration in the urine may be below the test's limit of detection.

A urine sample indicating the presence of buprenorphine but lacking norbuprenorphine suggests potential tampering, for instance, if a buprenorphine film or tablet was introduced into a urine sample to simulate medication intake. This scenario becomes more likely when buprenorphine levels are excessively high (exceeding 2,000).

Patients may manipulate their urine samples for various reasons. When a tampered specimen is identified, it is crucial to engage in a discussion with the patient to understand the underlying motives behind altering their sample.

- Is the patient experiencing difficulties with medication adherence, and if so, what factors contribute to this?Is

[137] Huhn, A. S., J. G. Hobelmann, G. A. Oyler, and E. C. Strain. "*Protracted Renal Clearance of Fentanyl in Persons with Opioid Use Disorder.*" Drug and Alcohol Dependence 214 (September 1, 2020): 108147. https://doi.org/10.1016/j.drugalcdep.2020.108147. Epub July 2, 2020. PMID: 32650192; PMCID: PMC7594258.

[138] Chiang, C. Nora, and Richard L. Hawks. "*Pharmacokinetics of the Combination Tablet of Buprenorphine and Naloxone.*" Drug and Alcohol Dependence 70, no. 2, Supplement (2003): S39-S47. https://doi.org/10.1016/S0376-8716(03)00058-9

the patient utilizing urine substitution to conceal any other substance usage?

- Is the patient involved in diverting medications? If so, what circumstances led to this behavior?

Monitoring Alcohol Use through Drug Testing

Urine ethyl glucuronide (EtG) and ethyl sulfate (EtS) are markers that can indicate recent alcohol consumption, offering a window of up to 72 hours for identification. While EtG may be produced by alcohol-generating bacteria in the gastrointestinal tract, the inclusion of EtS—known for its higher specificity—enhances test reliability. These tests prove particularly beneficial for monitoring abstinence. However, it's important to note their limitations in discerning between light and heavy drinking, as well as the frequency and timing of alcohol intake. False positives may arise from the consumption of alcohol-containing foods or certain medications. Notably, these urine tests necessitate confirmation through send-out laboratory analysis.

In addition to urine tests, alcohol breath testing devices are now readily available for both in-office and at-home utilization. Home devices offer the convenience of linking to smartphones or tablets and may feature facial recognition or video monitoring functionalities, enabling witnessed breath alcohol testing even beyond clinical settings. Such testing methodologies cater to individuals obligated to demonstrate abstinence for legal compliance or personal accountability.

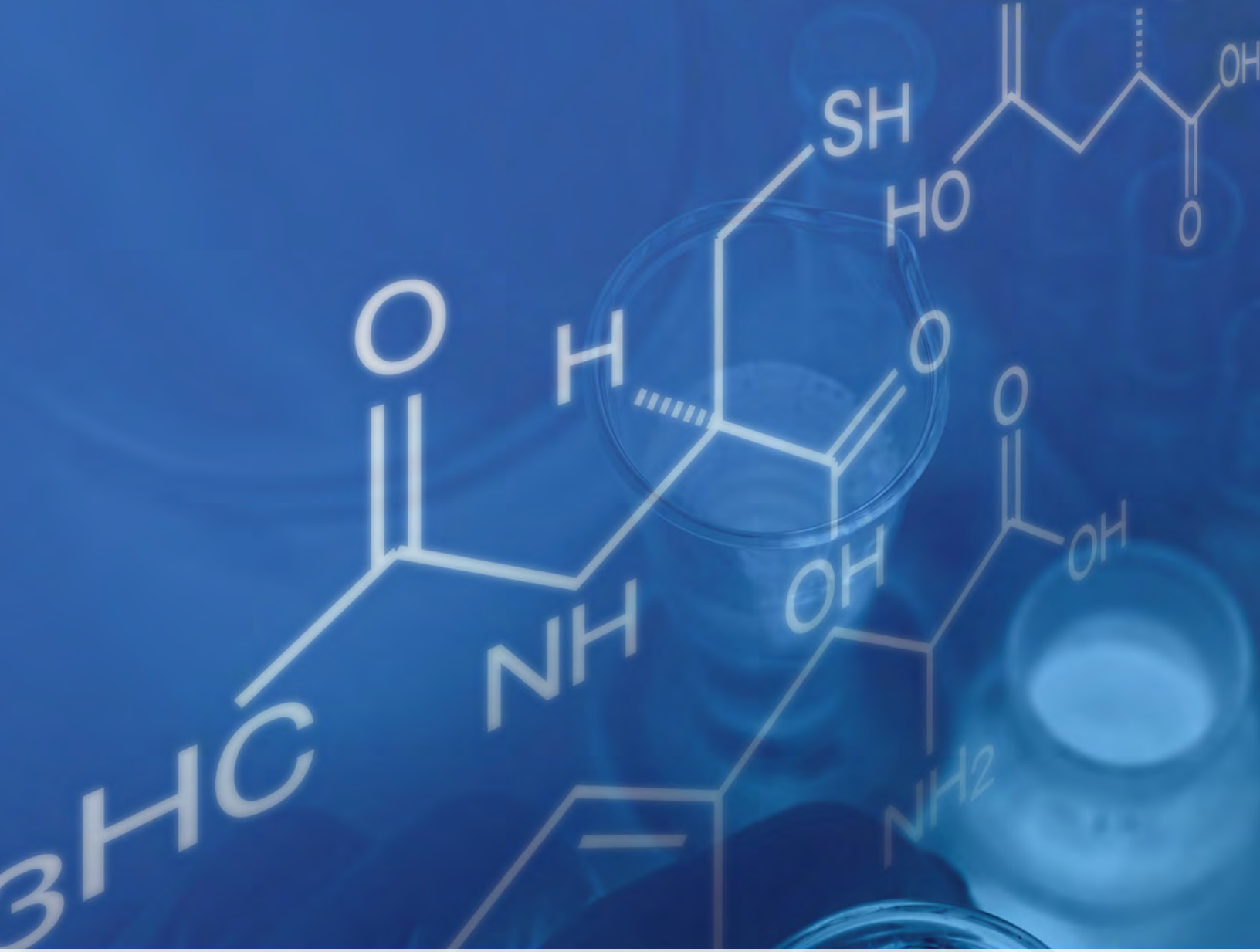
Responding to Drug Test Results

No matter what the results of a drug test are (positive, negative, unclear), the provider should present the test results in an objective manner, focusing on the therapeutic response of the results.

Using the terms "dirty" or "clean" in reference to a test result is stigmatizing because of its pejorative connotation. Use proper medical terminology such as a test result that is negative/positive/equivocal/as-expected/unexpected.

Ongoing unexpected drug test results during treatment may indicate the need to reassess the patient and revise the treatment plan. Repeated unexpected results may indicate the following:

- Patient is taking the medication incorrectly (such as taking more than prescribed or sharing their meds and running out early)
- Patient is not taking some, or all of their medication
- Patient may need a different brand or formulation of medication
- Patient may benefit from directly observed medication administration
- Medication dose may need to be increased or decreased
- Patient may need treatment for triggering comorbid medical or mental health disorders (pain, insomnia, anxiety)
- Patient may need treatment for comorbid SUD (medication for alcohol use disorder, contingency management for stimulant use)
- Patient may need more psychosocial treatment or referral to a SUD treatment program
- Patient may need more recovery support services
- Patient might be unknowingly exposed to one substance (such as fentanyl) when intentionally using another substance (like cocaine) and might benefit from access to harm reduction drug checking resources



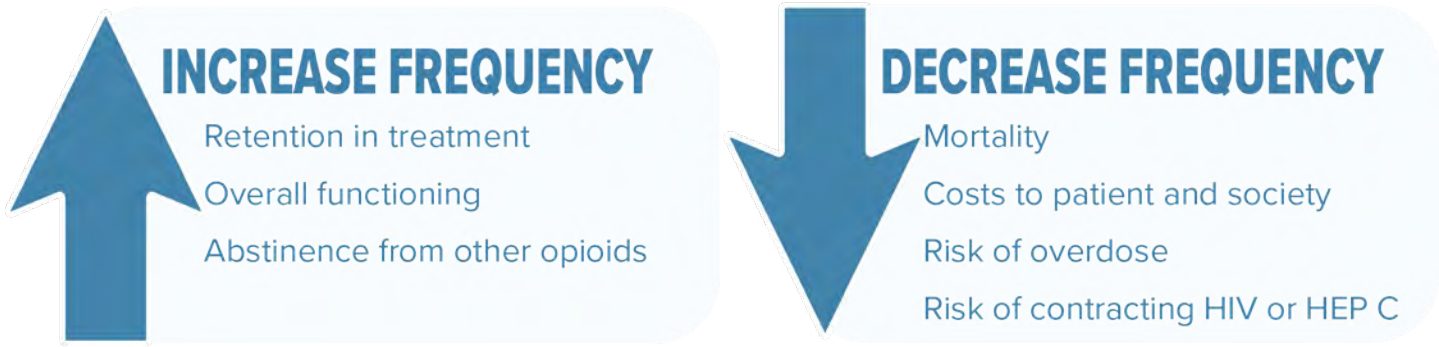
SECTION III:
Medications

Chapter 10: Overview of Opioid Use Disorder Medications

Medications for Opioid Use Disorder

Prescribed medication to treat opioid use disorder (OUD) is comparable to prescribed medication to manage diabetes or heart disease. Appropriate use of medications for OUD greatly improves treatment outcomes and the quality of life for patients. Medication treatment is part of a comprehensive treatment plan to support patient's functioning in all aspects of their lives. Psychosocial needs are assessed, and patients are offered or referred to psychosocial treatment based on their individual needs; however, if a patient declines psychosocial treatment or it is unavailable, pharmacotherapy should not be delayed or precluded.[139] Medication, counseling and positive social support are all important factors that contribute to success in recovery.

Figure 8. MOUD is linked to many positive outcomes including:[140]



Three medications are approved by the U.S. Food & Drug Administration (FDA) for treating OUDs: methadone, buprenorphine, and naltrexone. Most of these medications have several brands or formulations available.

Though all three pharmacotherapies are approved options with different indications and contraindications, this guide focuses primarily on buprenorphine, as it is the most widely utilized and accessible MOUD.

Methadone

A full opioid agonist that reduces withdrawal, cravings, overdose risk, and can blunt the effect of other opioids. Methadone is available only at an Opioid Treatment Program (OTP), generally with directly observed daily dosing, most commonly in liquid form. Participation in full psychosocial support programs is recommended.

Naltrexone

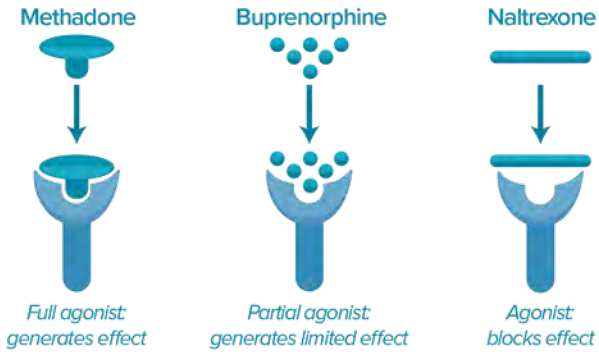
(Vivitrol)

An opioid antagonist that blocks the effects of opioids and can reduce cravings. Administered as a monthly injection by any medical provider.

Buprenophrine

A partial opioid agonist/antagonist that blocks other opioids while reducing withdrawal, cravings, and overdose risk. Available by prescription from any outpatient provider. Administered as a daily sublingual film or tablet, or weekly or monthly injection.

Figure 9



[139] American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update.* Published March 2020. Accessed September 14, 2024. https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline.

[140] Mayo Clinic Proceedings. "*Opioid Use Disorder: Management of Acute Withdrawal and Chronic Maintenance*." Accessed September 14, 2024. https://www.mayoclinicproceedings.org/article/S0025-6196(19)30393-3/fulltext

Choosing the Most Appropriate Medication

Ideally, all FDA approved medications for the treatment of OUD should be available to all patients. The medication that the patient is most motivated to take is often the best fit. Providers should evaluate all relevant risks and benefits for each medication in the unique context of each individual patient and discuss this with their patients. Providers should offer patients adequate counseling and information to support them in making an informed treatment decision regarding their care.

Table 6. Opioid Use Disorder Medication Differences

The following table provides a brief overview of the differences between the three opioid use disorder (OUD) medications.

Prescribing considerations	Methadone	Buprenorphine	Naltrexone
Product/ Formulation	Generic methadone	Suboxone, Buprenorphine Mono-product (BUP), Zubsolv,*Brixadi, Sublocade	Extended-release injectable depot: Vivitrol
Mechanism of Action	Full agonist: Binds to and activates receptors. Long acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Partial agonist/antagonist: Binds to and partially activates opioid receptors. Also competitively blocks other opioids Long acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	Antagonist: Binds and competitively blocks opioid reward effects.
Uses of Medication	Withdrawal management and treatment	Withdrawal management and treatment	Treatment
Route of Administration	Oral tablet or liquid (liquid used at OTPs)	Sublingual tablet or film (with or without naloxone), subcutaneous depot injection	Intramuscular (IM) depot injection (Oral formulation not for OUD treatment)
Frequency of Administration	Daily	Based on formulation and clinical needs of the patient.	Monthly
Dosage	Based on formulation and clinical needs of the patient.	Based on formulation and clinical needs of the patient.	Based on formulation and clinical needs of the patient.
Regulatory Context	May only be dispensed at a certified opioid treatment program or administered in inpatient setting.	Any licensed prescriber with a DEA registration.	Any licensed prescriber.
Typical Visit Requirement	Initial: Daily	Initial: Weekly Interval may change based on course of treatment	Monthly for injection, weekly monitoring in early treatment.
Cost of Medication	Low	Depends on product	High
Controlled Substance Schedule	Schedule II	Schedule III	Not a scheduled medication
Diversion Value	High (rare)	High (sublingual) Low (long-acting injection)	Low
Discontinuation of Medication	Tapering required	Tapering required	No tapering required
Level of evidence for treating OUD and reducing mortality	High	High	Low

Chapter 11: Buprenorphine

Buprenorphine is a partial opioid agonist indicated for the treatment of moderate to severe opioid use disorder. Buprenorphine acts by binding strongly to the mu-opioid receptor, blocking the effect of other opioids. The higher the serum buprenorphine level, the denser the opioid blockade is. Buprenorphine has a "ceiling effect" on the mu receptor, meaning even large doses do not cause respiratory depression or escalating intoxicating effects in adults with sufficient opioid tolerance. This ceiling effect gives buprenorphine a lower risk for potential misuse versus full opioid agonists. Buprenorphine provides both positive reinforcement by relieving withdrawal symptoms, improving mood, reducing pain, and negative reinforcement (if patients stop their medication, they experience withdrawal symptoms). This combination of reinforcing effects promotes treatment retention. [141]

Buprenorphine initiation can be performed at home, at an outpatient clinic, in the emergency department, or hospital. Buprenorphine may be prescribed without first requiring the patient to complete withdrawal. For most patients with moderate to severe opioid use disorder, buprenorphine is a good first-line choice, and it's the most widely used medication in Alaska and nationwide.

Many sublingual formulations of buprenorphine include the misuse deterrent naloxone. [142] The role of naloxone in these formulations is often misunderstood. Naloxone has very low sublingual bioavailability, meaning it has no clinical effect when taken as directed— it neither precipitates withdrawal nor blocks opioids. However, when the combination product is injected or snorted, naloxone can induce precipitated withdrawal in patients using opioids. This discourages misuse of the medication by injection or insufflation, potentially reducing the risk of diversion. [143] [144]

For more detailed prescribing information, please refer to the American Society of Addiction Medicine (ASAM) National Practice Guidelines, and Food & Drug Administration (FDA) Prescribing Information for buprenorphine.

- Prescribing information for sublingual buprenorphine
- Prescribing information for sublingual buprenorphine/naloxone
- Prescribing information for long-acting injectable buprenorphine:
  - Sublocade
  - Brixadi

Starting Patients on Buprenorphine

Buprenorphine is indicated for the treatment of moderate to severe opioid use disorder. Initiation (also called induction) is the process of starting buprenorphine for such treatment. Initiation includes starting buprenorphine without causing precipitated withdrawal, managing any side effects, and adjusting the dose to minimize the patient's cravings and withdrawal symptoms without causing sedation. When considering an initiation strategy, the provider evaluates the patient's previous experience with buprenorphine, their ability to understand and follow instructions, their living situation, and their medical comorbidities to create a suitable initiation plan. The provider then establishes the timing, setting, and dosing instructions for buprenorphine initiation and is responsible for evaluating and monitoring the patient during the initiation. The use of case managers or nurses to assist with patient education and follow up is recommended.

To determine the appropriate initiation procedure, the provider assesses whether the patient is currently physically dependent on opioids. Patients may present with one of the following scenarios:

- Currently dependent on short-acting opioids (such as heroin or immediate release prescription opioids).
- Currently dependent on long-acting opioids (such as methadone, chronic high dose fentanyl, or extended-release prescription opioids).
- History of opioid dependence but currently abstinent.
- Currently taking buprenorphine, either from another provider or illicitly.

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[141] Kumar, R., O. Viswanath, and A. Saadabadi. "*Buprenorphine*." Last updated June 8, 2024. In StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing, January 2024–. https://www.ncbi.nlm.nih.gov/books/NBK459126/.

[142] Mauger, S., R. Fraser, and K. Gill. "*Utilizing Buprenorphine-Naloxone to Treat Illicit and Prescription-Opioid Dependence*." Neuropsychiatric Disease and Treatment 10 (2014): 587–598. https://doi.org/10.2147/NDT.S39692.

[143] ASAM. "National Practice Guideline". 2020.

[144] Grande, L. A. 2022. "*Prescribing the Buprenorphine Monoproduct for Adverse Effects of Buprenorphine-Naloxone*." Journal of Addiction Medicine 16 (1): 4–6. https://doi.org/10.1097/ADM.0000000000000837.

Patients who are currently abstinent from opioids are generally started at lower doses of buprenorphine to avoid over sedation and nausea. Patients with high levels of opioid tolerance may need higher initial doses to control their symptoms. Patients taking long-acting opioids may need targeted initiation strategies to reduce risk of precipitated withdrawal. Patients currently taking buprenorphine can usually be continued on their current effective dose.

Considerations for buprenorphine dosing for patients using fentanyl

Illegally manufactured fentanyl (IMF) is a highly potent synthetic opioid found in almost all illicit opioid formulations. Chronic use of fentanyl can lead to significant opioid tolerance and dependence. Due to its lipophilic properties, fentanyl accumulates in the body's fatty tissues, leading to prolonged renal excretion after cessation. Withdrawal symptoms can begin as early as 6 hours after the last dose. However, even after 48 hours of abstinence, substantial amounts of fentanyl may remain on opioid receptors, which can occasionally trigger precipitated withdrawal when the patient first takes buprenorphine.

ASAM recently published a document ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids, that provides guidance such as alternative buprenorphine initiation strategies, precipitated withdrawal avoidance and treatment, buprenorphine dosing, and formulation considerations and addressing polysubstance use.

Considerations for Patients using IMF when starting buprenorphine:

1. Alternative dosing strategies including low dose overlapping and high dose starts should be considered
2. Patients should be instructed on a plan to treat precipitated withdrawal should it occur.
3. Patients may initially need high doses of buprenorphine (32+ mg per day) to control withdrawal symptoms and cravings and to block the effects of fentanyl.
4. High dose long-acting injectable buprenorphine may be considered as a strategy to obtain higher serum buprenorphine levels; however, supplemental sublingual buprenorphine may be needed to augment until stable state is reached (3-6 months).
5. Consideration should be given to the possibility of contamination of fentanyl with xylazine or other drugs that can complicate withdrawal management.

Table 7. A comparison of buprenorphine formulations

Buprenorphine Formulations	Monthly injection (RBP-6000: Sublocade®)	Weekly injection (CAM2038: Buvidal®/ Brixadi®)	Monthly injection (CAM2038: Buvidal®/ Brixadi®)	SL tab (Suboxone®)
FDA Indication	Moderate-severe OUD, tolerating SL bup at 8-24 mg/day for ≥7 days. Counseling & Psychological Support should be part of tx plan.	Moderate-severe OUD after a single SL dose or already on bup. Counseling & psychological support should be part of tx plan.	Moderate-severe OUD after a single SL dose or already on bup. Counseling & psychological support should be part of tx plan.	Maintenance tx of opioid dependence, counseling, etc.
Cavg bup at steady state (ng/ml)	100 mg: 2.87 300 mg: 6.32	Weekly 8mg: - 16 mg: 2.1 24 mg: 2.9 32 mg: 4.2	Monthly 64 mg: 2.0 96 mg: 2.9 128 mg: 3.9	8/2 & 8 mg: 1.19 24 mg: 2.91
CMAX bup after single dose (ng/ml)	100 mg injection: 1.54 300 mg injection: 5.37	Weekly 16 mg: 3:08 24 mg: 3.64 32 mg: 5.27	Monthly 64 mg: 3.81 96 mg: 5.47 128 mg: 6.59	8/2 & 8 mg: 300 16/4 mg: 4.70
Time to peak	~24 hours	Weekly Within 24 hours	Monthly Within 6-10 hrs	24-42 hrs
Terminal half-life	43-60 days	3-5 days	19-26 days	24-42 hrs
Solvent	N-methyl-2-pyrrolidone (nmp) 278 and 833 mg NMP	Weekly: Ethanol 16-61 mgs*	Monthly: NMP 57-115 mg	-

Coe MA, Lofwall Mr. Walsh SL. Buprenorphine Pharmacology Review: Update on Transmucosal and Long-acting Formations. J Addict Med, 2019. FDA package inserts.

Understanding Precipitated Withdrawal

Precipitated withdrawal is a sudden onset of worsening withdrawal symptoms after a patient takes their first dose of buprenorphine too soon after taking another opioid.[145][146] To prevent precipitated withdrawal, patients must wait until they are in moderate withdrawal - usually 12-36 hours since their last use of opioids - before they take their first dose of buprenorphine.[147] Moderate withdrawal is defined as a Clinical Opiate Withdrawal Scale (COWS) score >12. COWS is a tool which can be utilized in both inpatient and outpatient settings to rate the severity of withdrawal in patients.[148]

Table 8. Buprenorphine Initiation Withdrawal Timing

Opioid	How long to stop before buprenorphine initiation
Short-acting (heroin, IR oxycodone, hydrocodone)	12-24 hours
Long-acting (XR oxycodone, XR morphine, chronic fentanyl use)	24-36 hours
Methadone (30 mg/day or less)	48-72+ hours

Moderate withdrawal = COWS > 12
or

4+ symptoms (at home)

Symptoms include: nausea, vomiting, abdominal cramps, diarrhea, restlessness, tremor, sweating, goosebumps, anxiety, yawning, rhinorrhea, tearing

Precipitated withdrawal (PW) is more commonly experienced by patients taking non-prescribed buprenorphine. Patients who experience PW often fail to initiate treatment and may be anxious about future initiation attempts, so it is important to try to prevent this from occurring. Patients who are at high risk for PW should be offered office-based initiation as well as alternative dosing strategies when desired by the patient.

Patients at higher risk of PW:

- Chronic high dose fentanyl use.
- Recent use of methadone or those taking long- acting opioids.
- No prior experience with buprenorphine.

Patients who are at higher risk for initiation-related complications:

- Simultaneous withdrawal management for alcohol or benzodiazepines.
- Transitioning from high dose methadone (over 30 mg/day).
- Severe medical comorbidities (such as end-stage organ failure).
- High-risk pregnancy greater than 20 weeks gestational age.

These patients may be better suited to inpatient initiation or addiction medicine specialist consultation.

Offering flexible MOUD initiation strategies

Southcentral Foundation (SCF) treats each patient as an individual and thus can adapt each individual's MOUD initiation strategy to what they need, whether that be through their residential SCF Detox program, the outpatient Four Directions specialty MOUD program, or their Primary Care Clinics. They offer standard, low-dosing, and high-dosing initiations using sublingual buprenorphine products and adjunctive medications, as well as standard and rapid-start using injectable buprenorphine, and withdrawal management using both buprenorphine and non-buprenorphine medications as a segway to utilizing naltrexone(Vivitro).l

[145] National Alliance of Advocates for Buprenorphine Treatment. "*What Is Precipitated Withdrawal?*" Accessed January 11, 2021. https://www.naabt.org/documents/NAABT_PrecipWD_HiRes.pdf.

[146] Whitley, S. D., N. L. Sohler, H. V. Kunins, A. Giovanniello, X. Li, G. Sacajiu, and C. O. Cunningham. "*Factors Associated with Complicated Buprenorphine In3ductions*." Journal of Substance Abuse Treatment 39, no. 1 (2010): 51–57. https://doi.org/10.1016/j.jsat.2010.04.001.

[147] IT MATTRs. *A Patient's Guide to Starting Buprenorphine at Home. American Society of Addiction Medicine*. Accessed September 14, 2024. https://www.asam.org/docs/default-source/education-docs/unobserved-home-induction-patient-guide.pdf.

[148] Wesson, D. R., and W. Ling. "The Clinical Opiate Withdrawal Scale (COWS)." Journal of Psychoactive Drugs 35, no. 2 (2003): 253–259.

It is a common misconception that the naloxone in Suboxone initiates precipitated withdrawal. This is false. The naloxone can only initiate precipitated withdrawal if injected into a person tolerant to opioids. Taken sublingually, the naloxone has virtually no effect.

— National Alliance of Advocates for Buprenorphine Treatment

Management of Precipitated Withdrawal

Precipitated withdrawal can typically be prevented by ensuring patients receive thorough education on the medication initiation strategy that best meets their individual needs. Sometimes low doses (2-6mg) of buprenorphine may displace opioids but not provide a strong enough agonist effect to prevent withdrawal symptoms, triggering PW. Giving higher doses of buprenorphine may provide enough agonist effect to relieve these symptoms.

Rapid administration of high dose buprenorphine (16 mg sublingual, then repeat 8-16 mg every hour as needed up to 40mg or more) is the first line treatment for precipitated withdrawal.

In addition to high dose buprenorphine, supportive medications can also reduce PW symptoms. These medications can also be helpful for patients to manage withdrawal symptoms during the first few days prior to starting their buprenorphine.

Supportive medications for opioid withdrawal management: [149]

- Myalgias: NSAIDs and acetaminophen
- Muscle spasms: tizanidine
- Nausea: ondansetron or promethazine
- Restlessness and sweating: clonidine
- Anxiety and rhinorrhea: hydroxyzine
- Insomnia: trazodone

Benzodiazepines are generally avoided in outpatient settings as they increase the risk of overdose death if the patient returns to full opioid agonist use. However, a single dose of benzodiazepine administered in a medically monitored setting can be helpful for anxiety associated with withdrawal. Severe intractable precipitated withdrawal may need to be treated in the emergency room with IV opioids (hydromorphone or fentanyl) and low dose ketamine.

Resource: Enhanced Care Practice: Precipitated Withdrawal 90-Minute Bundle

Choosing the Most Appropriate Initiation Setting

Both office-based and home-based buprenorphine initiation are considered safe and effective. Buprenorphine can also be initiated in the emergency room or inpatient hospital setting. The provider is recommended to select the setting which best matches the patient's individualized needs. The provider is also recommended to have a conversation with the patient to discuss the risks and benefits of initiation setting, in a shared decision-making process.

At-Home Initiation

For most patients home initiation is appropriate. In some cases, the patient may be evaluated via telemedicine without an in-person visit (see the Telemedicine in Alaska section in Chapter 2).

The patient may be given an instruction guide that explains the at-home initiation protocol such as the following:

- Buprenorphine: What You Need to Know
- Buprenorphine Self-Start (single page instructions, high dose protocol)
- A Patient's Guide to Starting Buprenorphine at Home (more detailed instructions, medium dose protocol)

If at-home initiation is chosen, a provider, nurse, or case manager would provide follow up care, ideally reaching out to the patient daily to check on progress and symptoms until stable. If possible, the patient will also be given access to an after-hours number to call in case of urgent medical questions. The patient will also be scheduled to return to the office in a week or less to reevaluate.

Office-Based Initiation

In an office setting, the patient is provided a supportive environment in which the patients' withdrawal symptoms can be monitored in real time. Supportive medication can be provided in the event of a PW. Office-based initiation can be helpful for patients who are nervous about initiation or who are at elevated risk of PW.

[149] Mauger S, Fraser R, Gill K. *Utilizing buprenorphine-naloxone to treat illicit and prescription-opioid dependence*. Neuropsychiatr Dis Treat.2014;10:587–598. doi:10.2147/NDT.S39692.

Table 9. Pros and Cons of Starting Buprenorphine in the Doctor's Office

Pro	Cons
Medical team is available to check on the patient and provide comfort medications. Medical team verifies patient's readiness to start and to ensure medication is taken properly. Patient is at a reduced risk of precipitated withdrawal.	Patient may have to make multiple visits to the office the first week. Patient may have transportation or other access challenges Patient may not be as comfortable as they would be at home. Patient may have difficulty timing withdrawal. Burdensome on provider's schedule.

Table 10. Pros and Cons of Starting Buprenorphine at Home

Pro	Cons
More flexibility in timing patient's first dose. Patient may be more comfortable at home. Patient doesn't need to drive anywhere.	Waiting for the patient to be in enough withdrawal to start buprenorphine may be difficult. Medical team is unavailable to assist patient in person.

Emergency Department and Hospital Initiation

Emergency department initiation of buprenorphine is now the standard of care[150] when treating patients experiencing opioid withdrawal in this setting.

Hospitalized patients who are started on buprenorphine or methadone during their stay have:

- Reduced premature discharge against medical advice
- Reduced readmission rates [151]
- Improved engagement in outpatient treatment [152]

Even patients who have acute pain from trauma or surgery can be started on buprenorphine through approaches such as low dose overlapping starts. [153][154] See Section V, Chapter 23 for more information about acute pain management for patients on buprenorphine.

Patients discharged from the emergency department (ED) or hospital should be given a prescription for at least 1 week of buprenorphine or administered long-acting injectable buprenorphine before discharge. Whenever possible, an immediate referral should occur to outpatient buprenorphine providers with the capacity to provide follow up within 3-7 days. However, hospital providers should still provide buprenorphine treatment even if follow-up plans are unclear. Primary care providers, substance use disorder (SUD) providers, behavioral health providers, and other buprenorphine prescribers are encouraged to reach out to their local hospital ED to establish clear pathways for quick referrals and follow-up care. After- hours case management (which may be provided by peer support professionals, Community Health Aide Practitioner (CHAP)/ behavioral health aides (BHAs), or SUD treatment navigator specialists) can ease the transition from the ED to outpatient care, by providing a "warm handoff." These services may be provided in person or virtually.

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[150] Hawk, Kathryn, Jason Hoppe, Eric Ketcham, Alexis LaPietra, Aimee Moulin, Lewis Nelson, Evan Schwarz, Sam Shahid, Donald Stader, Michael P. Wilson, and Gail D'Onofrio. "*Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department*." Annals of Emergency Medicine 78, no. 3 (2021): 434-442. https://doi.org/10.1016/j.annemergmed.2021.04.023.

[151] Wang, Sijie Jason, Elizabeth Wade, Jennifer Towle, Tabitha Hachey, Jennifer Rioux, Omrie Samuels, Casey Bonner, Christina Kirkpatrick, Sandra O'Loughlin, and Keith Foster. "*Effect of Inpatient Medication-Assisted Therapy on Against-Medical-Advice Discharge and Readmission Rates*." The American Journal of Medicine 133, no. 11 (2020): 1343-1349. https://doi.org/10.1016/j.amjmed.2020.04.025.

[152] Solomon, KT, J. O'Connor, JB Gibbons, et al. "*Association Between Hospital Adoption of an Emergency Department Treatment Pathway for Opioid Use Disorder and Patient Initiation of Buprenorphine After Discharge*." JAMA Health Forum 4, no. 3 (2023): e230245. https://doi.org/10.1001/jamahealthforum.2023.0245.

[153] Hayes, Benjamin T., Phoebe Li, Tess Nienaltow, Kristine Torres-Lockhart, Laila Khalid, and Aaron D. Fox. "*Low-Dose Buprenorphine Initiation and Treatment Continuation Among Hospitalized Patients With Opioid Dependence: A Retrospective Cohort Study*." Journal of Substance Use and Addiction Treatment 158 (2024): 209261. https://doi.org/10.1016/j.josat.2023.209261.

[154] Bhatraju, Elenore P., Jared W. Klein, Allana N. Hall, David R. Chen, Matthew Iles-Shih, Judith I. Tsui, and Joseph O. Merrill. "*Low Dose Buprenorphine Induction With Full Agonist Overlap in Hospitalized Patients With Opioid Use Disorder: A Retrospective Cohort Study*." Journal of Addiction Medicine, published December 23, 2021. https://doi.org/10.1097/ADM.0000000000000947.

There are excellent ED/hospital toolkits available online that contain program development guidance, pre-made algorithms, patient instructional handouts, and educational materials for physicians.

- Bridge to Treatment Buprenorphine Emergency Department Quick Start
- Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department
- EMS Opioid Withdrawal Treatment Guidelines
- Buprenorphine Initiation after Overdose
- Blueprint for Hospital Opioid Use Disorder Treatment
- Clinical Considerations for Order Sets
- Buprenorphine in the Hospital FAQs

Inpatient consults: Improving outcomes for hospitalized patients

Studies evaluating patients hospitalized with serious infections related to opioid use found that inpatient addiction consultation was associated with increased MOUD receipt, decreased premature discharge, and reduced 90-day readmission. Several hospitals have developed arrangements with addiction specialists to offer inpatient consultation and bridge to treatment including Fairbanks Memorial (with Tanana Valley Clinic doctors), Providence Anchorage (with the new addiction medicine fellowship), and South Peninsula Hospital (with Dr. Spencer from the Ninilchik Community Clinic via telemedicine). Telemedicine can be an excellent way to access specialty consultation services when they aren't available locally. These specialty consultations have been very helpful to support the medical staff when managing complicated patients and ensure patients are started on appropriate treatment for their addiction prior to leaving the hospital.

Emergency Department Initiation of Extended-Release Injectable Buprenorphine

A number of recent and ongoing studies have reported good outcomes following ED administration of long-acting injectable buprenorphine (BUP-XR), even in patients presenting with minimal withdrawal symptoms.[155] [156]In this case series, Rapid induction onto extended-release injectable buprenorphine following opioid overdose, the authors observed:

- "Emergency Departments can help expand opioid use disorder treatment access" utilizing BUP-XR.
- "No precipitated withdrawal or serious adverse events were observed during induction."
- "No repeat overdoses, deaths [occurred] in patients inducted onto injectable buprenorphine."[157]

Emergency department BUP-XR resources:

- Buprenorphine Extended Release: What You Need to Know Patient Education
- BUP-XR Sample Discharge Instructions Extended Release Buprenorphine Providers Guide

Choosing a Sublingual Buprenorphine Initiation Strategy

When counseling patients on initiation options, there are 3 major approaches to consider: traditional (medium dose start), high dose start, and low dose overlapping start.[158]

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[155] D'Onofrio, G., et al. "*199 Extended-Release Injectable Buprenorphine for Emergency Department Patients with Opioid Use Disorder in Minimal Withdrawal.*" Annals of Emergency Medicine 78, no. 4 (2021): S80.

[156] Yarborough, Bobbi Jo H., Scott P. Stumbo, Shannon L. Janoff, Erin M. Keast, Michael C. Leo, and Sarah J. Leitz. "*Reduced Emergency Department Use Among Insured Individuals Receiving Extended-Release Buprenorphine in a Health System Setting.*" Drug and Alcohol Dependence Reports 11 (2024): 100233. https://doi.org/10.1016/j.dadr.2024.100233.

[157] Ochalek, T. A., K. J. Ringwood, T. T. Davis, T. S. Gal, B. K. Wills, R. T. Sabo, L. Keyser-Marcus, C. E. Martin, K. Polak, K. L. Cumpston, and F. G. Moeller. "*Rapid Induction onto Extended-Release Injectable Buprenorphine Following Opioid Overdose: A Case Series.*" Drug and Alcohol Dependence Reports 7 (2023): 100144. https://doi.org/10.1016/j.dadr.2023.100144.

[158] Spreen, L. A., E. N. Dittmar, K. C. Quirk, and M. A. Smith. "*Buprenorphine Initiation Strategies for Opioid Use Disorder and Pain Management: A Systematic Review.*" Pharmacotherapy 42, no. 5 (2022): 411–427. https://doi.org/10.1002/phar.2676.

Table 11. Comparison of Initiation Strategies

Initiation Strategy	Traditional (Medium dose)	High Dose Start	Low Dose Overlapping Start
First Day initial dose	4-8 mg	8-16 mg	0.5 mg
First Day Max Dose	8-16 mg	32-40 mg	0.5-4 mg
Dose Increases	8 mg/day, max 24 mg	8-16 mg every hour	Dose typically doubled daily
Days to Reach Therapeutic Dose	1-3 days	1 day	3-7 days
Moderate withdrawal required before start	Yes	Yes	No, full opioid agonist is continued until >12 mg BUP
Complexity of instructions	Moderate	Simple	More Complex
Suggested target Populations	Patients using short acting opioids who have previous positive experiences initiating Buprenorphine, Patients who have low levels of opioid tolerance.	Patients who are at risk for PW and need to reach therapeutic levels rapidly, commonly used in ED.	Patients who are at risk for PW and have time and ability to follow detailed instructions, also hospitalized patients on full agonists.

Basic Instructions for administering sublingual buprenorphine films or tablets:

- Wet mouth first, avoid smoking before taking dose
- Dissolve under tongue for 15-20 mins (between gum and cheek also acceptable)
- No talking, eating, drinking, smoking while medicine is dissolving
- Spit out excess saliva (swallowing can increase nausea)
- Rinse and spit after finished (residue may soften tooth enamel)
- Peak effect seen in 1-2 hours

Dosing frequency

Buprenorphine has a slow dissociation rate from the mu opioid receptor, providing prolonged suppression of opioid withdrawal and blocking the effects of exogenous opioids for 24-48 hours. For some patients, once-daily dosing is sufficient to manage drug cravings and withdrawal symptoms. However, many prefer split dosing. Because buprenorphine has a relatively short duration of analgesic action (around 6 hours), dosing 3-4 times daily may be considered for patients with chronic pain. The optimal dosing frequency is the one that best supports the patient's well-being. Equally important is ensuring that the patient is motivated and able to maintain a consistent dosing regimen.

Benefits of once daily dosing

- Simpler routine, less risk of missed doses.
- No need to carry meds for mid-day dosing.May reduce psychological dependence on ritualized dosing.
- Less risk of drug overuse or for inappropriate reasons (such as to get more energy, as primary coping tool for stress, etc.).

Benefits of split dosing

May provide more steady serum medication levels throughout the day.

May provide improved analgesic effect.

Common prescriptions written on first patient visit

- Buprenorphine/naloxone 8/2 mg tab or film, as directed, max 24 mg/day, dispense #21
- Ondansetron 4-8 mg ODT SL tid prn, disp #12
- Clonidine 0.1 mg, 1-2 tid prn restlessness and sweating, disp #30
- Naloxone nasal spray kit (refill X3)

Sublingual Buprenorphine Basic Initiation Instructions

Traditional Medium Dose Start

- Wait 12-24 hours after last opioid use until 4+ withdrawal symptoms or COWS>12
- Administer 4-8 mg SLBUP (2 mg, if no active opioid tolerance)
- Repeat 4 mg SL every one to two hours as needed for withdrawal symptoms or cravings up to 16 mg on day one.
- On morning of day two, administer first day total dose
- Additional 4 mg SL every 1-2 hours as needed for withdrawal symptoms or cravings up to 24 mg on day 2
- Ongoing daily dose 16-24 mg/day

High dose start

- Wait 12-24 hours after last opioid use until 4+ withdrawal symptoms or COWS>12
- Administer 8-16 mg SLBUP
- Repeat 8-16 mg SL every 1-2 hours as needed for withdrawal symptoms or cravings up to 24-32 mg on day 1
- Ongoing daily dose is total dose given on day 1
- After initial withdrawal symptoms fully resolved (3-5 days) may attempt to reduce daily dose to 24 mg if required by insurance quantity limits.

Low dose overlapping start

Continue taking opioid of choice at usual dosage.

Some patients prefer to gradually taper the dosage during the overlap. Some patients may choose to self-treat withdrawal symptoms with additional opioid agonist doses.

In the hospital, patients should be administered potent full opioid agonists, most commonly hydromorphone, titrated to control symptoms with cardiorespiratory monitoring.

Dose of sublingual buprenorphine (SLBUP, combo or mono-product, films are easier to cut).

Day 1: 0.5 mg SLBUP (1/4 of a 2 mg film/tab)

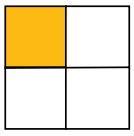
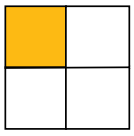
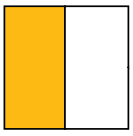
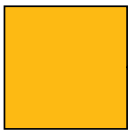
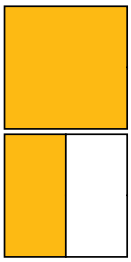
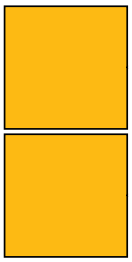
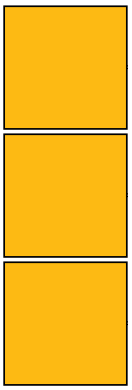
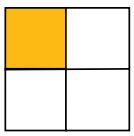
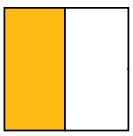
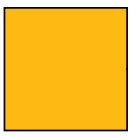
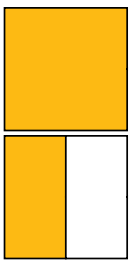
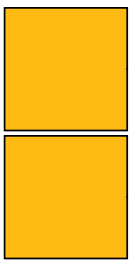
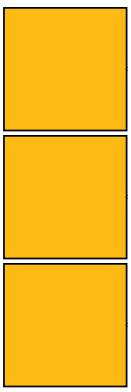
Day 2: 0.5 mg BID

Day 3: 1 mg (1/2 strip or tablet) BID

Days 4-7: Continue to double dose daily until taking 16-24 mg, then stop full opioid agonist.

Pauses or reduced rates of taper may be necessary if uncomfortable withdrawal symptoms occur.

If at any point PW occurs, switch to protocol to manage PW, which may include administration of high dose full opioid agonists in the hospital. Pharmacy prefilled dose-packs can simplify dosing for outpatients, as can instructional infographics.

Table 12. Dose	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine dose	0.5mg (¼ strip daily)	0.5mg (¼ strip) twice daily	1mg (½ strip) twice daily	2mg (1 strip) twice daily	3mg (1 ½ strips) twice daily	4mg (2 strips) twice daily	6mg (3 strips) twice daily
Morning dose							
Night dose							

If patient experiences precipitated withdrawal:

- Immediately take 16 mg of buprenorphine (2 strips or tablets) dissolve under tongue for 20 mins. You may repeat 8-16 mg of buprenorphine again every hour if needed (up to 40 mg)
- Ondansetron 4-8 mg dissolve under tongue for nausea
- Clonidine 0.1 mg 1-2 tabs every four hours for restlessness and sweating

Severe intractable PW may need to be treated in the emergency room with IV opioids (hydromorphone or fentanyl) and low dose ketamine. Resource: Enhanced Care Practice: Precipitated Withdrawal 90-Minute Bundle

Initiation of Extended-Release Injectable Buprenorphine

Two brands of extended-release injectable buprenorphine (BUP-XR) are available: Sublocade in doses of 100 and 300 mg, and Brixadi in weekly and monthly formulations of various doses. These medications are ordered from a specialty pharmacy and shipped directly to the clinic. The patient's insurance company determines which specialty pharmacy the prescription is delivered from.

DEA Compliance

Extended-Release Injectable Buprenorphine (BUP-XR) must never be in the possession of the patient due to the risk of embolism if injected intravenously. The medication must be securely stored in a locked box, inside a locked refrigerator (for Sublocade), or within a locked room. Strict inventory records are required, documenting the date of delivery and the date of administration or disposal of every dose. If a patient does not return for their injection within 45 days, their medication must be disposed of. The medication cannot be administered to any patient other than the one it was prescribed for, nor can it be transferred to a location outside the clinic to which it was sent.

There is one exception to the strict storage and administration rules: the "Black Bag Exception." This exception allows providers to transport a patient's controlled substance to a different location for administration outside the clinic, but only if this occurs on an infrequent and random basis, such as during a home visit or a visit to a remote clinic with rotating providers. The prescriber may also arrange for the BUP-XR to be shipped directly to the clinic or hospital where the patient will receive the injection, provided there is a Drug Enforcement Administration (DEA) registrant at that location designated as the receiving provider. Any trained medical staff, such as a nurse or CHAP, may administer the BUP-XR, provided they are properly trained and authorized by their supervising physician. For further details, refer to the Chapter 4: Regulatory and Administrative Considerations.

Sublocade

Sublocade is a monthly extended-release injectable buprenorphine available in 100 mg and 300 mg doses. Previously Sublocade was labeled to initiate after stabilizing one week on sublingual buprenorphine, but the labeling was changed in 2025 to be given to patients who are actively using opioids and not taking sublingual buprenorphine. Although the labeling suggests giving an observed 4 mg test dose of sublingual buprenorphine prior to the first injection, providers must be aware that this may cause precipitated withdrawal in high risk patients and may decide it in the patient's best interest to skip this test dose. Patients should be informed of

the small risk of precipitated withdrawal with this direct dosing approach and should be counseled on how to manage symptoms if they occur. Off-label use should only be offered with the patient's informed consent.

Local anesthesia with injectable lidocaine is useful prior to injection to reduce the pain associated with the large 19-gauge syringe and viscous medication. Ice application or topical anesthetics are an alternative to injectable lidocaine. Injection site pain, swelling, and itching occur in about 1 in 5 patients and are managed supportively. For symptom management, cold packs are preferred to heat, as the application of heat to the site may cause increased blood levels of buprenorphine. After injection, the depot is palpable as a firm 3 cm subcutaneous mass that will slowly shrink in size to about 1-2 cm over the next 4 weeks, and then gradually dissolve completely over 3-5 months.

Immediately after injection, most patients won't need to take sublingual buprenorphine as the blood levels the first week after the first injection are quite high, similar to levels achieved by 16-24 mg/day sublingual dosing. However, it can take time for medication levels to stabilize, and later in the first month buprenorphine levels may drop down below 2ng/ml, resulting in uncontrolled cravings in many patients as well as an inadequate opioid blockade. For patients who experience uncontrolled cravings, administration of supplemental sublingual buprenorphine (4-16 mg/day) can bring medication levels back up to therapeutic ranges, thus improving patient experience and safety. Supplemental buprenorphine is typically required the last half of the first month, and at times, during the end of the second month. Patients with chronic pain may occasionally need SLBUP

for acute pain exacerbations. Continued cravings while utilizing supplemental SLBUP can be managed individually, and measuring serum medication levels when patients are having peak symptoms can be helpful to interpret symptoms. Drug liking[159] is best suppressed over 3 ng/ml, and maximal blockade of fentanyl occur with levels >5 ng/ml.[160] Symptoms of high serum medication levels in the first week after injection (sweating, nausea, dizziness) can sometimes be confused with withdrawal symptoms. Especially for patients who have been stable on SLBUP for an extended period, the switch to BUP-XR can be anxiety provoking, as patients may fear loss of control over their symptom management, and some may require psychosocial support to assist them with managing comorbid anxiety.

Sublocade injection is repeated every 4 weeks; however, the labeling was recently changed to allow the second dose to be given one week after the first dose when indicated. The first 2 months doses are 300 mg/month for most patients, then 100 mg/month thereafter to maintain serum medication levels at a steady state around 2-3 ng/ml. Patients who are still experiencing use or craving at the end of the second month should be maintained on 300 mg and not reduced to 100 mg. Patients maintained on 300 mg will take 5-6 months to reach peak steady-state serum medication levels that will average 5-6 ng/ml, twice that seen on the 100 mg maintenance. A recent study showed patients who inject opioids have improved retention when maintained on the 300 mg injection.

After the medication levels reach a steady state at 3-6 months, the patient may be able to extend the time between injections up to 6 weeks without experiencing significant withdrawal symptoms or loss of therapeutic effect. This flexibility in timing of administration can be well suited to patients who live in remote areas where travel to appointments can be challenging, or who work in occupations such as fishing or oil field work, when they are away from home for long periods of time. If a patient is expecting to miss injections (due to remote work for example), then they should be continued on the 300 mg dose, as medication levels may remain therapeutic for several months after cessation.

Brixadi (prescribing information)

Brixadi is an extended-release subcutaneous injection available in weekly doses (8 mg, 16 mg, 24 mg, 32 mg) and monthly doses (64 mg, 96 mg, 128 mg). This product offers flexible dosing options and includes labeling that allows for initiation without a sublingual buprenorphine (SLBUP) lead-in. For patients not currently on buprenorphine, the recommended approach is to start with a test dose of 4 mg of transmucosal buprenorphine to ensure it is tolerated without PW, followed by a transition to Brixadi (weekly). For patients without current opioid tolerance, the 8 mg weekly injection can be administered. During the first week, additional 8 mg injections can be given every 1-3 days (up to four injections) to titrate to an effective dose.

In emergency room settings, the administration of high-dose weekly Brixadi to patients with COWS scores above 4 has been well tolerated, often without the need for a prior test dose of sublingual buprenorphine. However, some addiction specialists believe that administering 4 mg of sublingual buprenorphine to a patient using fentanyl increases the risk of PW. Early in treatment, patients on Brixadi may require supplemental sublingual buprenorphine to manage uncontrolled symptoms until a steady state is achieved, as noted in the Sublocade section above.

A Comparison of Brixadi and Sublocade:

Table 13. Brixadi shares many of the same characteristics as Sublocade, with some notable exceptions:

Component	Brixadi	Sublocade
Refrigeration	Does not require refrigeration	Requires refrigeration (by 2025 Sublocade will be stable at room temp up to 12 weeks)
Administration	Can be given at alternate sites (arm) once stable (after 4 injections)	Can be given at various Subcutaneous sites
Pain of administration	No need for local anesthesia (smaller volume does not leave a palpable lump and may result in less painful injection)	Local anesthesia recommended (ice or medication)

[159] Berridge, Kent C., and Terry E. Robinson. "*Liking, Wanting, and the Incentive-Sensitization Theory of Addiction.*" The American Psychologist 71, no. 8 (2016): 670–679. https://doi.org/10.1037/amp0000059.40.

[160] Grande, Lauren A., Danielle Cundiff, Mark K. Greenwald, Michael Murray, Theresa E. Wright, and Stephen A. Martin. "*Evidence on Buprenorphine Dose Limits: A Review.*" Journal of Addiction Medicine 17, no. 5 (2023): 509–516. https://doi.org/10.1097/ADM.0000000000001189.

Component	Brixadi	Sublocade
Pregnant patients	Weekly formulation preferred (see pregnancy section for more information)	Can be considered when weekly Brixadi is not appropriate
Dose	Highest dose of monthly-128mg (produces serum medication levels that are higher than 100 mg Sublocade but lower than 300 mg)	Highest dose of monthly-300 mg produces higher serum drug levels than 128 mg Brixadi
Half-life	19-26 days	43-60 days
REMS/ordering procedure	(same as Sublocade)	Same as Brixadi
DEA Requirements	(same as Sublocade)	Same as Brixadi
Cost	Slightly less expensive than Sublocade	Slightly more expensive than Brixadi

Maintenance Prescribing of Buprenorphine

During follow-up visits, patients are assessed to determine the effectiveness of their current buprenorphine dose. If a patient experiences uncontrolled cravings or continues using opioids, it generally indicates the need for a dose increase. Doses can be adjusted by 2-8 mg per visit and should be reevaluated weekly to assess effectiveness. ASAM recommends a minimum daily dose of 16 mg in early treatment. However, recent studies suggest that higher doses may be linked to better treatment retention and more effective fentanyl blockade.

It's important to note that doses below 16 mg may not be as effective in blocking the effects of illicit opioids. Therefore, patients with more severe opioid use disorder (OUD) who are at high risk of return to use may benefit from higher buprenorphine doses. Stabilization and maintenance dosing vary based on individual patient needs, typically ranging from 16-24 mg daily. Some patients may require up to 32 mg daily for adequate control of cravings, though higher doses may require insurance prior authorization. Patients with low levels of opioid tolerance may stabilize on doses below 12 mg daily.

Patients who continue to use additional opioids while on the maximum dose of buprenorphine covered by insurance may be better suited to alternate treatment strategies. Such approaches may include monthly injectable buprenorphine (with sublingual supplementation if needed in early treatment), which provides higher serum medication levels once stable, or referral to an Opioid Treatment Program (OTP) for methadone, if available. Refer to Section III, Chapter 11 on starting long-acting injectable buprenorphine for information on making this transition.

A typical follow up schedule for patients on a maintenance buprenorphine would include weekly visits until dose is stable and illicit opioid use is extinguished, then bi-weekly visits for the next 3-6 months, then monthly visits thereafter. Some patients benefit from continued shorter prescribing intervals for increased levels of support and accountability.

Follow up visits should include:

- Checking Prescription Drug Monitoring Program (PDMP) regularly to ensure prescriptions are filled, and to check other prescriptions.
- Ordering appropriate drug testing and considering confirmatory testing for unexpected results. Testing can facilitate open communication and behavior change.
- Discussion and inquiry as to how patient is taking their medication.
- Discussion about cravings including what triggers cravings, and what support the patient may feel is needed.
- Discussion regarding side effects and management.
- Adjustment of dose, as needed to control cravings.
- Inquiry on, and addressing comorbid disorders (anxiety, depression, for example) and primary care needs (annual exams, screening exams, immunizations, nutrition counseling, and other as appropriate).
- Appropriate referral to supportive psychosocial care, including but not limited to psychological counseling, peer supports, and other community-based recovery supports as available.

All forms of Medications for Opioid Use Disorder (MOUD), including buprenorphine, are intended to be taken for a long period of time. Patients who continue buprenorphine for less than one year have very high relapse rates and high risk of overdose. There is no limit as to how long a patient can take buprenorphine, and some patients require a lifetime of treatment.[161] The Surgeon General has

[161] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's Spotlight on Opioids*. Washington, DC: HHS, September 2018. https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf.

recognized that patients who are treated for at least three years have lower rates of relapse.[162]

Understanding and Preventing Buprenorphine Diversion

Buprenorphine is a controlled substance with potential for misuse and diversion. Medication diversion is a medical and legal issue, where legally prescribed controlled substances have been transferred from the person for whom they were prescribed to another person for non-prescribed use. Decades of research have shown that the benefits of MOUD greatly outweigh the risks associated with diversion.[163] Providers who take steps to proactively address diversion may reduce the incidence of inappropriate use of prescribed buprenorphine. The use of diverted buprenorphine is commonly reported in patients presenting for OUD treatment. Studies evaluating the use of diverted buprenorphine found that more than 90% of patients reported using illicit buprenorphine to relieve withdrawal symptoms, reduce cravings and avoid opioid use.[164] Buprenorphine was reported as a medication of misuse to “get high” in less than 5% of patients. Additionally recent population-based studies suggest that even non-prescribed buprenorphine may reduce overdose risk in those that take it.[165], [166]

The main concern about a patient diverting their prescribed buprenorphine is not so much the harm that the diverted product might cause to the end user, but rather the harm that can occur to the patient that is not taking their medication as prescribed. This is because stopping buprenorphine or taking a subtherapeutic dose can result in return to use and increased overdose risk.

Buprenorphine has a lower risk of abuse compared to full opioid agonists, due to its nature as a partial agonist. As a partial agonist, it activates opioid receptors just enough to alleviate withdrawal symptoms and cravings without producing a "high" in patients with opioid tolerance. Its long half-life and high receptor affinity, which allows it to bind strongly to receptors and block them for over 24 hours, further contribute to its lower misuse potential.[167] Additionally, non-prescribed buprenorphine is typically more expensive and harder to obtain than heroin or fentanyl, further limiting its misuse.

While the plain buprenorphine (mono-product) has been shown in some studies to be more susceptible to diversion than the combination product (buprenorphine/naloxone), data on this is limited. The addition of naloxone does not alter the clinical effects of buprenorphine when taken as prescribed, but it does act as a misuse deterrent. Naloxone reduces the effects of buprenorphine if it is injected or insufflated and can potentially cause precipitated withdrawal if misused. Similarly, plain buprenorphine can also cause PW if injected by an individual dependent on opioids.

Some patients report intolerance to naloxone-containing products, most commonly experiencing nausea and/or headaches that peak 1-2 hours after administration. If these symptoms persist despite trying different brands and optimizing the administration technique, the patient may be a candidate for sublingual mono-buprenorphine or a switch to long-acting injectable buprenorphine, depending on the preferences of both the provider and patient.

Because buprenorphine can cause intoxication in opioid-naïve individuals, implementing strategies to reduce diversion is crucial to prevent exposure to its opioid effects, particularly among youth and those without prior opioid use.

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[162] Substance Abuse and Mental Health Services Administration, and Office of the Surgeon General. *Facing Addiction in America: The Surgeon General’s Spotlight on Opioids.* Washington, DC: U.S. Department of Health and Human Services, 2018. https://www.ncbi.nlm.nih.gov/books/NBK538436/.

[163] U.S. Department of Health and Human Services. Facing Addiction in America: *The Surgeon General’s Report on Alcohol, Drugs, and Health.* Washington, D.C.: Office of the Surgeon General, November 2016. https://library.samhsa.gov/product/facing-addiction-america-surgeon-generals-report-alcohol-drugs-and-health-full-report/sma16-4991.

[164] Cicero, Timothy J., Matthew S. Ellis, and Henry D. Chilcoat. "*Understanding the Use of Diverted Buprenorphine.*" Drug and Alcohol Dependence 193 (2018): 117–123. https://doi.org/10.1016/j.drugalcdep.2018.09.007.

[165] Carlson, Robert G., Raminta Daniulaityte, Sydney M. Silverstein, Ramzi W. Nahhas, and Silvia S. Martins. "*Unintentional Drug Overdose: Is More Frequent Use of Non-Prescribed Buprenorphine Associated with Lower Risk of Overdose?*" International Journal of Drug Policy 79 (2020): 102722. https://doi.org/10.1016/j.drugpo.2020.102722.

[166] Adams, J. W., M. Duprey, S. Khan, et al. "*Examining Buprenorphine Diversion Through a Harm Reduction Lens: An Agent-Based Modeling Study.*" Harm Reduction Journal 20 (2023): 150. https://doi.org/10.1186/s12954-023-00888-6.

[167] Yokell, M. A., N. D. Zaller, T. C. Green, and J. D. Rich. "*Buprenorphine and Buprenorphine/Naloxone Diversion, Misuse, and Illicit Use: An International Review.*" Current Drug Abuse Reviews 4, no. 1 (2011): 28–41. https://doi.org/10.2174/1874473711104010028.

Strategies to Reduce Buprenorphine Diversion

- Utilize drug testing to identify buprenorphine and other substances used with confirmation testing to verify presence of norbuprenorphine metabolite. See Chapter 5: Drug Testing.
- Perform medication counts, randomly if possible, which may be done virtually
- Provide short prescriptions for patients who tend to run out early
- Query PDMP for other prescriptions of controlled substances or early refills
- Directly observed therapy (in person or video chat observation of patient taking their medication) for patients who struggle with adherence
- Consider changing to injectable long-acting injectable buprenorphine for patients who continue to be at risk for diversion
- Counsel patients against sharing medications with friends and family, offer connection to treatment
- Prescribe combination products (buprenorphine/naloxone) rather than mono product (plain buprenorphine) whenever possible

See this SAMHSA publication for more tips on reducing diversion.

Discontinuation of Buprenorphine

Discontinuation of buprenorphine is associated with increased risk of return to use and overdose.[168] When patients express a desire to discontinue buprenorphine, the provider should have an open and frank discussion regarding this option with the patient, including their reasons for discontinuation. Sometimes reasons may be related to pressure from loved ones to discontinue their medications before it is medically appropriate, and the provider should explore this thoroughly with the patient. Zweben and colleagues (2021) explore common patient concerns related to discontinuation and options for management. Tapering medications should generally be patient-initiated, and providers should counsel patients to meet the following criteria before discontinuing their medications:

- No instances of return to use for 2 years.
- Stable housing, job, and family life.
- No major stressors (legal, financial, etc.).
- Stable mental and physical health.
- Actively engaged in strong recovery support system.[169]

Tapering of all chronic opioid agonists should occur slowly, if possible, with a reduction of 10% or less in the dose per month. Faster tapers can be negotiated with the patient depending on their needs and readjusted as needed. Bozinoff and colleagues (2022) discuss tapering strategies associated with better outcomes. If a patient insists on a rapid taper against medical advice, inpatient withdrawal management is the safest manner to do so.[170] A recent study found that patients who underwent chronic opioid tapers in less than 21 days had a 50% likelihood of requiring hospital care to manage withdrawal symptoms.[171]

An alternative strategy to taper sublingual buprenorphine is to utilize long-acting injectable buprenorphine (BUP-XR). Patients taking less than 8 mg SLBUP may be given a single 100 mg BUP-XR injection. Patients on 8+ mg SLBUP may be given 1 or more 300 mg BUP-XR injections before stopping or taping the dose of the shot. The slow, gradual reduction in serum buprenorphine levels that occurs over several months after cessation is a comfortable and simple transition for many patients. Patients currently maintained on BUP-XR may choose to reduce their monthly dose or simply discontinue injections and often tolerate the cessation well.[172]

If a patient stops taking their buprenorphine, and is abstinent from opioids, a transition to monthly naltrexone injections can act as a safety net to help protect against

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[168] Williams, A. R., H. Samples, S. Crystal, and M. Olfson. "*Acute Care, Prescription Opioid Use, and Overdose Following Discontinuation of Long-Term Buprenorphine Treatment for Opioid Use Disorder.*" The American Journal of Psychiatry 177, no. 2 (2020): 117–124. https://doi.org/10.1176/appi.ajp.2019.19060612.

[169] Zweben, J. E., Sorensen, J. L., Shingle, M., & Blazes, C. K. (2021). *Discontinuing Methadone and Buprenorphine: A Review and Clinical Challenges*. Journal of addiction medicine, 15(6), 454–460. https://doi.org/10.1097/ADM.0000000000000789

[170] Williams, A. R., H. Samples, S. Crystal, and M. Olfson. "*Acute Care, Prescription Opioid Use, and Overdose Following Discontinuation of Long-Term Buprenorphine Treatment for Opioid Use Disorder.*" The American Journal of Psychiatry 177, no. 2 (2020): 117–124. https://doi.org/10.1176/appi.ajp.2019.19060612.

[171] Mark, T. L., and W. Parish. "*Opioid Medication Discontinuation and Risk of Adverse Opioid-Related Health Care Events*." Journal of Substance Abuse Treatment 103 (August 1, 2019): 58–63. https://doi.org/10.1016/j.jsat.2019.05.001.

[172] Jones, A. K., E. Ngaimisi, M. Gopalakrishnan, et al. "*Population Pharmacokinetics of a Monthly Buprenorphine Depot Injection for the Treatment of Opioid Use Disorder: A Combined Analysis of Phase II and Phase III Trials*." Clinical Pharmacokinetics 60 (2021): 527–540. https://doi.org/10.1007/s40262-020-00957-0.

overdose and return to use. See the starting naltrexone Section III, Chapter 13 for more information. Naltrexone initiation may be difficult or impossible within a year of last long-acting injectable buprenorphine administration.

Patients who discontinue buprenorphine should be warned that overdose risk after stopping pharmacotherapy can be very high. It is recommended that patients be provided education about overdose prevention and a naloxone rescue kit, as well as an open invitation to return to care if cravings or use recurs.

Chapter 12: Methadone

Methadone

Methadone is a long-acting full opioid agonist used as a first-line treatment for opioid use disorder (OUD), particularly for those with moderate to severe cases or who experience precipitated withdrawal when starting buprenorphine. The medication is safe and effective, and a first line treatment for anyone with a moderate to severe opioid use disorder, and particularly those who experience precipitated withdrawal (PW) when initiating buprenorphine.[173] It effectively reduces opioid cravings and withdrawal symptoms while blunting the effects of other opioids. It also has higher retention rates than buprenorphine and naltrexone. Methadone is prescribed exclusively, dispensed, and administered through Substance Abuse and Mental Health Services Administration (SAMHSA)-certified opioid treatment programs (OTPs) and must be administered under medical supervision. Dosages are individualized, and with proven adherence and stability, patients may be permitted to take methadone at home between program visits.

OTPs provide comprehensive support, including counseling, employment assistance, referrals to social services, medical care, and mental health treatment. Methadone is a suitable option for patients needing high levels of support, those with severe chronic pain unmanageable by buprenorphine, and those unable to tolerate buprenorphine due to PW. However, methadone has several drug-drug interactions, making it less suitable for some patients with complex medication regimens. For instance, the risk of lethal overdose is higher when combined with other central nervous system (CNS) depressants. While, prior to 2024, access to methadone in rural areas was limited, with the new technology of asynchronous dosing as well as the changes to 42 CFR Part 8, as noted in Section I, those living in rural communities will increasingly be able to receive methadone. Visit this SAMHSA resource to find an OTP in Alaska.

See the special populations Section V, Chapter 25 for more information on the use of methadone in pregnancy.

Services offered at Opioid Treatment Programs

OTPs are encouraged to offer a broad range of support services, which commonly include:

- Individual and group counseling and peer support (participation in counseling is often required).
- Development of patient centered treatment plans and case management support.
- Special support for pregnant women, parents and guardians, including family accessible facilities.
- Referrals to manage medical and psychiatric comorbid conditions.
- Drug and alcohol testing.
- Lab testing (pregnancy, HIV, hepatitis, STIs, TB, liver function, etc.)
- Assistance with transportation to and from the facility.
- Access to vocational rehabilitation, education, and employment services.
- Access to community supports to address issues such as food and housing insecurity.

The Admission Process

To qualify for OTP admission, the patient must meet the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria and provide informed consent to treatment. The admission criteria is based on 42 CFR Part 8:

An OTP shall maintain current procedures designed to ensure that patients are admitted to treatment by qualified personnel who have determined, using accepted medical criteria, that:

- *The individual has an active moderate to severe OUD, or OUD in remission, or is at high risk for recurrence or overdose. Such decisions must be appropriately documented in the patient's clinical record.*
- *In addition, a health care practitioner shall ensure that each patient voluntarily chooses treatment with medications for Opioid Use Disorder (MOUD) and that all relevant facts concerning the use of MOUD are clearly and adequately explained to the patient, and that each patient provides informed consent to treatment.*

For those under 18 years of age:

- *Except in States where State law grants persons under 18 years of age the ability to consent to*

[173] Wakeman SE, Larochelle MR, Ameli O, et al. *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder.* JAMA Netw Open. 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622

OTP treatment without the consent of another, no person under 18 years of age may be admitted to OTP treatment unless a parent, legal guardian, or responsible adult designated by the relevant State authority consents in writing to such treatment.[174]

Although there may sometimes be waitlists for admission to an OTP, as of 2024, most Alaskan OTPs report the ability to admit patients in less than a week, and some offer walk-in services. Priority is given to pregnant women, injecting substance users, previous clients, and people recently released from incarceration.

Patients who come to nonprofit or Tribal health organization OTPs are not turned away for inability to pay, and staff can assist patients to enroll in insurance coverage.

The following organizations across the following communities offer OTPs:

Table 14. Organizations Offering OTPs

Community	Organization	Phone Number
Anchorage	Narcotic Drug Treatment Center	907-276-6430
Anchorage	WCHS, Inc. Anchorage Comprehensive Treatment Center	907-865-9653
Anchorage	Community Medical Services	907-782-4750
Wasilla	Community Medical Services	907-290-3760
Fairbanks	Interior AIDS Association	907-452-4222
Ketchikan	Comprehensive Addiction Services at Ketchikan RISE Wellness Center	907-228-2410
Juneau	SEARHC Comprehensive Addiction Services	907-463-0600
Sitka	SEARHC Opioid Treatment Clinic	907-966-9797
Klawock	SEARHC Alicia Roberts Medical Center	907-755-4925

While this is the current list of OTPs in Alaska, it is an ever changing and expanding list. Please check out the following website for continual updates of the list: SAMHSA Opioid Treatment Program Directory

SEARHC addiction treatment services: Bringing Opioid Treatment Programs (OTP) services to those that need it.

The OTP operated by South East Alaska Regional Health Corporation (SEARHC) is the first program in Alaska run by a preexisting community medical clinic, rather than a stand-alone program run by a corporation or AIDS services nonprofit. Operated by SEARHC Comprehensive Addiction Services, Front Street Clinic is Juneau's only Federally Qualified Health Centers (FQHC) which, provides general primary care services comprised of medical, dental, and behavioral health as well as the OTP.

SEARHC is the first organization to open OTPs in rural areas, recently opening OTPs in Kethchikan, Klawock, and Sitka. Given that the Alaskan Native health consortiums (ANTHC and SEARHC) are core providers of health care in rural Alaska, tribal health organizations opening OTPs is an important and underutilized pathway to increasing MOUD access in remote areas. Operating an OTP in rural areas presents unique challenges, including securing a physical location for the clinic and staffing with nurses and behavioral health professionals; however, they have found the OTP model to be workable even in rural Alaska. "There are certain benefits to FQHCs obtaining dual status as OTPs, including the ability to provide and bill Medicare for a broader scope of medication-assisted treatment and associated services, and the capacity to use a broader variety of clinical professionals."

[174] 42 CFR 8.12(e)

Contraindications to Methadone Treatment:

Methadone can cause respiratory depression, particularly during dose titration.[175] The goal of methadone dosing in the first weeks of treatment is to relieve withdrawal but avoid oversedation and respiratory depression. Patients who are older, are using other CNS depressants (such as benzodiazepines or alcohol) or who have chronic diseases are more susceptible to respiratory depression and must be treated cautiously with lower doses.

- Methadone may be contraindicated in patients with:
- Allergy to methadone
- Severe pulmonary disease
- QT prolongation
- Dependance on benzodiazepines or alcohol (patients may be required to taper off CNS depressants prior to starting methadone, depending on provider discretion, contact your local OTP for their policy)

Important medication interactions

"Because methadone is metabolized chiefly by the CYP3A4 enzyme system (a part of the CYP450 system), drugs that inhibit or induce the CYP450 system can alter the pharmacokinetic properties of these medications. Drugs that inhibit or induce this system can cause clinically significant increases or decreases, respectively, in serum and tissue levels of opioid medications."[176]

Medications that can INCREASE the serum drug level or the opioid effect of Methadone:

- Tricyclic antidepressants: Amitriptyline
- Antibiotics: Ciprofloxacin, erythromycin
- Diazepam
- Ethanol
- Antifungals: Fluconazole, ketoconazole
- SSRIs: Fluoxetine, fluvoxetine, paroxetine, sertraline
- Spironolactone

Medications that can REDUCE the serum medication level or the effect of Methadone:

- Antiretrovirals: Amprenavir, Efavirenz, Nelfinavir, Nevirapine, Ritonavir
- Neuroleptics: carbamazepine, Phenobarbital, Phenytoin
- Rifampin 160
- Methadone Initiation:

After patients are assessed and admitted to the OTP, they must travel to the program for directly observed dosing of their methadone daily until approved for take-home doses or asynchronous dosing.

Patients are typically started on 30-40 mg of methadone with dose increases of 5-10 mg every 3-7 days until cravings or controlled and illicit opioid use is extinguished. As it can take 5 days to see peak serum medication levels after dose increase, more rapid titration can result in oversedation, respiratory depression, or death. Patients should be evaluated daily for signs of oversedation before their daily dose is given. Patients with low levels of tolerance may be started at lower doses. Patients with very high levels of tolerance and severe withdrawal symptoms, as may be seen with heavy fentanyl use, may qualify for higher starting doses and faster titration based on the provider's clinical judgement. It may take weeks or months for a patient to reach a therapeutic dose of methadone, which typically ranges from 80-160 mg/day. Some patients with high levels of dependance on potent synthetic opioids like fentanyl need higher than average doses of methadone to control their withdrawal and cravings.

Split doses:

"Dosing must be individualized because methadone's bioavailability, clearance, and half-life vary among patients, affecting their clinical responses and requiring doses to be changed. Many factors can affect serum levels and clinical responses to treatment. Along with age and diet, these factors include:

- Other medications and herbs (e.g., St. John's wort)
- Genetic differences in metabolizing enzymes
- Pregnancy
- Changes in urinary pH

Serum methadone levels can be informative in patients who report feeling drowsy 2-4 hours after dose administration but develop craving or withdrawal symptoms before the next dose is due to be administered. This often occurs in pregnancy, when concomitant medications interact with

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[175] Durrani, M., and K. Bansal. "*Methadone*." Updated January 11, 2024. In StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing, 2024. https://www.ncbi.nlm.nih.gov/books/NBK562216/.

[176] Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005. *(Treatment Improvement Protocol (TIP) Series, No. 43.) Chapter 3. Pharmacology of Medications Used to Treat Opioid Addiction.* https://www.ncbi.nlm.nih.gov/books/NBK64158/.

methadone, or when patients rapidly metabolize opioids. In such cases, consider dividing the daily methadone dose into twice-daily dosing"[177]

Take-Home Medications

Take-home medication refers to allowing the client to take unsupervised doses. Any OTP patient may receive a single take-home dose for a day when the OTP is closed for business, including Sundays and State and Federal holidays. Prior to COVID-19, it could take 2 years for patients to earn a month of take-home doses by meeting numerous strict criteria. Regulatory changes have made permanent many of the COVID-19 flexibilities that eased take home requirements.

> *"OTP decisions regarding dispensing methadone for unsupervised use under this exemption shall be determined by an appropriately licensed OTP medical practitioner or the medical director. In determining which patients may receive unsupervised doses, the medical director or program medical practitioner shall consider, among other pertinent factors that indicate whether the therapeutic benefits of unsupervised doses outweigh the risks"*[178]

Transitions of Care: Bridging a patient between the hospital, the justice system and the opioid treatment program

Guest dosing

When patients are traveling away from home, then can arrange to receive guest dosing at a distant OTP. This can require advanced planning, require exchange of information between clinics, and is limited to stable patients. For more info on guest dosing see AATOD's Guidelines for Guest Medication.

Assuring Access to Methadone for Incarcerated Individuals with Opioid Use Disorder

The Drug Enforcement Administration (DEA) Narcotic Treatment Program Manual: A Guide to DEA Narcotic Treatment Program Regulations (Revised 2022) provides various options and corresponding regulations to ensure access to methadone for treating individuals with OUD in correctional settings. Below is a condensed version of these options. Additionally, the term Narcotic Treatment Program ("NTP") has been updated to "OTP" for improved user-friendliness. Please see specific details and language for these options in the NTP manual.

- A correctional facility may transport inmates to the OTP at which they are enrolled as patients to receive their medication in accordance with State Opioid Treatment Authority (SOTA) and SAMHSA requirements.
- Staff employed by the correctional facility may take custody from the OTP of a locked container that holds patient-specific medications.
- A practitioner may register with DEA as an OTP at a correctional facility.
- A correctional facility may register with DEA as a hospital/clinic. Under a hospital/clinic registration, a physician or authorized hospital staff may administer or dispense narcotic drugs to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.
- A DEA-registered physician who is not specifically registered to practice in an OTP may administer up to three days of narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment.[179]

See Section V Chapter 26 Criminal Justice for more information about treating OUD in this population.

Continuing Methadone Treatment During Hospitalization

When a patient already receiving methadone from an OTP is hospitalized, it is crucial to obtain a 42 CFR Part 2-compliant bidirectional release of information. This allows the OTP to share essential details, such as the patient's verified methadone dosage and the timing of their last administration, and to provide dosing guidance if doses are missed. It's important to note that OTPs are not required

[177] Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005. (Treatmecxnt Improvement Protocol (TIP) Series, No. 4c3.) https://www.ncbi.nlm.nih.gov/books/NBK64164/.

[178] U.S. Department of Health and Human Services. "*4c2CFR § 8.12 - Opioid Treatment Programs." Electronic Code of Federal Regulations.* Accessed September 21, 202c4. https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8/subpart-C/section-8.12.

[179] Grande, Lauren A., Danielle Cundiff, Mark K. Greenwald, Michael Murray, Theresa E. Wright, and Stephen A. Martin. "*Evidence on Buprenorphine Dose Limits: A Review.*" Journal of Addiction Medicine 17, no. 5 (2023): 509–516. https://doi.org/10.1097/ADM.0000000000001189.

to input any data into the Prescription Drug Monitoring Program (PDMP).

Maintaining ongoing communication with the OTP throughout the patient's hospitalization is vital for effective care coordination and discharge planning. If medication doses are adjusted or rapidly increased during the hospital stay, ensure the OTP can safely continue these doses in the outpatient setting. Hospitals should also provide the OTP with discharge summaries and updated medication reconciliation lists to support seamless transition and continuity of care.

Starting methadone in the hospital

Before starting methadone in the hospital, it is important to verify that the patient has access to an OTP in their community and understands the daily attendance and other participation requirements.

The Bridge program has an excellent Methadone Hospital Quick Start Guide.[180] Bridge is a program focused on "bridging emergency care and community health to create an integrated system that improves health and equity".

[180] California Bridge. "California Bridge: Addiction Treatment." Accessed September 21, 2024. https://bridgetotreatment.org/addiction-treatment/ca-bridge/.

Chapter 13: Extended-Release Naltrexone (Vivitrol)

Extended-release naltrexone is an opioid antagonist which can reduce cravings and block the effects of opioids for approximately 4 weeks. Extended-release naltrexone is injected in the gluteal muscle once monthly and helps reduce return to opioid use after withdrawal management. Although a daily oral formulation of naltrexone exists, it has no efficacy in treating opioid use disorder (OUD) and should only be used in the treatment of alcohol use disorder (AUD). Since naltrexone does not activate the opioid receptors, extended-release naltrexone does not provide any positive reinforcement, such as treating withdrawal symptoms or pain. Additionally, this medication does not provide negative reinforcement, since patients don't experience withdrawal symptoms if they stop taking their medication. Thus, naltrexone is best suited for patients who are highly motivated to stay in treatment and have strong recovery supports in place. Before starting extended-release naltrexone, the patient must be opioid-free for a minimum of 7-14 days to avoid precipitated withdrawal (PW).

Naltrexone is the least utilized medication for Opioid Use Disorder (MOUD) and has the smallest amount of evidence supporting its efficacy.[181][182] Naltrexone has not been consistently shown to reduce overdose risk.

Naltrexone may be a good first-line therapy in patients with a mild opioid use disorder. Naltrexone is suggested as second line medication treatment for moderate to severe opioid use disorder in patients who have had poor responses to buprenorphine and methadone.[183] Extended-release naltrexone may be considered for patients with comorbid AUD and OUD.[184]

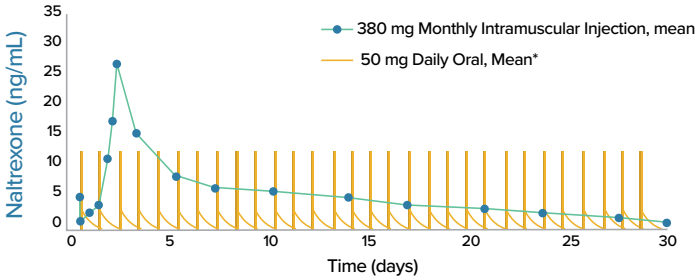
Naltrexone is an opioid antagonist, meaning that it binds strongly to and blocks the mu-opioid receptors. It may help reduce cravings and blocks the effect of opioids if they are used. This medication is not a controlled substance and may be ordered and picked up at any pharmacy by the patient, but the patient must be cautioned not to self-administer the medication at home.

Highlights and full prescribing information for Vivitro.

Starting Extended-Release Naltrexone (Vivitrol)

The recommended dose of Extended-Release naltrexone (XR-NTX) is 380 mg delivered intramuscularly every four weeks. It is important to note that serum naltrexone levels steadily decline after the first week triggering uncontrolled cravings in some towards the end of the month, and patients who experiment with continued opioid use may find they don't have an adequate blockade of fentanyl. These patients may benefit from shorter intervals between administration (such as every three weeks) or utilization of supplemental oral naltrexone if dosing interval is limited by insurance coverage. It's also important to counsel patients that serum medication levels will no longer be protective by five weeks after the last injection, so following a strict injection schedule (every twenty-six to twenty-eight days) is critical to maintain protective medication effect. Patients should be warned about the risk of overdose if they return to use, especially after missing an injection.

Figure 10. Vivitrol. "Once-Monthly Vivitrol." **Accessed September 21, 2024.**



The injection should be administered by a health care provider as an intramuscular (IM) gluteal injection, in alternating buttocks for each subsequent injection. It is important to use a long enough needle for the injection to ensure deep IM administration, as injection of the depo into the fatty tissue can cause severe injection site reactions.[185]

[181] Wakeman et al., 2020

[182] American Academy of Family Physicians. 2019. "*Dyslipidemia: Management in Adults.*" American Family Physician, October 1, 2019. https://www.aafp.org/pubs/afp/issues/2019/1001/p416.html.

[183] UpToDate. 2024. "*Opioid Use Disorder: Treatment Overview.*" Accessed November 20, 2024. https://www.uptodate.com/contents/opioid-use-disorder-treatment-overview#H3961595908.

[184] Mintz, Carrie M., Ned J. Presnall, Kevin Y. Xu, Sarah M. Hartz, John M. Sahrmann, Laura J. Bierut, and Richard A. Grucza. "*An Examination Between Treatment Type and Treatment Retention in Persons with Opioid and Co-Occurring Alcohol Use Disorders.*" Drug and Alcohol Dependence 226 (2021): 108886. https://doi.org/10.1016/j.drugalcdep.2021.108886.

[185] Vivitrol. Prescribing Information. Accessed September 21, 2024. https://www.vivitrol.com/content/pdfs/prescribing-information.pdf.

Naltrexone may rarely cause hepatic dysfunction, and so it is recommended to check the patient's liver function tests prior to first injection, and then again after the first month of therapy then periodically. Transaminase elevations of up to five times normal are tolerable. If elevations exceed this, then naltrexone should be discontinued, and transaminase levels generally return to baseline without long-term hepatic damage. Patients with liver disease should be monitored closely while on naltrexone. Although contraindicated in decompensated cirrhosis, studies have demonstrated that patients with compensated disease may tolerate naltrexone.

Prior to initiating XR-NTX, an opioid-free duration of a minimum of seven to ten days is recommended for patients to avoid precipitation of opioid withdrawal which, may be severe enough to require hospitalization. Patients who are taking long-acting agonist medications such as methadone or buprenorphine may require fourteen days or longer of abstinence before they can receive XR-NTX. Patients discontinuing long-acting injectable buprenorphine may not tolerate naltrexone administration for up to a year or more after BUP-XR discontinuation. This extended period of abstinence can be very difficult for patients to achieve and is most easily accomplished in an inpatient or residential setting. Even with inpatient withdrawal management, over one-third of patients may have uncontrolled symptoms or cravings and leave treatment prior to receiving their naltrexone injection. It is important to offer medications for relief of withdrawal symptoms, and to counsel patients that "abrupt cessation of opioids may lead to strong cravings, and/or acute withdrawal syndrome which can put the patient at risk for relapse, overdose, and overdose death".[186]

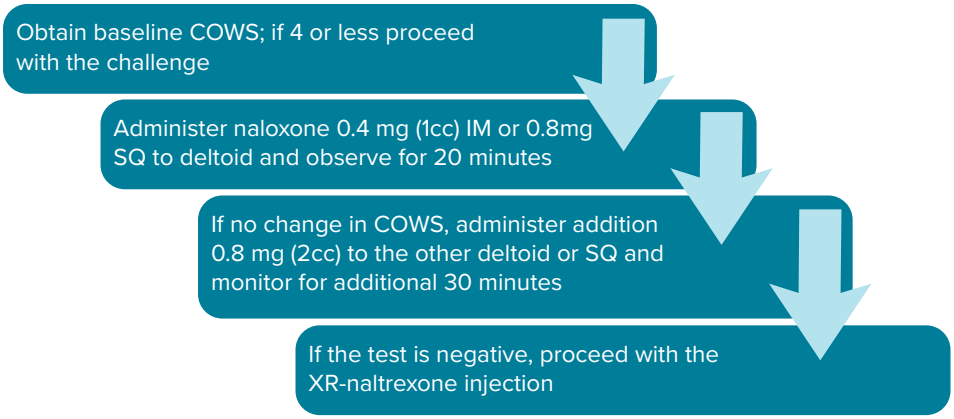
Prior to the first injection, the patient's urine must be free of all opioids (consider testing for fentanyl) and the patient should undergo a naloxone challenge test. The test is considered positive if there is an increase of two or more points from the pre-injection Clinical Opiate Withdrawal Scale (COWS) score. In case of positive challenge, do not administer XR-NTX, wait one to two days and repeat the challenge. Additionally, patients may also undergo an oral naltrexone challenge test where oral naltrexone is given instead, which may be a more accurate test of readiness for patient's switching from buprenorphine. However, it is important to note that oral naltrexone has a long half-life, which means withdrawal symptoms may be prolonged, if they do occur.[187]

Anecdotally, in rare cases, patients have reported a transient yet severe emotional distress after receiving XR-NTX, even after passing the naloxone challenge test. All patients should be instructed to report such adverse effects immediately and seek help for symptom control or crisis services until the distress improves.

Naloxone challenge testing does not need to be repeated prior to subsequent monthly injections unless the patient is more than 2 weeks late for their injection and reports consistent opioid use or has a urine drug screen positive for opioids.

The Providers Clinical Support System MOUD program offers a concise Guide to Initiating XR-Naltrexone. SAMHSA offers a brief guide, Clinical Use of Extended Release Injectable Naltrexone in the Treatment of OUD.

Figure 11. Naloxone Challenge Test



[186] American Society of Addiction Medicine. "National Practice Guideline." Accessed September 21, 2024. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline.

[187] U.S. Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder (Treatment Improvement Protocol Series, No. 63). Exhibit 3C.1. Naloxone Challenge. Published June 1, 2019. Accessed January 11, 2021. https://www.ncbi.nlm.nih.gov/books/NBK535266/box/p3.b36/.

An off-label strategy that has been reported to facilitate quicker initiation of naltrexone, particularly when transitioning from buprenorphine, is the ultra-low dose titration approach.[188] This method, akin to a low dose overlapping start with buprenorphine, involves gradually tapering the patient off buprenorphine while simultaneously introducing very low doses of oral naltrexone (less than 5 mg daily). The naltrexone dose is then progressively increased, often by doubling each day, until the patient can tolerate a full 50 mg dose, at which point XR-NTX can be administered. This approach may be considered for patients attempting to initiate naltrexone 6-12 months after stopping long-acting injectable buprenorphine (BUP-XR). However, no established protocols exist for this transition. Patients considering BUP-XR treatment should be advised that transitioning to naltrexone after starting BUP-XR may not be feasible.

Patients should receive their XR-NTX injections every 4 weeks. To increase treatment adherence, the following are recommended: family involvement, motivational incentives/contingency management, and active outreach by case managers and peer support specialists.

Particularly in adolescents and young adults, an assertive outreach approach to on-time dosing appears to improve outcomes.[189]

Providers should monitor for depression as a possible side effect and should monitor liver function tests periodically. Common side effects include nausea, loss of appetite, and weight loss.

Although research is limited on the length of time for naltrexone treatment, the general consensus is that longer courses of substance use disorder (SUD) treatment have better outcomes. Most patients are recommended to continue naltrexone for a year or longer, until they are stable in long term recovery.

When patients discontinue naltrexone, they are at higher risk of return to opioid use and overdose. It is critical to provide overdose prevention education and naloxone rescue kits to all patients discontinuing naltrexone therapy.

Patients who fail to tolerate opioid withdrawal/naltrexone initiation should be offered opioid agonist therapy (buprenorphine or methadone).

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[188] Shulman, M., M. G. Greiner, H. M. Tafessu, et al. "*Rapid Initiation of Injection Naltrexone for Opioid Use Disorder: A Stepped-Wedge Cluster Randomized Clinical Trial.*" JAMA Network Open 7, no. 5 (2024): e249744. https://doi.org/10.1001/jamanetworkopen.2024.9744.

[189] Fishman, M., K. Wenzel, H. Vo, J. Wildberger, and R. Burgower. "*A Pilot Randomized Controlled Trial of Assertive Treatment Including Family Involvement and Home Delivery of Medication for Young Adults with Opioid Use Disorder.*" Addiction 116, no. 3 (2021): 548–557. https://doi.org/10.1111/add.15181.

SECTION IV:
Addressing Comorbid Substance Use

Chapter 14: Overview of Alcohol Use Disorder and Medications for Alcohol Use Disorder

About Alcohol Use Disorder

Alcohol use disorder (AUD) is a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences. It encompasses the conditions that some people refer to as alcohol abuse, alcohol dependence, alcohol addiction, and the colloquial term, alcoholism. Considered a brain disorder, AUD can be mild, moderate, or severe. Lasting changes in the brain caused by alcohol misuse perpetuate AUD and make individuals vulnerable to relapse. The good news is that no matter how severe the problem may seem, evidence-based treatment with behavioral therapies, mutual-support groups, and/or medications can help people with AUD achieve and maintain recovery. Current evidence shows that medications are underused in the treatment of AUD despite the high prevalence of alcohol problems in the general population.[190] AUD is a common comorbidity affecting patients with opioid use disorder (OUD). In patients with chronic pain and OUD, up to one third of patients also have AUD.[191] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 2015:

Medications have shown much promise in reducing alcohol use and promoting abstinence in patients diagnosed with alcohol use disorder. Considerable research evidence and consensus among experts support the use of pharmacologic treatments in primary care settings. Several FDA-approved medications have been shown to be important elements of such treatment.

Treating Opioid use disorder in patients with alcohol use disorder

Many patients experience co-occurring AUD and OUD. Both alcohol and opioids are central nervous system depressants and have a greater chance of inducing respiratory depression or overdose than either substance alone. Current American Society of Addiction Medicine (ASAM) guidelines state that opioid agonist treatments should not be withheld from patients with AUD or sedative (benzodiazepine) use disorders, while the FDA additionally cautions against it.[192] Although there is some risk of respiratory suppression when patients combine buprenorphine with alcohol or benzodiazepines, the risk of overdose related to full opioid agonist use in a patient with untreated OUD is much higher.[193] The previous hesitancy to offer buprenorphine to patients with comorbid AUD is now addressed with the clarifying ASAM guidelines.

Alcohol withdrawal management

The initial step in treating AUD for many patients is managing withdrawal. The ASAM has published The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, which outlines evidence-based recommendations for this process. Withdrawal management can be conducted in either an inpatient or outpatient setting, depending on the patient's risk factors.

Alcohol withdrawal symptoms are the result of overactivity in the autonomic nervous system, which regulates the body's response to stress. These symptoms typically manifest within 6-48 hours after a significant reduction in alcohol consumption. Early signs include headache, tremor, sweating, agitation, anxiety, irritability, nausea, vomiting, heightened sensitivity to light and sound, disorientation, and difficulty concentrating. In more severe cases, patients may experience transient hallucinations, seizures, or delirium tremens (DTs)—a life-threatening condition characterized by severe agitation, tremor, disorientation, persistent hallucinations, and marked increases in heart rate, respiration, and blood pressure.

The Prediction of Alcohol Withdrawal Severity Scale

[190] U.S. Substance Abuse and Mental Health Services Administration. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*. Published October 2015. Accessed January 11, 2021. https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907.

[191] Witkiewitz, K., and K. E. Vowles. "*Alcohol and Opioid Use, Co-Use, and Chronic Pain in the Context of the Opioid Epidemic: A Critical Review.*" Alcoholism: Clinical and Experimental Research 42, no. 3 (2018): 478–488. https://doi.org/10.1111/acer.13594.

[192] U.S. Food and Drug Administration. "*FDA Drug Safety Communication: FDA Urges Caution About Withholding Opioid Addiction Medications.*" Accessed September 21, 2024. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medi

[193] Maust, DT, K. Petzold, J. Strominger, H. M. Kim, and A. S. B. Bohnert. "*Benzodiazepine Discontinuation and Mortality Among Patients Receiving Long-Term Benzodiazepine Therapy.*" JAMA Network Open 6, no. 12 (2023): e2348557. https://doi.org/10.1001/jamanetworkopen.2023.48557.

(PAWSS) is a useful tool for determining the appropriate setting for withdrawal management. Patients with PAWSS scores of 4 or higher are at a high risk for moderate to severe withdrawal complications and should generally be managed in an inpatient setting.

According to ASAM, “patients at risk of developing severe or complicated alcohol withdrawal may be treated in ambulatory settings at the discretion of providers with extensive experience in managing alcohol withdrawal. Such patients should receive preventative pharmacotherapy."[194] Benzodiazepines are the first-line treatment for withdrawal due to their proven effectiveness in reducing withdrawal symptoms, including the incidence of seizures and delirium.[195]

ASAM recommends that, when possible, treatment for AUD should be initiated concurrently with alcohol withdrawal management, provided the patient's cognitive status allows. It is crucial to have a plan in place to begin AUD treatment with medications and/or psychosocial support before attempting alcohol withdrawal, as most patients are likely to return to alcohol use without it. Repeated withdrawal episodes can lead to the "kindling effect," where withdrawal symptoms worsen with each subsequent attempt. For more detailed information, refer to the ASAM Clinical Practice Guideline on Alcohol Withdrawal Management for more information about treating alcohol withdrawal.

Medications for alcohol use disorder

There are two types of evidence-based treatment for AUD: behavioral health care and medications, they can be combined or tailored to improve outcomes for each patient. There are currently three Food & Drug Administration (FDA)-approved medications to treat AUD: Disulfiram, Naltrexone and Acamprosate. Medications can help patients with AUD increase days of abstinence and reduce heavy drinking days.[196] SAMHSA has published a helpful guide to Managing Medications for AUD (pages 3-6 have a useful table that compares medications) and a pocket guide called Medication for the Treatment of Alcohol Use Disorder. As with all medications to treat substance use disorder (SUD), these medications should be prescribed for a year or longer to help the patient achieve long-term abstinence and risk of return to use is decreased.

Disulfiram

Disulfiram, also called Antabuse, interacts with and inhibits the metabolism of alcohol. Acetaldehyde, a toxic compound builds up when alcohol is ingested and causes symptoms such as flushing, headache, respiratory difficulty, nausea, vomiting, sweating, chest pain, palpitations, blurred vision, and confusion. The patient’s alcohol level must be 0 prior to first dose. It is dosed orally, usually at 250 -500 mg daily, and should be used in caution with patients with cirrhosis. Liver function tests should be monitored at baseline and 2 weeks after initiating treatment. Disulfiram works as a psychological deterrent to alcohol use. If this medication adherence is the major barrier, efficacy can be optimized with supervised administration such as having a support person assist the patient with accountability to take their medication daily. Video observation of therapy is another monitoring option, either through secure video chat or an app designed to securely store and forward medication dosing videos. See the Technology part in Section I Chapter 2 for more information. See Disulfiram has several medication interactions; therefore, patients should ask their provider or pharmacy check for drug-drug interactions prior to prescribing new medications. Patients need to avoid all foods, drinks, medications, and other substances that contain any alcohol.

Naltrexone

Naltrexone is an FDA-approved medication for treating AUD. It is available in two forms: a pill known as Revia, taken orally at a dose of 50 mg once daily, and Vivitrol, an intramuscular (IM) injection administered as a 380 mg extended-release depot once a month. Naltrexone is an opioid receptor antagonist that works by diminishing the reward and pleasure associated with alcohol consumption and reducing cravings, helping patients maintain abstinence.

While naltrexone blocks the activation of opioid receptors, which prevents the euphoria linked to drinking, it does not block alcohol's effects on the body. Patients taking naltrexone may still experience impaired judgment,

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[194] American Society of Addiction Medicine (ASAM). n.d. "*Alcohol Withdrawal Management Guideline.*" Accessed November 20, 2024. https://www.asam.org/quality-care/clinical-guidelines/alcohol-withdrawal-management-guideline.

[195] Hammond, C. J., M. J. Niciu, S. Drew, and A. J. Arias. "*Anticonvulsants for the Treatment of Alcohol Withdrawal Syndrome and Alcohol Use Disorders.*" CNS Drugs 29, no. 4 (2015): 293–311. https://doi.org/10.1007/s40263-015-0240-4.

[196] McPheeters, M., E. A. O'Connor, S. Riley, et al. "*Pharmacotherapy for Alcohol Use Disorder: A Systematic Review and Meta-Analysis.*" JAMA 330, no. 17 (2023): 1653-65. doi: 10.1001/jama.2023.19761

reasoning, coordination, and response times, and are at risk for alcohol poisoning and respiratory depression if they consume alcohol heavily.

Naltrexone is particularly useful for treating patients with both AUD and OUD; however, it cannot be used in combination with buprenorphine or methadone therapy for OUD. Although naltrexone can be used in patients who are still drinking, it is most effective in those who have abstained from alcohol for at least 1 week before the first dose.

Due to the potential for hepatic side effects, liver function tests should be conducted before the first dose, at 1 month, and periodically thereafter. Treatment should be avoided or discontinued if transaminase levels exceed five times the upper limit of normal. For more detailed prescribing information, refer to Chapter 13.

Acamprosate

Acamprosate, a GABA antagonist also known as Campral, works to reduce alcohol cravings through altering the levels of certain brain chemicals on GABA receptors. This helps lessen some of the negative post-acute withdrawal symptoms, such as anxiety, that can trigger cravings and return to use. Acamprosate can be used in patients who are still drinking but is more effective in patients who have been abstinent for a week prior to first dose. Dosing for this medication is 666mg (usually two 333 mg tabs) three times a day, which can be a barrier to adherence in some patients. It's safe to use with hepatic impairment, but the dosage should be adjusted in patients with renal impairment.

Off label medications for alcohol use disorder

Many other medications have been investigated for their therapeutic potential in the treatment of AUD, and some have shown potential efficacy, including baclofen, gabapentin and topiramate. Fischler and colleagues (2022) identify the existing evidence for off label medications to treat AUD.[197]

Managed Alcohol Use

Strategies focusing on reducing alcohol-related harms in homeless populations with severe AUD continue to gain acceptance, especially when conventional modalities focused on alcohol abstinence have been unsuccessful. One such strategy is the managed alcohol program (MAP), an alcohol harm reduction program managing consumption by providing eligible individuals with regular doses of alcohol as a part of a structured program and often providing resources such as housing and other social services. MAPs have been shown to reduce emergency room visits and hospital admissions and improve quality of life for patients.[198]

Although Alaska does not have any existing MAPs, there are Housing First facilities that provide some support for patients with ongoing alcohol use such as RurAL Cap's Karluk Manor in Anchorage.

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[197] Fischler, P. V., Soyka, M., Seifritz, E., & Mutschler, J. (2022). *Off-label and investigational drugs in the treatment of alcohol use disorder: A critical review.* Frontiers in pharmacology, 13, 927703. https://doi.org/10.3389/fphar.2022.927703

[198] Smith-Bernardin, S.M., Suen, L.W., Barr-Walker, J. et al. *Scoping review of managed alcohol programs*. Harm Reduct J 19, 82 (2022). https://doi.org/10.1186/s12954-022-00646-0

Chapter 15: Addressing Stimulant Use Disorder Treatment

Stimulant use disorders (StUD) pose significant public health challenges, affecting individuals who use substances like cocaine, methamphetamine, and prescription amphetamines. In June 2024, American Society of Addiction Medicine (ASAM) released "The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder," a guide to treating stimulant use disorder.[199] The guide offers evidence-based strategies for treating stimulant use disorders (StUDs), addressing stimulant intoxication and withdrawal, and preventing harms related to stimulant use through secondary and tertiary prevention. The guideline was developed by the Clinical Guideline Committee (CGC), consisting of experts from ASAM and AAAP with experience across various clinical settings and patient populations. Using a modified GRADE methodology, the development process involved a systematic literature review and targeted supplemental searches. The CGC employed Evidence to Decision tables assess available evidence and rate the strength of each recommendation. Following external stakeholder review, the guideline was revised. Key insights include contingency management as the current standard of care for StUDs; off-label use of pharmacotherapies for StUD treatment; the need for appropriate care levels for life-threatening stimulant intoxication; and the importance of secondary and tertiary prevention strategies to mitigate the harms associated with risky stimulant use.

The most effective treatment for stimulant use disorders is a combination of contingency management and a community reinforcement approach to enhance motivation and make abstinence more rewarding to the patient.[200] [201]Patients who participate in programs that combine both, experience reduced drug use, increased retention in treatment, and reduction in anxiety levels. The Northwest Addiction Technology Transfer Center (NW ATTC) has a self-paced course for Contingency Management for Health Care Settings.

Contingency Management: Incentivizing treatment engagement.

Interior Aid Association offers a robust contingency management program. Interior Medication Assisted treatment IMAT consumers are rewarded immediately in the moment for providing drug test samples free of at least one of their drugs of abuse and for tests free of all illicit drugs. Clients receive tokens for meeting goals and the tokens are exchanged along a continuum of reward values so saving tokens and delaying gratification can be learned. 1 token = small basket prize; candy bar, ChapStick, granola bars, etc. 2 tokens = $10 gift card. 3 tokens = $25 gift card or $25 towards their monthly balance if applicable. They gather client feedback regarding preferred rewards, which may include gift cards to Fred Meyers, Ulta, Barnes and Noble, and Walmart. Some consumers have asked to hold onto the token as a symbol of their progress rather than exchanging for a prize.

Community Reinforcement Approach Contingency Management Examples

Behaviors Rewarded

- Attending counseling
- Arriving on time for scheduled appointments
- Drug free urine test
- Following medication assisted treatment (MAT) prescription

Reward Offers

- Gift cards
- Draw ticket for prize
- Useful items (clothing, hygiene items, etc.)

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[199] American Society of Addiction Medicine and American Academy of Addiction Psychiatry. *The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder.* Journal of Addiction Medicine 18, no. 1S (May/June 2024): 1–56. https://doi.org/10.1097/ADM.0000000000001299.

[200] Stitzer, M.L., H.E. Jones, M. Tuten, and C. Wong. "*Community Reinforcement Approach and Contingency Management Interventions for Substance Abuse.*" In Handbook of Motivational Counseling: Goal-Based Approaches to Assessment and Intervention with Addiction and Other Problems, edited by W.M. Cox and E. Klinger, 549–569. Chichester, UK: John Wiley & Sons, Ltd., 2011. https://doi.org/10.1002/9780470979952.ch23.

[201] Meyers, Robert J., Henk G. Roozen, and Jane E. Smith. "*The Community Reinforcement Approach: An Update of the Evidence.*" Alcohol Research & Health 33, no. 4 (2011): 380-88. PMID: 23580022.

Figure 12. Community Reinforcement Approach

Medications for Stimulant Use Disorder

While psychosocial interventions play a crucial role in treating these disorders, there is currently no Food & Drug Administration (FDA)-approved pharmacotherapy for StUD.

Medications for StUD are being investigated at this time. A clinical trial using mirtazapine demonstrated a 20% reduction in methamphetamine use.[202] Other medications that may help to reduce cravings and use, include bupropion (alone or combined with naltrexone) and topiramate.[203] Although extended-release amphetamines are also being studied to treat stimulant use disorders with mixed results, they have a high risk of misuse and should only be used by addiction medicine specialists. Symptoms associated with stimulant use, such as depression and insomnia, should be treated with non-narcotic medications to help improve quality of life. The article "Treatment of stimulant use disorder: A systematic review of reviews".[204]

[202] Naji, Leen, Brittany Dennis, Tea Rosic, Wojtek Wiercioch, James Paul, Andrew Worster, Lehana Thabane, and Zainab Samaan. "*Mirtazapine for the Treatment of Amphetamine and Methamphetamine Use Disorder: A Systematic Review and Meta-Analysis.*" Drug and Alcohol Dependence 232 (2022): 109295. https://doi.org/10.1016/j.drugalcdep.2022.109295

[203] Madhukar H. Trivedi, Robrina Walker, Walter Ling, Adriane dela Cruz, Gaurav Sharma, Thomas Carmody, Udi E. Ghitza, Aimee Wahle, Mora Kim, Kathy Shores-Wilson, Steven Sparenborg, Phillip Coffin, Joy Schmitz, Katharina Wiest, Gavin Bart, Susan C. Sonne, Sidarth Wakhlu, A. John Rush, Edward V. Nunes, and Steven Shoptaw. "*Bupropion and Naltrexone in Methamphetamine Use Disorder.*" New England Journal of Medicine 384, no. 2 (2021): 140-153. https://doi.org/10.1056/NEJMoa2020214.

[204] Ronsley, C., Nolan, S., Knight, R., Hayashi, K., Klimas, J., Walley, A., Wood, E., and Fairbairn, N. "*Treatment of Stimulant Use Disorder: A Systematic Review of Reviews.*" PloS One 15, no. 6 (2020): e0234809. https://doi.org/10.1371/journal.pone.0234809.

Chapter 16: Sedative-Hypnotic Use

Sedative-hypnotic drugs—sometimes referred to as "depressants"—and anxiolytic (anti-anxiety) drugs slow down the activity of the brain. **The best-known sedative-hypnotic drugs include benzodiazepines (such as Ativan, Halcion, Librium, Valium, Xanax, and Rohypnol), "Z" drugs like zolpidem and eszopiclone, and an older class of drugs called barbiturates (including Amytal, Nembutal, Seconal, and phenobarbital).** Benzodiazepines are commonly used to treat anxiety and sleep disorders. They are generally safer than barbiturates, causing sedation but rarely interfering with a person's breathing or causing death. However, they can cause side effects such as over-sedation, memory impairment, poor motor coordination, and confusion. Withdrawal from benzodiazepines can be severe, especially in patients taking high doses for long periods, and can mimic alcohol withdrawal symptoms.[205]

Barbiturates, on the other hand, are used to treat seizures and for anesthesia during major surgery. Using barbiturates to get "high" can be extremely dangerous due to the narrow therapeutic effect (the small margin between the desired dose and an overdose). Withdrawal from barbiturates is similar to, and sometimes more severe than, alcohol withdrawal, with the risk of seizures and potential death. These drugs can lead to dependence, where withdrawal symptoms occur if the drug is suddenly stopped. Regular use often leads to drug tolerance, requiring higher doses to achieve the desired effect. Combining these drugs or using them with alcohol or opioids can have dangerous effects.[206]

The Food & Drug Administration (FDA) has issued a black box warning against the use of sedative-hypnotics (including benzodiazepines and "Z" drugs like zolpidem and eszopiclone) with opioids; however, they have also clarified that patients should not be denied medications for Opioid Use Disorder (MOUD) due to their use.[207] Although prescribed benzodiazepine use has been associated with elevated mortality risk in patients with opioid use disorder (OUD), it may also be linked to improved retention on MOUD.[208] Lower doses of benzodiazepines have a lower risk of associated overdose.[209] It is also important to note that rapid discontinuation of chronic benzodiazepines is not recommended and is associated with increased mortality.[210] Risks and benefits on continuing, tapering, or discontinuing sedatives should be weighed carefully on an individual basis. For more information see the American Society of Addiction Medicine (ASAM) guide to tapering benzodiazepines.

Tapers of prescribed benzodiazepines should generally occur slowly and usually include a transition from short-acting medications (like alprazolam or lorazepam) to long-acting formulations (usually diazepam) to provide more steady serum medication levels and reduce inter-dose withdrawal symptoms. Rapid tapering or sudden cessation of benzodiazepines can result in fatal seizures, so when required should occur in the inpatient setting.[211] There are several adjunctive medications that can be helpful to improve tolerability of tapers.[212] Psychosocial support can also be critical to helping patients learn to manage their symptoms without benzodiazepines. Patients who are

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[205] Bounds, C.G., and P. Patel. "*Benzodiazepines*." Last updated January 30, 2024. In StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing, 2024–. https://www.ncbi.nlm.nih.gov/books/NBK470159/.

[206] Suddock, J.T., K.J. Kent, A.C. Regina, et al. "*Barbiturate Toxicity*." Last updated February 28, 2024. In StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing, 2024–. https://www.ncbi.nlm.nih.gov/books/NBK499875.

[207] U.S. Food and Drug Administration. "*FDA Drug Safety Communication: FDA Urges Caution About Withholding Opioid Addiction Medications*." FDA, accessed September 25, 2024. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications.

[208] Park, T. W., M. R. Larochelle, R. Saitz, N. Wang, D. Bernson, and A. Y. Walley. "*Associations Between Prescribed Benzodiazepines, Overdose Death and Buprenorphine Discontinuation Among People Receiving Buprenorphine*." Addiction 115, no. 5 (2020): 924–932. https://doi.org/10.1111/add.14886.

[209] Xu, Kevin Y., Jacob T. Borodovsky, Ned Presnall, Carrie M. Mintz, Sarah M. Hartz, Laura J. Bierut, and Richard A. Grucza. *Association Between Benzodiazepine or Z-Drug Prescriptions and Drug-Related Poisonings Among Patients Receiving Buprenorphine Maintenance: A Case-Crossover Analysis*. American Journal of Psychiatry, AJP, 178, no. 7 (July 2021): 651–59. doi:10.1176/appi.ajp.2020.20081174.

[210] Maust, D.T., K. Petzold, J. Strominger, H.M. Kim, and A.S.B. Bohnert. "*Benzodiazepine Discontinuation and Mortality Among Patients Receiving Long-Term Benzodiazepine Therapy*." JAMA Network Open 6, no. 12 (2023): e2348557. https://doi.org/10.1001/jamanetworkopen.2023.48557.

[211] Brett, J., and B. Murnion. "*Management of Benzodiazepine Misuse and Dependence*." Australian Prescriber 38, no. 5 (2015): 152–155. https://doi.org/10.18773/austprescr.2015.055.

[212] Fluyau, D., N. Revadigar, and B. E. Manobianco. "*Challenges of the Pharmacological Management of Benzodiazepine Withdrawal, Dependence, and Discontinuation*." Therapeutic Advances in Psychopharmacology 8, no. 5 (2018): 147–168. https://doi.org/10.1177/2045125317753340.

using non-prescribed benzodiazepines or meet criteria for benzodiazepine use disorder may be unable to follow an outpatient taper of benzodiazepines; however, some patients with lower levels of tolerance and less severe use disorders can successfully participate in an outpatient taper trial. Providers should consider utilizing confirmatory drug testing when monitoring tapers to identify the specific drugs and metabolites present to verify that patient is taking the prescribed medication versus a non-prescribed drug. It is important to note that clonazepam and most novel illicit benzodiazepines may NOT be detected with a rapid urine drug screen. See Section IV Chapter 19 for more information on novel illicit benzodiazepines. This report includes an equivalency table for some designer benzodiazepines that may be useful when planning withdrawal management.[213]

Some resources to assist with tapering benzodiazepines:

Talking with your patient about deprescribing benzodiazepines

- How to approach a benzodiazepine taper
- Benzodiazepine Tapering Strategies and Solutions
- The Ashton Manual: Benzodiazepines How They Work and How to Withdraw
- Effective Treatments for PTSD: Helping Patients Taper from Benzodiazepines from the VA
- A patient mutual support group

[213] Pérez Orts, Mireia, Arian van Asten, and Isabelle Kohler. "*The Evolution Toward Designer Benzodiazepines in Drug-Facilitated Sexual Assault Cases*." Journal of Analytical Toxicology 47, no. 1 (January 2023): 1–25. https://doi.org/10.1093/jat/bkac017.

Chapter 17: Tobacco Use Disorder

In 2021, 25% of adults in Alaska currently used some form of tobacco or nicotine[214], compared to 18.7% of adults nationwide.[215] Tobacco use among Alaska Native adults was significantly greater than among non-Native adults.[193]

There is mounting evidence that addressing smoking and other drug use concurrently leads to improved psychiatric and polysubstance use outcomes. At minimum, research has found that smoking cessation while in treatment has no negative effect on other drug use outcomes. Encouragingly, meta-analysis of smoking cessation interventions found that individuals who treat their addiction to tobacco and other substances simultaneously are 25% more likely to sustain their recovery, compared to individuals who do not address tobacco while in treatment from other drugs.[216]

Medications for tobacco use disorder (including varenicline, bupropion and nicotine replacement products) are shown to increase rates of sustained abstinence.[217]; [218] Pharmacotherapies for quitting tobacco should lessen withdrawal symptoms and stop nicotine's reinforcing effects without having too many side effects. Both behavioral counseling and pharmacotherapy are effective treatments when used individually, but they are most effective when combined.[219]

Information for Utilizing Medications for Smoking Cessation

The American Thoracic Society identified the following guidelines to support treatment:

- Varenicline is more effective than nicotine patches and bupropion with similar or fewer adverse events, even with comorbid psychiatric or substance abuse conditions.
- Combining varenicline with nicotine patches appears to be more effective than using varenicline alone based on limited evidence.
- For people who smoke and are not ready to quit, prescribing varenicline increases six-month abstinence, with a number needed to treat (NNT) of 6, compared with waiting for readiness.
- Extending treatment beyond 12 weeks increases abstinence, with an NNT of 19, compared with shorter treatment durations.[220]

Anthenelli and colleagues (2016) conducted a trial coined as the EAGLES (Evaluating Adverse Events in a Global Smoking Cessation Study) trial. This randomized, double-blind clinical trial of 8,144 people evaluated the neuropsychiatric safety and effectiveness of varenicline and bupropion compared to nicotine patch and placebo in smokers with and without psychiatric conditions. Conducted across 140 sites in sixteen countries, it found no significant increase in neuropsychiatric adverse events linked to varenicline or bupropion. Varenicline was the most effective in promoting smoking cessation, with a higher six-month quit rate of 21.8%, outperforming placebo, nicotine patch (15.7%), and bupropion (16.2%). Both bupropion and nicotine patch were more effective than placebo. Common side effects varied by treatment group, including nausea, insomnia, and abnormal dreams.[221]

[214] Alaska Department of Health. Alaska Tobacco Facts 2024. Juneau, AK: Division of Public Health, 2024. https://health.alaska.gov/media/iwcf2znh/2024_aktobaccofacts.pdf.

[215] Cornelius, M. E., C. G. Loretan, A. Jamal, B. C. Davis Lynn, M. Mayer, I. C. Alcantara, and L. Neff. "Tobacco Product Use Among Adults - United States, 2021." MMWR. Morbidity and Mortality Weekly Report 72, no. 18 (2023): 475–483. https://doi.org/10.15585/mmwr.mm7218a1.

[216] Morris, C. D., and C. E. Garver-Apgar. "Nicotine and Opioids: A Call for Co-treatment as the Standard of Care." The Journal of Behavioral Health Services & Research 47, no. 4 (2020): 601–613. https://doi.org/10.1007/s11414-020-09712-6.

[217] Rose, J. E., and F. M. Behm. "Combination Treatment with Varenicline and Bupropion in an Adaptive Smoking Cessation Paradigm." The American Journal of Psychiatry 171, no. 11 (2014): 1199–1205. https://doi.org/10.1176/appi.ajp.2014.13050595.

[218] Caponnetto, Pasquale, et al. "Varenicline for Smoking Cessation in Individuals Who Smoke Cigarettes and Use Electronic Cigarettes: A Double-Blind, Randomised, Placebo-Controlled Phase 3 Trial." eClinicalMedicine 66 (2024): 102316.

[219] Stead, L. F., and T. Lancaster. "Behavioural Interventions as Adjuncts to Pharmacotherapy for Smoking Cessation." The Cochrane Database of Systematic Reviews 12 (2012): CD009670. https://doi.org/10.1002/14651858.CD009670.pub2.

[220] "Pharmacologic Therapy for Smoking Cessation." American Family Physician 103, no. 6 (2021): 380–381. https://www.aafp.org/pubs/afp/issues/2021/0315/p380.html.

[221] Anthenelli, R. M., N. L. Benowitz, R. West, L. St Aubin, T. McRae, D. Lawrence, J. Ascher, C. Russ, A. Krishen, and A. E. Evins. "Neuropsychiatric Safety and Efficacy of Varenicline, Bupropion, and Nicotine Patch in Smokers with and without Psychiatric Disorders (EAGLES): A Double-Blind, Randomised, Placebo-Controlled Clinical Trial." Lancet 387, no. 10037 (2016): 2507–2520. https://doi.org/10.1016/S0140-6736(16)30272-0.

This review article includes a table that summarizes the dosing instructions, risks, and benefits of each medication for nicotine dependence.[222]

Nicotine Replacement Therapy

Nicotine replacement therapy (NRT) involves the controlled delivery of nicotine, which helps individuals abstain from tobacco by partially substituting the nicotine they would otherwise obtain from smoking. NRT serves two primary purposes: It stimulates nicotine receptors to alleviate cravings and withdrawal symptoms immediately, while also gradually reducing the number of nicotine receptors over several weeks. This latter effect contributes to a progressive decrease in tobacco dependence.[223]

The choice of the NRT product should reflect the patient's preferences. Combination NRT (short plus long-acting products) is superior to single NRT and is the current standard of care. Transdermal nicotine patches deliver nicotine at a relatively steady rate, so they are the most suitable routes of administration to reduce withdrawal symptoms.[201] On the other hand, chewing gums, lozenges, inhalers, and nasal sprays reduce symptoms faster than patches and can be helpful for as needed craving coverage.

Nicotine replacement therapy usually lasts twelve weeks, although treating heavy smokers for longer intervals may be reasonable, at least until the patient feels confident enough not to relapse. Long-term NRT is not associated with increased incidence of harm.[224]

Typical adverse events common to all NRT products include gastrointestinal symptoms (nausea, vomiting, abdominal pain, diarrhea), dizziness, headache, and local irritation, according to the route of administration.

Varenicline

Varenicline is a partial agonist selective for nicotinic acetylcholine receptors, one of the receptors related to dopamine release following nicotine binding which relieves symptoms of craving and withdrawal (agonist activity), while simultaneously reducing the rewarding by preventing nicotine binding (antagonist activity).

Smokers should stop smoking 1-2 weeks after the first dose of varenicline, in order to reach the steady state. Smokers may also choose to gradually taper down on their tobacco use while taking varenicline.

The drug is progressively titrated to minimize side effects (mainly gastrointestinal symptoms, such as nausea). Dosing starts at 0.5 mg daily then may be increased to 1 mg twice daily over a week as tolerated. Varenicline is substantially excreted by the kidney. Dose reduction is needed in patients with severe renal impairment. Varenicline is safe to use in patients with cardiovascular and psychiatric comorbidities.

Patients who cannot tolerate adverse reactions of varenicline may lower the dose temporarily or permanently. Nausea could be reduced by taking varenicline with food; sleep disorders, particularly vivid dreams, could be avoided by progressively reducing the evening dose until suspension, maintaining the morning dose only.

Initial therapy is continued for at least 12 weeks; however, can be continued for an additional 12 weeks or longer to assist in maintaining abstinence.

Bupropion, Sustained-Release

The precise mechanism of action of bupropion is not well understood but appears to inhibit the reuptake of both dopamine and norepinephrine. When taken to quit smoking, bupropion may confer both anti-craving and anti-withdrawal effects by inhibiting dopamine reuptake. Bupropion also acts by alleviating some of the symptoms of nicotine withdrawal, which include depression, reducing the overall severity of withdrawal syndrome. Bupropion is recommended also to reduce weight increase after smoking cessation.

Bupropion should be started two weeks before the patient's planned quit day. The recommended dosage of bupropion is 300 mg daily (150 mg twice daily). Bupropion should be used with caution in patients with liver disease and renal disease. The reduced dose recommended in these patients is 150 mg daily. Therapy can be continued for three to six months, or longer, if patients desire.

Insomnia, dry mouth, and headache are the most common adverse events associated with bupropion use. Insomnia can be avoided by taking the first dose of bupropion early in the morning and the second dose in the late afternoon,

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[222] Giulietti, F., Filipponi, A., Rosettani, G., et al. "*Pharmacological Approach to Smoking Cessation: An Updated Review for Daily Clinical Practice.*" High Blood Pressure & Cardiovascular Prevention 27 (2020): 349–362. https://doi.org/10.1007/s40292-020-00396-9.

[223] Wadgave, U., and L. Nagesh. "*Nicotine Replacement Therapy: An Overview.*" International Journal of Health Sciences 10, no. 3 (2016): 425–435.

[224] Lee, P. N., and M. W. Fariss. "*A Systematic Review of Possible Serious Adverse Health Effects of Nicotine Replacement Therapy.*" Archives of Toxicology 91, no. 4 (2017): 1565–1594. https://doi.org/10.1007/s00204-016-1856-y.

at least four hours prior bedtime. A very small risk of seizure exists, occurring in about 1 in 1000 patients; this is associated with risk factors such as severe head injury, epilepsy, cerebrovascular disease, and concomitant use of other medications that lower the seizure threshold.[225]

Alaskan resources for tobacco cessation

Alaska's Tobacco Quit Line offers customizable online, email, and telephone-based support, along with limited free medication access.

Alaska Native Tribal Health Consortium (ANTHC) Tobacco Prevention & Control offers training and technical assistance to tobacco prevention programs.

ANTHC Tobacco Educational Materials Order Form

Alaska Tobacco Prevention and Control Program

Electronic nicotine delivery systems as a cessation approach

Although e-cigarettes are linked to the development of tobacco use disorder in youth, there is mounting evidence that vaporized nicotine (e-cigarettes, or ECs) can be a useful tool in smoking cessation for adults.[226] A recent randomized clinical trial found that varenicline and nicotine-containing ECs were both equally effective in helping individuals in quitting smoking conventional cigarettes for up to six months.[227] It is important to note that, although e-cigarettes can help people stop combustible tobacco use, they do not tend to be effective for complete nicotine cessation, meaning users usually continue long-term vaporized nicotine use. Although there are still some risks associated with their use, evidence suggests e-cigarettes are far less harmful than smoking. The switch from combustible tobacco to e-cigarettes may greatly reduce carcinogen exposure. Most of the toxins in tobacco smoke are not found in the vapor of e-cigarettes or are present at much lower levels.205 England's National Health Service officially recommends e-cigarettes as a smoking cessation intervention,[228] although U.S. health officials have not yet made this recommendation. Attention must be paid to the nicotine content of vaporized products as this can vary widely, although some products allow users to control the dose of nicotine to assist with gradual tapering. A switch to vaporized nicotine should be considered for any patient who wishes to reduce the risks to their health but is not ready to stop using inhaled nicotine.

Resources for e-cigarette use

- Action on Smoking and health: electronic cigarettes (UK)
- Adult Smoking Cessation — The Use of E-Cigarettes,U.S. surgeon general 2020

[225] Khan, S. R., R. T. Berendt, C. D. Ellison, A. B. Ciavarella, E. Asafu-Adjaye, M. A. Khan, and P. J. Faustino. "*Chapter One - Bupropion Hydrochloride.*" In Profiles of Drug Substances, Excipients and Related Methodology, edited by Harry G. Brittain, 41:1-30. Academic Press, 2016. https://doi.org/10.1016/bs.podrm.2015.12.001.

[226] Lindson, N., A. R. Butler, H. McRobbie, C. Bullen, P. Hajek, R. Begh, A. Theodoulou, C. Notley, N. A. Rigotti, T. Turner, J. Livingstone-Banks, T. Morris, and J. Hartmann-Boyce. "*Electronic Cigarettes for Smoking Cessation.*" Cochrane Database of Systematic Reviews 2024, no. 1 (2024): Art. No. CD010216. https://doi.org/10.1002/14651858.CD010216.pub8. Accessed September 26, 2024.

[227] Tuisku, A., M. Rahkola, P. Nieminen, and T. Toljamo. "Electronic Cigarettes vs Varenicline for Smoking Cessation in Adults: A Randomized Clinical Trial." JAMA Internal Medicine 184, no. 8 (2024): 915–921. https://doi.org/10.1001/jamainternmed.2024.1822.

[228] NHS. "Using E-Cigarettes to Stop Smoking." Accessed September 26, 2024. https://www.nhs.uk/live-well/quit-smoking/using-e-cigarettes-to-stop-smoking/.

Chapter 18: Cannabis Use Disorder

Cannabis is the most used illicit drug in the world[229], and in the United States, it is increasingly becoming a commonly used legal drug in many states.[230] Cannabis use disorder (CUD) is an underappreciated risk of using cannabis that affects about 10% of cannabis users worldwide, and an estimated 4.5–7 million individuals in the United States are thought to meet criteria for CUD in a given year.[231]

Although study findings have been mixed, it is apparent that at least for some individuals with vulnerabilities, heavy cannabis use is associated with increased risk of anxiety, depression, and psychosis.[232] Adolescents and young adults are at highest risk of these psychiatric comorbidities.[233] Several studies have demonstrated negative effects of cannabis use in patients with schizophrenia. Specifically, THC in cannabis has been associated with an increased risk of psychosis in a dose-dependent manner: regular cannabis users and heavy cannabis users are 2- and 4-times more likely to develop psychosis, respectively [212] About 50% of respondents in a 2017 Canadian cannabis survey claimed that cannabis had a positive effect on anxiety.[234] Despite this claim, much of the research to date suggests otherwise, and cannabis use appears to be associated with increased anxiety symptoms.[235]

Although cannabis use is common among people with opioid use disorder (OUD); in a systematic review, Costa and colleagues (2023) found no significant association between cannabis use and non-medical opioid use among patients receiving pharmacotherapies for OUD.[236] While some argue that cannabis legalization has contributed to a decrease in opioid-related morbidity and mortality in the U.S., the evidence remains mixed. Despite considerable interest in using medical cannabis for pain management, there is insufficient data on both its safety and efficacy for treating chronic nonmalignant pain conditions.[237] The Drug Enforcement Administration (DEA) is in the process of rescheduling cannabis from a Schedule I drug to a Schedule III drug, which will make it easier for researchers to study its effects and potential medical uses.[238], [239]

Cognitive behavioral therapy, motivational enhancement therapy, and contingency management can substantially reduce cannabis use and cannabis-related problems, but long-term abstinence is uncommon. In a meta-analysis of 7 controlled clinical trials of adults with CUD, psychosocial

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[229] Degenhardt, Louisa, Emily Stockings, John Strang, et al. "*Illicit Drug Dependence*." In Mental, Neurological, and Substance Use Disorders: Disease Control Priorities, Third Edition (Volume 4), edited by Vikram Patel, David Chisholm, and Tarun Dua, Chapter 6. Washington, DC: The International Bank for Reconstruction and Development / The World Bank, March 14, 2016. https://www.ncbi.nlm.nih.gov/books/NBK361953/. https://doi.org/10.1596/978-1-4648-0426-7_ch6.

[230] Congressional Research Service. "*Tobacco Control: Federal Regulation of E-Cigarettes and Other Electronic Nicotine Delivery Systems*." Accessed September 26, 2024. https://crsreports.congress.gov/product/pdf/IF/IF12270.

[231] Connor, J. P., D. Stjepanović, B. Le Foll, et al. "*Cannabis Use and Cannabis Use Disorder*." Nature Reviews Disease Primers 7 (2021): 16. https://doi.org/10.1038/s41572-021-00247-4.

[232] National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on the Health Effects of Marijuana: An Evidence Review and Research Agenda. *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*. Washington, DC: National Academies Press (US), January 12, 2017. Chapter 12, Mental Health. https://www.ncbi.nlm.nih.gov/books/NBK425748/.

[233] Lowe, D. J. E., J. D. Sasiadek, A. S. Coles, and T. P. George. "*Cannabis and Mental Illness: A Review*." European Archives of Psychiatry and Clinical Neuroscience 269, no. 1 (2019): 107–120. https://doi.org/10.1007/s00406-018-0970-7.

[234] Health Canada. "*Canadian Cannabis Survey 2017: Summary*." Accessed September 26, 2024. https://www.canada.ca/en/health-canada/services/publications/drugs-health-products/canadian-cannabis-survey-2017-summary.html.

[235] Tournier, M., F. Sorbara, C. Gindre, J. D. Swendsen, and H. Verdoux. "*Cannabis Use and Anxiety in Daily Life: A Naturalistic Investigation in a Non-Clinical Population*." Psychiatry Research 118, no. 1 (May 1, 2003): 1–8. https://doi.org/10.1016/s0165-1781(03)00052-0. PMID: 12759155.

[236] Costa, Gabriel P. A., Julio C. Nunes, Daniel L Heringer, Akhil Anand, and Joao P. De Aquino. 2024. "*The Impact of Cannabis on Non-Medical Opioid Use among Individuals Receiving Pharmacotherapies for Opioid Use Disorder: A Systematic Review and Meta-Analysis of Longitudinal Studies*." The American Journal of Drug and Alcohol Abuse 50 (1): 12–26. doi:10.1080/00952990.2023.2287406.

[237] Nguyen, H. V., E. E. McGinty, S. Mital, and G. C. Alexander. "*Recreational and Medical Cannabis Legalization and Opioid Prescriptions and Mortality*." JAMA Health Forum 5, no. 1 (2024): e234897. https://doi.org/10.1001/jamahealthforum.2023.4897.

[238] U.S. Drug Enforcement Administration. *Scheduling NPRM*. Accessed September 26, 2024. https://www.dea.gov/sites/default/files/2024-05/Scheduling%20NPRM%20508.pdf.

[239] Strand, N., R. S. D'Souza, J. Karri, H. Kalia, J. Weisbein, B. J. Kassa, N. Hussain, A. Chitneni, R. R. Budwany, J. Hagedorn, J. E. Pope, T. R. Deer, D. Sayed, and A. Abd-Elsayed. "*Medical Cannabis: A Review from the American Society of Pain and Neuroscience*." Journal of Pain Research 16 (2023): 4217–4228. https://doi.org/10.2147/JPR.S425862.

treatments were shown to double the chances of abstinence at 3-4 months' follow-up (21% versus 10%).[240]

Although data on pharmacologic interventions for CUD are scarce, evidence exists that several drug classes, including cannabinoids and SSRIs, are ineffective.[241] Because of increasing access to and use of cannabis in the general population, along with a high prevalence of CUD among current cannabis users, an urgent need exists for more research to identify effective pharmacologic treatments.[242], [243]

An increasingly common and lesser-known complication or chronic cannabis use is cannabinoid hyperemesis syndrome (CHS), a condition in which a patient experiences cyclical nausea, vomiting, and abdominal pain after using cannabis. This disorder is characterized by 1) several years of preceding cannabis use, predating the onset of illness; 2) a cyclical pattern of hyperemesis every few weeks to months, at which time the patient is still using cannabis; and 3) resolution of the symptoms after cessation of cannabis use, confirmed by a negative urine drug screen. The almost pathognomonic aspect of a patient's presenting history is that their symptoms are relieved by hot baths or shower. Vomiting may not respond to typical antiemetics, although haloperidol has been reported effective in some patients.[244]

[240] Gates, P. J., P. Sabioni, J. Copeland, B. Le Foll, and L. Gowing. "*Psychosocial Interventions for Cannabis Use Disorder.*" Cochrane Database of Systematic Reviews 2016, no. 5 (May 5, 2016): CD005336. https://doi.org/10.1002/14651858.CD005336.pub4. PMID: 27149547; PMCID: PMC4914383.

[241] Kondo, Karli K., Benjamin J. Morasco, Shannon M. Nugent, et al. "*Pharmacotherapy for the Treatment of Cannabis Use Disorder: A Systematic Review.*" Annals of Internal Medicine 172 (2020): 398–412. [Epub March 3, 2020]. https://doi.org/10.7326/M19-1105.

[242] Nguyen, H. V., E. E. McGinty, S. Mital, and G. C. Alexander. "*Recreational and Medical Cannabis Legalization and Opioid Prescriptions and Mortality.*" JAMA Health Forum 5, no. 1 (2024): e234897. https://doi.org/10.1001/jamahealthforum.2023.4897.

[243] Strand, N., R. S. D'Souza, J. Karri, H. Kalia, J. Weisbein, B. J. Kassa, N. Hussain, A. Chitneni, R. R. Budwany, J. Hagedorn, J. E. Pope, T. R. Deer, D. Sayed, and A. Abd-Elsayed. "*Medical Cannabis: A Review from the American Society of Pain and Neuroscience.*" Journal of Pain Research 16 (2023): 4217–4228. https://doi.org/10.2147/JPR.S425862.

[244] Cue, L., F. Chu, and M. Cascella. "*Cannabinoid Hyperemesis Syndrome.*" Updated July 3, 2023. In StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing, 2024. https://www.ncbi.nlm.nih.gov/books/NBK549915/.

Chapter 19: Novel Substances of concerns for patients with opioid use disorder

Xylazine

Xylazine, also know by the street name "Tranq," is an animal tranquilizer increasingly being found in the U.S. illegal drug supply and linked to overdose deaths. Xylazine, which is not approved for use in people, can be life-threatening and is especially dangerous when combined with opioids like fentanyl or heroin. When combined with opioids, it intensifies and prolongs the euphoria induced by these substances. Unfortunately, there is currently no approved reversal agent for xylazine in humans. Xylazine has a variable duration of action (ranging from 8-72 hours) depending on the dose, route of administration, and other drugs it's mixed with. Its powdered form makes it difficult to identify by physical properties, increasing the risk of fatal overdose. Xylazine overdose should be suspected in cases of apparent opioid overdose that do not respond to naloxone. It can exacerbate typical opioid adverse effects such as bradypnea, apnea, bradycardia, and hypotension. Due to its impact on the opioid crisis, fentanyl adulterated with xylazine has been declared an emerging threat by the White House's Office of National Drug Control Policy[245]

> "Xylazine is making the deadliest drug threat our country has ever faced, fentanyl, even deadlier. DEA has seized xylazine and fentanyl mixtures in 48 of 50 States. The DEA Laboratory System is reporting that in 2022 approximately 23% of fentanyl powder and 7% of fentanyl pills seized by the DEA contained xylazine."
>
> —Drug Enforcement Administration (DEA) Administrator Milgram[246]

Although not yet commonly encountered, Alaska is starting to see positive toxicology detection of xylazine.

In the areas with a high prevalence of the use of xylazine contamination, painful skin ulcers are very often seen in users[247]. The mechanism is thought to be due to its direct vasoconstricting effect on local blood vessels and the resultant decreased skin perfusion. California Department of Public Health created this factsheet for treating xylazine wounds, and the city of Philadelphia created this factsheet for providers.

Xylazine test strips have recently become available for drug-checking harm reduction use.[248]

Kratom

Kratom (Mitragyna speciosa Korth., Rubiaceae) is a plant native to Southeast Asia, where it has been used for centuries as a mild stimulant and as medicine for various ailments. More recently, as kratom has gained popularity in the West, United States federal agencies have raised concerns over its safety leading to prohibition or regulation of sales in some states and cities; however, there are no regulations limiting its sale in Alaska. Although the DEA attempted to schedule kratom in 2016, it was met with significant resistance from advocates and withdrew its proposal. The DEA and Food & Drug Administration (FDA) identifies kratom as a substance of concern.[249], [250]The FDA regularly seizes kratom products that hold themselves out illegally as dietary additives or medical supplements.[251]

[245] The White House. "*Fact Sheet: In Continued Fight Against Overdose Epidemic, the White House Releases National Response Plan to Address the Emerging Threat of Fentanyl Combined with Xylazine*." July 11, 2023. https://bidenwhitehouse.archives.gov/briefing-room/statements-releases/2023/07/11/fact-sheet-in-continued-fight-against-overdose-epidemic-the-white-house-releases-national-response-plan-to-address-the-emerging-threat-of-fentanyl-combined-with-xylazine/#:~:text=2022%2D002)%2C%20the%20goal,U.S.%20census%20regions%20by%202025.

[246] U.S. Drug Enforcement Administration. "*DEA Reports Widespread Threat of Fentanyl Mixed with Xylazine*." Accessed September 26, 2024. https://www.dea.gov/alert/dea-reports-widespread-threat-fentanyl-mixed-xylazine.

[247] Malayala, S. V., B. N. Papudesi, R. Bobb, and A. Wimbush. "*Xylazine-Induced Skin Ulcers in a Person Who Injects Drugs in Philadelphia, Pennsylvania, USA*." Cureus 14, no. 8 (2022): e28160. https://doi.org/10.7759/cureus.28160.

[248] Reed, Megan K., Nicholas S. Imperato, Jeanette M. Bowles, Venise J. Salcedo, Amanda Guth, and Kristin L. Rising. "*Perspectives of People in Philadelphia Who Use Fentanyl/Heroin Adulterated with the Animal Tranquilizer Xylazine: Making a Case for Xylazine Test Strips*." Drug and Alcohol Dependence Reports 4 (2022): 100074. https://doi.org/10.1016/j.dadr.2022.100074.

[249] U.S. Drug Enforcement Administration. *Kratom 2022 Drug Fact Sheet*. Accessed September 26, 2024. https://www.dea.gov/factsheets/kratom

[250] U.S. Food and Drug Administration. "*Statement from FDA Commissioner Scott Gottlieb, M.D., on FDA Advisory About Deadly Risks Associated with Kratom*." Accessed September 26, 2024. https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-fda-advisory-about-deadly-risks-associated-kratom.

[251] U.S. Food and Drug Administration. "*Import Alert 1137: Kratom (Mitragyna speciosa) and Products Containing Kratom*." Accessed September 26, 2024. https://www.accessdata.fda.gov/cms_ia/importalert_1137.html.

At low doses, kratom has long been consumed orally as a stimulant to enhance stamina and productivity; however, high doses it can have sedating and analgesic effects. Mitragynine is the most prominent chemical component in kratom, and along with the alkaloid 7-hydroxymitragynine, is primarily responsible for the plant's unique psychoactive properties, which include opioid and non-opioid activities. Its use has been increasing in popularity in the United States with current prevalence ranges of 1.3%–6.1%.[252][253] It is typically taken orally in teas, capsules, or tinctures and has a relatively short half-life of 3-9 hours. Adverse effects, while uncommon, include the potential for liver problems, seizures, and dependence. Users of kratom cite beneficial effects including relief of various symptoms such as pain or anxiety.[254] Kratom has also become popular among people with opioid use disorder (OUD) attempting to self-treat opioid withdrawal and cravings.[255]

Mitragynine and 7-hydroxymitragynine are considered partial agonists at the mu-opioid receptor, and chronic use can result in escalating tolerance, physical dependance, and addiction. Sudden discontinuation of kratom results in classic opioid withdrawal symptoms, and although kratom use disorder (KUD) is most commonly seen in patients with underlying OUD, primary kratom use disorder is becoming more prevalent.[256]

Although literature is limited on the treatment of KUD, it appears to respond well to medications for opioid use disorder (MOUD), with buprenorphine being the most commonly used medication to treat KUD.[257] There are currently no official recommendations for dosage of buprenorphine in KUD, which should be individualized to patient's needs.

Tianeptine

Tianeptine (sold under the brand names Stablon, Tatinol, and Coaxil outside the United States), is an atypical tricyclic antidepressant, used mainly in the treatment of major depressive disorder, although it may also be used to treat anxiety, asthma, and irritable bowel syndrome. Tianeptine has antidepressant and anxiolytic effects with a relative lack of sedative, anticholinergic, and cardiovascular side effects. It has been found to act as an atypical agonist of the mu-opioid receptor with clinically negligible effects on the delta- and kappa-opioid receptors. Due to its effects at the mu-opioid receptor, tianeptine can induce euphoria at high doses, well above the normal therapeutic range. Tianeptine can also cause severe withdrawal symptoms after prolonged use at high doses.[258] Despite its lack of approval by the FDA, tianeptine has been distributed online and at small retail locations, lending to the term "gas station heroin". Overdoses involving tianeptine have been reported.[259] There is scant literature about Tianeptine use disorder; however, there have been reports of successful treatment with buprenorphine.

Novel Designer Benzodiazepines

Recently, there has been a significant rise in the number and availability of novel "designer" benzodiazepines (DBZ). These include bromazolam, clonazolam, deschloroetizolam, etizolam, flubromazolam, meclonazepam, and more.[260] Alaskans have reported ordering these illicit drugs

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[252] Henningfield, J. E., O. Grundmann, J. K. Babin, R. V. Fant, D. W. Wang, and E. J. Cone. "*Risk of Death Associated with Kratom Use Compared to Opioids.*" Preventive Medicine 128 (2019): 105851. https://doi.org/10.1016/j.ypmed.2019.105851.

[253] Covvey, J. R., S. M. Vogel, A. M. Peckham, and K. E. Evoy. "*Prevalence and Characteristics of Self-Reported Kratom Use in a Representative U.S. General Population Sample.*" Journal of Addiction Disorders 38 (2020): 506–513. https://doi.org/10.1080/10550887.2020.1788914.

[254] Garcia-Romeu, A., D. J. Cox, K. E. Smith, K. E. Dunn, and R. R. Griffiths. *"Kratom (Mitragyna speciosa): User Demographics, Use Patterns, and Implications for the Opioid Epidemic.*" Drug and Alcohol Dependence 208 (2020): 107849. https://doi.org/10.1016/j.drugalcdep.2020.107849.

[255] Boyer, E. W., K. M. Babu, J. E. Adkins, C. R. McCurdy, and J. H. Halpern. "*Self-Treatment of Opioid Withdrawal Using Kratom (Mitragynia Speciosa Korth).*" Addiction (Abingdon, England) 103, no. 6 (2008): 1048–1050. https://doi.org/10.1111/j.1360-0443.2008.02209.x.

[256] Palamar, J. J. "*Past-Year Kratom Use in the U.S.: Estimates from a Nationally Representative Sample.*" American Journal of Preventive Medicine 61, no. 2 (2021): 240–245. https://doi.org/10.1016/j.amepre.2021.02.004.

[257] Stanciu, Cornel, and Saeed Ahmed. "*Pharmacotherapy for Management of Kratom Use Disorder.*" WMJ: Official Publication of the State Medical Society of Wisconsin, February 22, 2021.

[258] Edinoff, A. N., S. Sall, S. P. Beckman, A. D. Koepnick, L. C. Gold, E. D. Jackson, D. M. Wenger, E. M. Cornett, K. S. Murnane, A. M. Kaye, and A. D. Kaye. "*Tianeptine, an Antidepressant with Opioid Agonist Effects: Pharmacology and Abuse Potential, a Narrative Review.*" Pain and Therapy 12, no. 5 (2023): 1121–1134. https://doi.org/10.1007/s40122-023-00539-5.

[259] U.S. Food and Drug Administration. "*Tianeptine Products Linked to Serious Harm, Overdoses, Death.*" Accessed September 26, 2024. https://www.fda.gov/consumers/consumer-updates/tianeptine-products-linked-serious-harm-overdoses-death.

[260] Edinoff, A. N., C. A. Nix, A. S. Odisho, C. P. Babin, A. G. Derouen, S. C. Lutfallah, E. M. Cornett, K. S. Murnane, A. M. Kaye, and A. D. Kaye. "*Novel Designer Benzodiazepines: Comprehensive Review of Evolving Clinical and Adverse Effects.*" Neurology International 14, no. 3 (2022): 648–663. https://doi.org/10.3390/neurolint14030053.

online. Compared with classical benzodiazepines, these compounds produce strong sedation and amnesia, and they increase the risk of respiratory depression and death when used in combination with other central nervous system (CNS) depressants including opioids.[261] The Centers for Disease Control and Prevention (CDC) report, Notes from the Field: Illicit Benzodiazepines Detected in Patients Evaluated in Emergency Departments for Suspected Opioid Overdose, analyzed samples from patients experiencing opioid overdose in 4 states, identifying illicit benzodiazepines in 14.9% of samples.[262] It can be particularly challenging to treat dependence on DBZ due to lack of available data on pharmacokinetics of each drug.[263] This report includes an equivalency table for some DBZ that may be useful when planning withdrawal management.[264]

[261] Brunetti, P., R. Giorgetti, A. Tagliabracci, M. A. Huestis, and F. P. Busardò. "*Designer Benzodiazepines: A Review of Toxicology and Public Health Risks*." Pharmaceuticals (Basel, Switzerland) 14, no. 6 (2021): 560. https://doi.org/10.3390/ph14060560.

[262] Aldy, K., D. Mustaquim, S. Campleman, et al. "*Notes from the Field: Illicit Benzodiazepines Detected in Patients Evaluated in Emergency Departments for Suspected Opioid Overdose — Four States, October 6, 2020–March 9, 2021*." MMWR Morbidity and Mortality Weekly Report 70 (2021): 1177–1179. https://doi.org/10.15585/mmwr.mm7034a4.

[263] Maskell, Peter. "*New Psychoactive Substances*." Abertay University, 2018. https://rke.abertay.ac.uk/ws/portalfiles/portal/15329645/Maskell_NewPsychoactiveSubstance_Accepted_2018.pdf.

[264] Pérez Orts, Mireia, Arian van Asten, and Isabelle Kohler. "*The Evolution Toward Designer Benzodiazepines in Drug-Facilitated Sexual Assault Cases*." Journal of Analytical Toxicology 47, no. 1 (January 2023): 1–25. https://doi.org/10.1093/jat/bkac017.

SECTION V:

Spotlight on Key Issues and Communities

Chapter 20: Harm Reduction and Polysubstance Use

"Harm reduction is about meeting people where they are, regardless of where they are on their recovery journey, and being open to creative ways to help them improve their health and wellness, and decrease their risks from their use disorder." — Unknown

Harm reduction refers to interventions designed to minimize the negative effects of risky health behaviors without necessarily eliminating them entirely. In the context of drug use, harm reduction encompasses a range of practical strategies aimed at mitigating the harmful outcomes associated with substance use. It is also a social justice movement rooted in the belief that people who use drugs deserve respect and support. Implementing harm reduction principles in health care settings can enhance clinical outcomes by improving the provider-patient relationship, which in turn fosters better health outcomes and treatment adherence. Unlike the traditional medical model of addiction that prioritizes abstinence, harm reduction emphasizes meeting individuals where they are, offering them tools and resources to help them achieve their personal goals and improve their quality of life. Examples of harm reduction strategies include prescribing naloxone, providing drug testing strips, ensuring access to syringe and smoking supplies, establishing supervised injection facilities, offering overdose prevention programs, providing Pre-exposure prophylaxis (PrEP), treating hepatitis C and other communicable diseases, and ensuring low-barrier access to medications for addiction treatment.

The National Harm Reduction Coalition offers on-demand courses.

Also see this resource:

Principles around harm reduction have been defined by numerous agencies and researchers. Hawk and colleagues (2017) developed principles based on data from qualitative interviews with 23 patients and 17 staff members at a U.S. HIV clinic. They used this data to outline harm reduction principles for health care settings. Six core principles were identified—humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination. Each principle is explained with examples of how health care providers can implement them in practice.

See it here: Harm reduction principles, definitions and approaches for health care settings [265]

The Harm Reduction Therapy Center provides medical and behavioral health staff training in applying harm reduction skills

Figure 13. Foundational Principles Central to Harm Reduction

Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
Understands drug use as a complex multifaceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence and acknowledges that some ways of using drugs are clearly safer than others.
Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.
Calls for the non-judgmental, non-coercive provision of services and resources to PWUD and the communities in which they live to assist them in reducing attendant harm.
Ensures that PWUD and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
Affirms PWUD themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies that meet their actual conditions of use.
Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

Source: National Harm Reduction Coalition.

[265] Hawk, Marsha, Robert W.S. Coulter, Jennifer E. Egan, et al. "*Harm Reduction Principles for Healthcare Settings*." Harm Reduction Journal 14 (2017): 70. https://doi.org/10.1186/s12954-017-0196-4.

Naloxone for Overdose Prevention

Naloxone is a medication that temporarily blocks and reverses the effects of opioids and is used in response to an opioid overdose. Patients who have been abstinent from opioid agonists for an extended period are at particular risk for overdose death if they use opioids again. After a few weeks of abstinence, tolerance to the respiratory depressive effects of opioids is decreased. When patients return to use after losing opioid tolerance, even small amounts of fentanyl can cause fatal respiratory depression. Since fentanyl contamination is common in even non-opioid illicit drugs (like cocaine, methamphetamines, and benzodiazepines), users may be unknowingly exposed to fentanyl, elevating overdose risk.

Naloxone administration is a safe and cost-effective way to reduce overdose mortality[266][267] In most cases the effect is immediate (within two minutes), reversing the effects of the overdose and respiratory depression. This gives time to seek emergency medical assistance. Its use is supported by many organizations, including the Centers for Disease Control and Prevention (CDC), the Office of National Drug Control Policy, and the World Health Organization. Nasal naloxone is generally well-tolerated, inducing less severe withdrawal symptoms than intravenous naloxone, making it well suited to use in community settings. Although higher 8 mg doses of nasal naloxone are now on the market, they have not been proven superior to standard 4 mg doses.[268] Additionally, although the Food & Drug Administration (FDA) recently approved a new long-acting opioid reversal agent nalmefene, The American College of Medical Toxicology released a position statement that nalmefene should not replace naloxone as the primary opioid antidote at this time, due to concerns of long-lasting precipitated withdrawal effects without evidence of improved outcomes[269].

Since return to use is common among individuals with opioid use disorder (OUD), it is critical to educate patients and their family members on how to recognize and respond to an overdose. According to the American Society of Addiction Medicine (ASAM), naloxone for the reversal of opioid overdose should be provided to patients being treated for, or with a history of, OUD.[270] Both patients and their family members or significant others should be trained in naloxone administration. Importantly, naloxone training and distribution do not promote drug use and have been shown to reduce risk-taking behaviors.[271] All patients seeking substance use disorder (SUD) services should receive naloxone training and be provided with a nasal naloxone kit or a prescription to fill at a local pharmacy. Training someone to use naloxone safely takes less than five minutes, and many training resources are available at no cost.

Primary care providers should consider having a naloxone kit available in their office during wellness visits with teens and their parents. This serves as a powerful tool to facilitate more meaningful conversations about the risks associated with drug use—whether it's prescription medication, known street drugs, or preventive discussions about the dangers of experimentation.

- Instructional handout for patients: How to Use Naloxone to Reverse an Overdose
- Instructional video for patients and family: CDC's How to Administer Naloxone
- List of Project HOPE locations to get a free naloxone kit

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[266] McDonald, R., and J. Strang. "*Are Take-Home Naloxone Programmes Effective? Systematic Review Utilizing Application of the Bradford Hill Criteria*." Addiction 111, no. 7 (2016): 1177–1187. https://doi.org/10.1111/add.13326.

[267] Cherrier, N., J. Kearon, R. Tetreault, S. Garasia, and E. Guindon. "*Community Distribution of Naloxone: A Systematic Review of Economic Evaluations*." PharmacoEconomics - Open 6, no. 3 (2022): 329–342. https://doi.org/10.1007/s41669-021-00309-z.

[268] Payne, E. R., S. Stancliff, K. Rowe, J. A. Christie, and M. W. Dailey. "*Comparison of Administration of 8-Milligram and 4-Milligram Intranasal Naloxone by Law Enforcement During Response to Suspected Opioid Overdose — New York, March 2022–August 2023*." MMWR Morbidity and Mortality Weekly Report 73 (2024): 110–113. http://dx.doi.org/10.15585/mmwr.mm7305a4.

[269] American College of Medical Toxicology and American Academy of Clinical Toxicology. "*ACMT-AACT Joint Position Statement on Nalmefene: Should Not Replace Naloxone as the Primary Opioid Antidote at This Time*." American College of Medical Toxicology, May 2023. https://www.acmt.net/news/acmt-aact-joint-position-statement-on-nalmefene-should-not-replace-naloxone-as-the-primary-opioid-antidote-at-this-time/.

[270] *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update.* Journal of Addiction Medicine 14(2S):p 1-91, March/April 2020. | DOI: 10.1097/ADM.0000000000000633

[271] Jones, J. D., Campbell, A., Metz, V. E., and Comer, S. D. "*No Evidence of Compensatory Drug Use Risk Behavior Among Heroin Users After Receiving Take-Home Naloxone*." Addictive Behaviors 71 (2017): 104–106. https://doi.org/10.1016/j.addbeh.2017.03.008.

The Alaska Native Medical Center (ANMC) outpatient pharmacy will provide a naloxone kit to anyone who requests one, regardless of whether they are an Indian Health Service (IHS) beneficiary. Additionally, the Alaska Native Tribal Health Consortium (ANTHC) offers naloxone, as well as harm reduction kits, that can be ordered online at **iknowmine.org** and shipped to remote communities.

Naloxone nasal spray is covered by most public and private insurances and is available over the counter without a prescription at most pharmacies, as well as from online retailers.

The State of Alaska offers free naloxone rescue kits through **Project HOPE**, which can be obtained by patients and family through public health offices free of charge. Clinics and providers can email ProjectHOPE@alaska.gov to sign up as an overdose response program (ORP) and order free naloxone nasal spray kits and educational materials through Project HOPE. These materials can be distributed free to patients, friends, and family who are at risk of witnessing an overdose.

As part of providing naloxone education, a provider may also counsel patients on other harm reduction measures:

Never using alone is key to survival. neverusealone.com and its connected phone number at 877-696-1996 is a national **"Overdose Prevention Lifeline"** where staff and volunteers stay on the line with someone who is using so that 911 can be called if the person does overdose.

- Never use alone.
- Use a smaller dose or "test shot".
- For route of administration, smoke rather than inject.
- Don't mix drugs.
- Always have a naloxone kit on hand.
- In addition to the "Never Use Alone" hotline, apps are also available to connect people who use drugs alone to a caring support person that can help.

Finally, Project Gabe, a harm reduction initiative and spin-off of Project HOPE, now works to prevent overdose deaths among industry at risk such as fisheries in Southeast Alaska.[272]

Fentanyl Strips

Fentanyl test strips can identify the presence of fentanyl in unregulated drugs. They can be used to test injectable drugs, powders, and pills. Being aware if fentanyl is present allows people to implement appropriate harm reduction strategies to reduce the risk of an overdose. Several harm reduction focused agencies throughout the state distribute fentanyl testing strips.

Contact ProjectHOPE@alaska.gov, or order online at iknowmine.org in Alaska for fentanyl test strips.

How To Test Your Drugs Using Fentanyl Test Strips

Xylazine test strips

Xylazine test strips recently became available, and may be purchased online for distribution to patients, and ordered at iknowmine.org.

How to use xylazine test strips

In an effort to save lives and improve people's wellbeing, Substance Abuse and Mental Health Services Administration (SAMHSA) is highlighting for grantees that federal funding may be used to purchase rapid fentanyl and xylazine test strips for drug checking purposes in certain grant programs. Grantees of such programs should always check with their federal project officers to ensure their purchases meet all grants policy requirements.[273]

Syringe Access

Alaska currently has four active syringe access programs (SAPs). At SAPs, people may bring in used syringes for the exchange of new syringes and supplies. There are no drug paraphernalia laws in Alaska that restrict syringe distribution. See here more information about Alaskan law.[274] SAPs provide opportunities for individuals who inject drugs to access information and referral to medical care to treat and prevent infectious disease. People

[272] Alaska Department of Health and Social Services. "*Press Release: Department of Health and Social Services Launches Project Gabe to Combat Opioid Overdoses.*" June 7, 2022. https://alaska.access.preservica.com/uncategorized/IO_0aa15955-fa5f-457e-b8f9-8b4b95e86067/

[273] Substance Abuse and Mental Health Services Administration (SAMHSA). "*Fentanyl and Xylazine Test Strips*." SAMHSA. Accessed September 26, 2024. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/fentanyl-xylazine-test-strips.

[274] Legislative Analysis and Public Policy Association, *Syringe Services Programs: Summary of State Law*s, September 2022, https://legislativeanalysis.org/wp-content/uploads/2022/09/Syringe-Services-Programs-Summary-of-State-Laws.pdf.

who inject drugs are offered access to testing, hepatitis vaccination, and PrEP to reduce the spread of viral disease. Many SAPs also offer referrals to substance use treatment, medical care, and social services. Individuals who utilize SAPs are five times more likely to seek substance use treatment than non-utilizers.[275] See the CDC's Syringe Access Program FAQ sheet for more information about the importance of SAPs. The CDC also has a guide to assist with SAP implementation: Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation.

Syringe Access Programs in Alaska

- Four A's Syringe Access Program, in Anchorage, the Matanuska-Susitna Valley, and Juneau
- Interior AIDS Association's Northern Exchange, in Fairbanks
- Megan's Place in Homer
- Yukon-Kuskokwim Health Corporation: harm reduction kits and naloxone kits are available in the Outpatient Clinic and at the Pharmacy, upon patient request.

I Know Mine program

ANTHC has a mail order harm reduction program that distributes safety kits with clean injection supplies, condoms, STD testing information, and needle disposal systems. They also have an outstanding harm reduction toolkit as well as a harm reduction service center, to help clinics incorporate harm reduction into their services. Patients can also ask questions on their website through the "Ask Nurse Lisa" chat. Find out more about the I Know Mine program on their website.

Distributing Syringes

A clinic can also purchase syringes in bulk to distribute to patients. The cost of syringes purchased through a nonprofit buyers' club can be significantly lower than retail—as little as $40 per case of 500. A resource for mail-order harm-reduction supplies is the North America Syringe Exchange Network, which also offers start-up kits and grants.

Pharmacy Syringe Access

When syringe access programs are unavailable, pharmacies can be an alternative access point to obtain injection supplies. In Alaska, injection supplies are over-the-counter, and a pharmacist may dispense syringes at their discretion without a prescription. As the pharmacy has control and discretion over syringe sales, pharmacies may choose to limit the quantity a patient can purchase, or may require patients to show ID or sign a logbook. Providers may talk with a local pharmacist about allowing patients to purchase syringes anonymously, as needed.

Example prescription for syringes:

- 29g, ½-inch "longs," or 31g, 5/16-inch "shorts", ½ or 1 cc
- (ask patient which they prefer)
- Dispense #__ boxes of 100 syringes
- Refill PRN x 1 year

Medications for Opioid Use Disorder as a Form of Harm Reduction in Patients with Severe Polysubstance Use Disorders

Polysubstance use involves consuming more than one drug simultaneously. Between 2018-2022, 63% of overdose deaths involved multiple substances, with fentanyl combined with psychostimulants being the most common lethal combination.[276] While polysubstance use often refers to the use of multiple illicit drugs, it also includes the misuse of prescription medications. This practice is widespread, with the prevalence of Alcohol Use Disorder (AUD) in patients with other SUDs exceeding 30%. Polysubstance use amplifies the dangers of drug consumption by increasing the severity of side effects, exacerbating health issues, and significantly raising the risk of overdose.

When it comes to polysubstance use, it is crucial to understand the effects of common drug combinations and the associated risks. Individuals may mix opioids with stimulants, such as cocaine or methamphetamine, to counterbalance the sedative effects of opioids with the stimulating effects of these drugs. Benzodiazepines are frequently combined with opioids to enhance sedation or manage anxiety associated with withdrawal, but this combination significantly increases the risk of respiratory depression and overdose. Alcohol is another substance

[275] Centers for Disease Control and Prevention. "*Syringe Services Programs*." Last modified September 15, 2023. Accessed September 26, 2024 https://www.cdc.gov/syringe-services-programs/php/index.html#:~:text=6%20New%20SSP%20users%20are,to%20recognize%20and%20prevent%20overdose

[276] Alaska Department of Health. "*Drug Overdose Mortality Update 2022*." Accessed September 26, 2024. https://health.alaska.gov/media/kzvbebor/drugoverdosemortalityupdate_2022.pdf.

often mixed with opioids or benzodiazepines, which can intensify the depressant effects on the central nervous system, leading to a higher likelihood of fatal overdose. For providers prescribing medications for opioid use disorder (MOUD) in Alaska, understanding these combinations is essential to educate patients about the heightened risks and to develop treatment plans that address the complexities of polysubstance use.

MOUD is one of the most commonly used and most effective forms of harm reduction for OUD with polysubstance use. Patients who have a comorbid SUD with an OUD may reduce their use of opioids by taking methadone, buprenorphine, or naltrexone, while they continue to use other drugs. MOUD can help to block opioids, helping to protect the patient from overdose if they do use. This is especially true for patients who use central nervous system (CNS) depressants, such as alcohol or benzodiazepines with opioids, which can be a particularly deadly combination.

The FDA advises that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the CNS. The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks. Careful medication management by health care professionals can reduce these risks.[277]

MOUD is a useful method of harm reduction for patients with severe OUD who struggle with engagement in treatment. MOUD helps keep a patient alive, so that they can access treatment when they are ready. The use of cannabis, stimulants, alcohol, and/or other addictive drugs should not be a reason to withhold or suspend OUD treatment. However, patients who are actively using substances during OUD treatment may require greater support, including a more intensive level of care.[278] Based on their ASAM assessment, providers can use motivational interviewing to encourage patients to follow recommendations for a more intensive level of care (SUD intensive outpatient, SUD residential treatment, etc.), but refusal to engage in these services does not disqualify them from receiving outpatient MOUD services.

Low-Threshold Care

Low-threshold treatment emphasizes removing the barriers common to conventional OUD treatment and ensuring equitable access to care and treatment. Low-threshold approaches prioritize a “medication first” approach to buprenorphine; individualized psychosocial support; and caring, long-term clinical relationships, through a harm-reduction perspective.

Key components of low-threshold treatment programs for patients with OUD include:

- Prompt (same day) initiation of buprenorphine prior to lengthy assessments or treatment planning sessions
- Maintenance buprenorphine delivery without arbitrary tapering or time limits
- Offering—but never requiring—individualized psychosocial services
- Buprenorphine continuation based solely on the patient's clinical circumstances; positive tests for illicit substances should not result in discontinuation of buprenorphine
- Offering drug testing but not requiring it to obtain MOUD
- Flexibility in dosing, protocols, policies, and workflows for initiating and maintaining buprenorphine therapy
- Availability in settings that best meet patient needs, such as primary care, mobile treatment sites, syringe access programs, and emergency departments

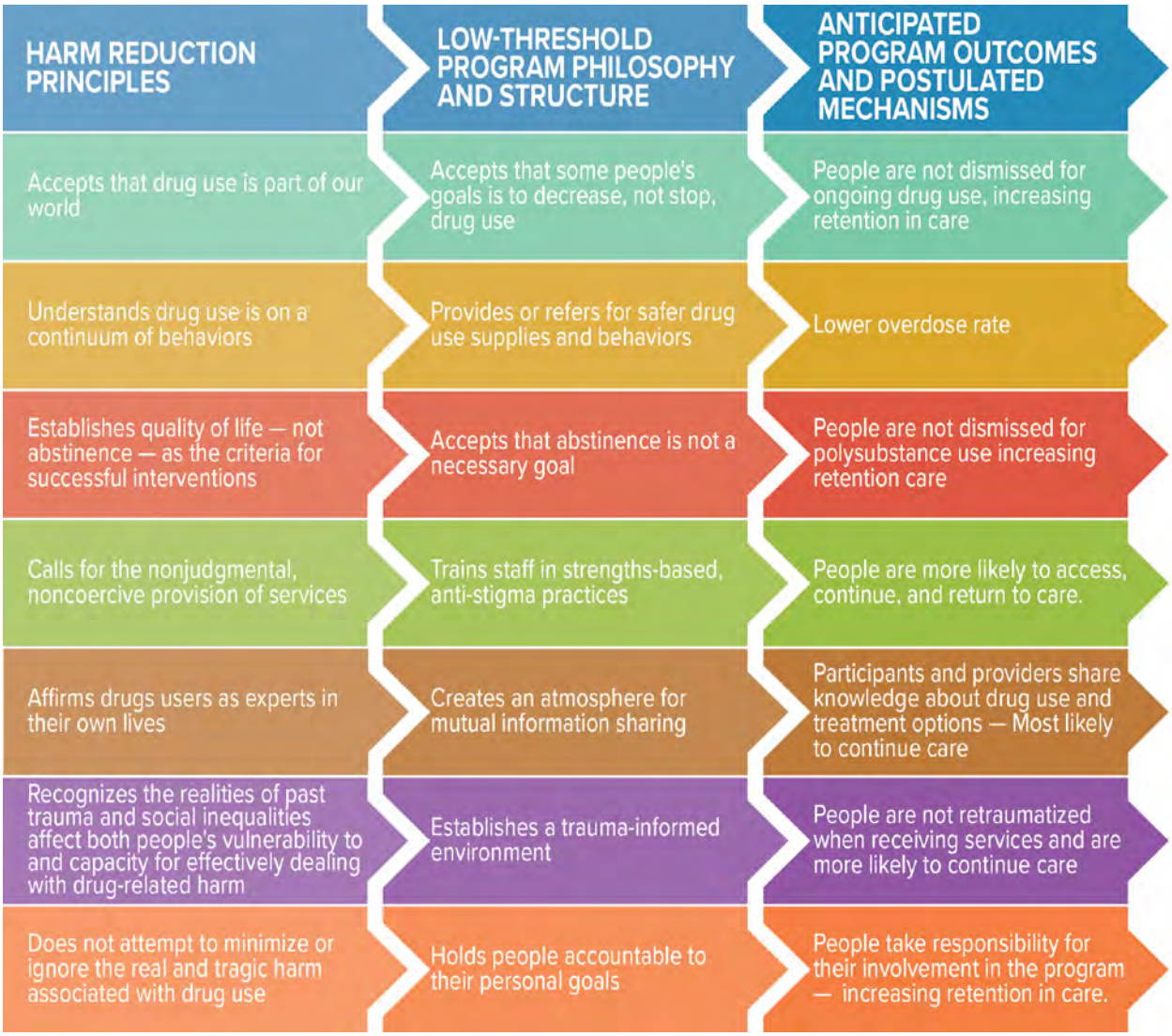
[277] U.S. Food and Drug Administration. "*FDA Drug Safety Communication: FDA Urges Caution About Withholding Opioid Addiction Medications from Patients Taking Benzodiazepines or CNS Depressants: Careful Medication Management Can Reduce Risks*." Published September 26, 2017. Accessed January 13, 2021. https://www.fda.gov/Drugs/DrugSafety/ucm575307.htm.

[278] American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*. Published March 2020. Accessed January 13, 2021. https://eguideline.guidelinecentral.com/i/1224390-national-practice-guideline-for-the-treatment-of-opioid-use-disorder-2020-update/13?.

Low Threshold Care: meeting patients where they are at.

Ninilchik Traditional Council Community Clinic offers a low-threshold MOUD option that serves patients with severe polysubstance use who have struggled to engage in traditional treatment programs. Most patients in this program have co-morbid fentanyl and methamphetamine use disorders, with a high co-morbidities of mental health disorders, justice involvement and untreated Hepatitis C. Located in the rural Southern Kenai, many patients struggle with accessing transportation to get to their appointments and the pharmacy. Services that have helped patients access treatment include same day and walk-in appointments for monthly buprenorphine injections without required sublingual buprenorphine lead-in or drug testing, after hours peer support and case management by text/phone, on-site primary care, behavioral health and harm reduction supplies, and gas cards to reduce transportation barriers. Many of their employees volunteer with the local syringe access program which has been instrumental in maintaining a connection to the active using community and allowing for warm hand-offs for SAP clients needing medical and BH service referrals. The NTC Clinic started providing mobile delivery to administer BUP-XR injections in rural areas of the Kenai Peninsula. The mobile clinic also partners with Kachemak Bay Family planning to provide lab services and with the SAP Megans Place to provide mobile access to harm reduction supplies.

Figure 14. Relationship of harm reduction principles to program philosophy and structure



Relationship of harm reduction principles to program philosophy and structure. *Image Source: Weinstein LC, Iqbal Q, Cunningham A, Debates R, Landistratis G, Doggett P, Silverio A. Retention of patients with multiple vulnerabilities in a federally qualifying health center buprenorphine program: Pennsylvania, 2017-2018. Am J Public Health. 2020 Apr; 110(4):580-586. American Public Health Association. doi:10.2105/AJPH.2019.305525. Epub 2020 Feb 20. PMID: 32078355; PMCID: PMC7067078.Image recreated by the Alaska Department of Health to ensure print quality, no content edits were made.*

Hepatitis C Screening and Treatment

Many patients with a history of intravenous drug use become infected with Hepatitis C virus (HCV). A systematic review of studies across the world identified that HCV prevalence among people who inject drugs can be from 44% to 82%,[279] while another systematic review indicated pool HCV incidence among IDUs was 12.1 per 100 person-years.[280] Nearly half of people with HCV are unaware of their infection status, and approximately 75%-85% of people with HCV don't have symptoms. Without testing, they can unknowingly transmit the virus to others. There is no vaccine to prevent HCV.[281]

One-time HCV screening is recommended for all adults, and periodic screening is recommended for all people who inject drugs or have other risk factors.[259] Screening is accomplished by performing an HCV antibody test; rapid Clinical Laboratory Improvement Amendments (CLIA) waived tests are available for outpatient use. If a patient screens positive for hepatitis C antibody, a follow-up test for viral DNA/RNA quantitative levels is recommended to confirm that the patient has active infection. ANTHC has a simple and user friendly to Guide to Simplified HCV Treatment.

Most insurances now provide good coverage of antiviral medications to cure hepatitis C, even in the absence of liver fibrosis. Alaska Medicaid does not require prior authorization for hepatitis C antivirals on its formulary (Mavyret and generic sofosbuvir-velpatasvir). For more resources, please visit the Alaska Department of Health Epidemiology website for Hepatitis C.

Active drug use is no longer a contraindication to initiating hepatitis C treatment.

Although guidelines recommend HCV treatment for drug users, "stigma … has resulted in insurance restrictions and reluctance from providers to offer appropriate medical therapy." They conclude that HCV-infected injection-drug users "can and should be treated with direct-acting antivirals."[282]

Studies have shown that individuals who inject drugs are no less likely than others who do not use drugs to achieve success in HCV treatment, with over 90% of patients achieving sustained virologic response at 12 weeks, and with low re-infection rates.[283]; [284] Prior to initiation of treatment, patients should be educated on safer injection practices and have access to new injection supplies to help prevent reinfection. Targeting treatment to individuals with active IV drug use can be an excellent way to reduce the spread of this virus among the highest risk population. See the University of Washington resource Treatment of HCV in Persons with Substance Use.

HIV Pre-Exposure Prophylaxis

Pre-exposure prophylaxis (PrEP) is medicine taken to prevent getting HIV. PrEP is highly effective for preventing HIV when taken as prescribed and reduces the risk of getting HIV from injection drug use by at least 74%.[285] PrEp comes in daily pills or a new monthly injection.

Most insurances cover PrEP. The CDC recommends offering PrEP to all injection drug users who share injection equipment (including cookers and cottons).

The CDC has an excellent resource page for provider and patient information on PrEP.

This pocket guide, created by the Cascade AIDS Project and the Mountain West AIDS Education and Training Center

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[279] Aghaei, Ardavan Mohammad, et al. "*Prevalence of Injecting Drug Use and HIV, Hepatitis B, and Hepatitis C in People Who Inject Drugs in the Eastern Mediterranean Region: A Systematic Review and Meta-Analysis.*" The Lancet Global Health 11, no. 8 (2023): e1225–e1237.

[280] Artenie, Adelina, Malvina Aladashvili, et al. "*Incidence of HIV and Hepatitis C Virus among People Who Inject Drugs, and Associations with Age and Sex or Gender: A Global Systematic Review and Meta-Analysis.*" The Lancet Gastroenterology & Hepatology 8, no. 6 (2023): 533–552.

[281] Centers for Disease Control and Prevention. "*Diagnosis and Testing for Hepatitis C.*" Last modified November 2, 2022. Accessed September 26, 2024. https://www.cdc.gov/hepatitis-c/hcp/diagnosis-testing/index.html.

[282] Grebely, Jason, Olav Dalgard, Brian Conway, et al. "*Sofosbuvir and Velpatasvir for Hepatitis C Virus Infection in People with Recent Injection Drug Use (SIMPLIFY): An Open-Label, Single-Arm, Phase 4, Multicentre Trial.*" Lancet Gastroenterology & Hepatology 3, no. 3 (2018): 153-161. https://doi.org/10.1016/S2468-1253(17)30404-1.

[283] Frankova, S., Z. Jandova, G. Jinochova, et al. 2021. "*Therapy of Chronic Hepatitis C in People Who Inject Drugs: Focus on Adherence.*" Harm Reduction Journal 18: 69. https://doi.org/10.1186/s12954-021-00519-y.

[284] Litwin, A. H., J. I. Tsui, M. Heo, et al. 2024. "*Hepatitis C Virus Reinfection Among People Who Inject Drugs: Long-Term Follow-Up of the HERO Study.*" JAMA Network Open 7 (8): e2430024. https://doi.org/10.1001/jamanetworkopen.2024.30024.

[285] Centers for Disease Control and Prevention. "*Pre-Exposure Prophylaxis (PrEP).*" Last modified September 18, 2023. https://www.cdc.gov/hiv/prevention/prep.html

Oregon Program, Prescribing Pre-Exposure Prophylaxis (PrEP) for HIV Prevention A Guide for Medical Providers, outlines critical information for counseling patients and medication management.

ANTHC's Early HIV Intervention Services program, through Alaska Native Medical Center (ANMC) Internal Medicine, provides HIV/AIDS patient services, case management, and counseling for Alaska Native and American Indian people.

Patients can order at-home HIV test kits and get information about treatment one the iknowmine website

The Alaskan AIDS Assistance Association (Four A's) offers support to HIV-positive individuals and their families. Some of the services they provide include access to include medications, health insurance, housing, behavioral health treatment, nutrition support, and oral health care.

ANTHC Early Intervention Services (EIS)/HIV Clinical Services

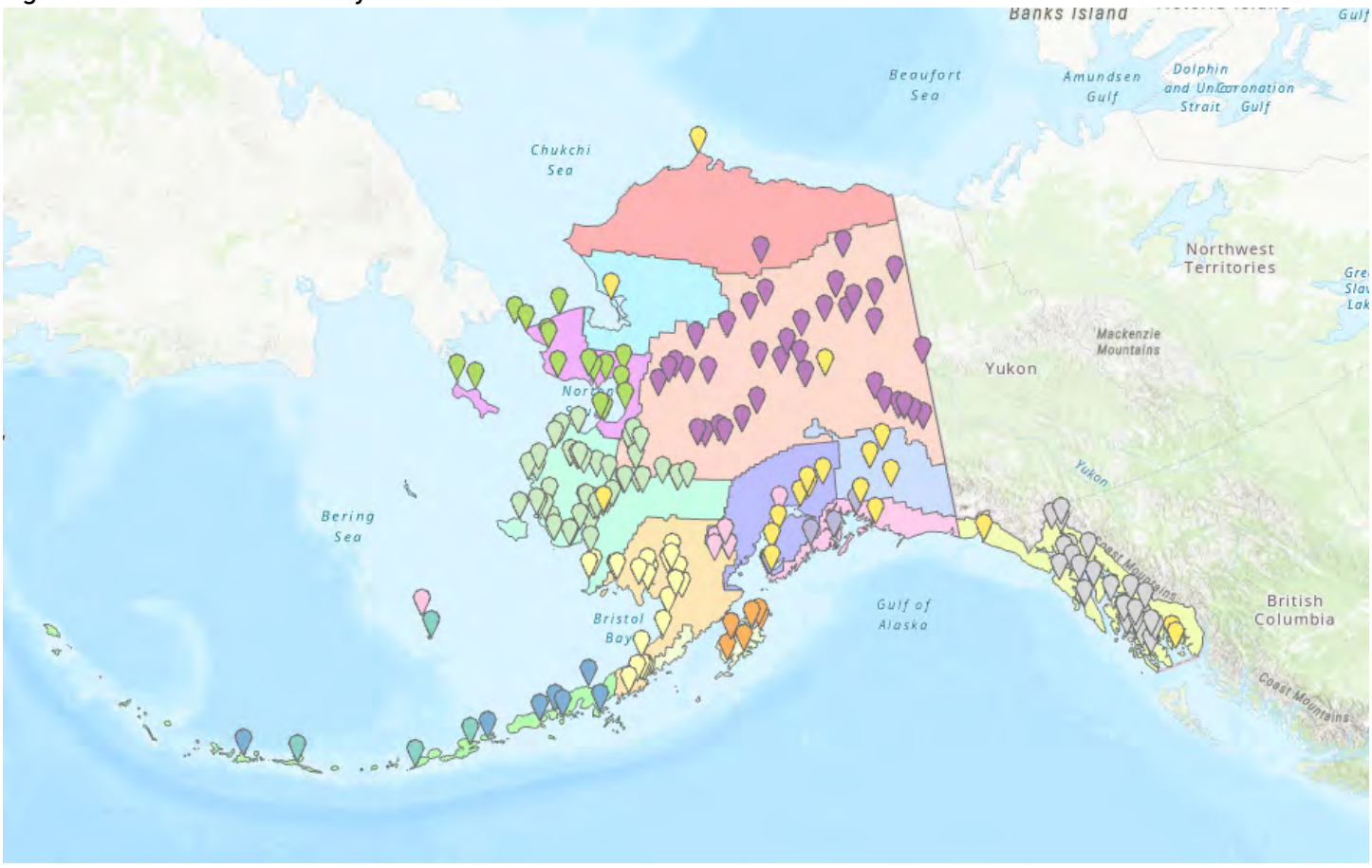
ANTHC EIS/HIV Clinical Services provide medical care and case management to people living with and at risk for HIV and AIDS. The Program is housed within the ANMC Internal Medicine clinic and funded in part by Ryan White Part C. EIS also provides field clinic visits to some regional Tribal Health Organizations around the State of Alaska to provide care to patients closer to their homes. Call 907-729-2907.

Alaska AETC (AIDS Education Training Center Program)

Alaska AETC trains clinicians on skills and knowledge to provide effective HIV prevention, management, and care. This EIS program includes comprehensive HIV education, experienced faculty members, ongoing support and resources and clinical consultation is available to all providers in Alaska. Email AETC@anthc.org.

Chapter 21: Alaska Tribal Health Systems

Figure 15. Alaska Tribal Health System



The Alaska Tribal Health System (ATHS) is a diverse and multifaceted health care system that has developed over the last 30 years. It represents the diversity of Alaska Native people. Alaska has 229 federally recognized tribes that live across 586,412 square miles of predominantly road-less land, the underlying reason for the creation of this innovative and essential statewide health system.

Tribal health organizations in most areas are the only health care providers available and therefore serve everyone in the area regardless of race. In 2022, there were 238,915 Alaska Native people eligible to receive services through the ATHS. Approximately 159,541 Alaska Native people actively seek care from the ATHS on an annual basis. With 178 village clinics who employed more than 468 community health aide/practitioners. Alaska is the only state in which over 99% of health programs are managed by Tribes and Native organizations. — Alaska Native Health Board

Substance-related poisonings and deaths have increased among American Indians and Alaska Natives (AI/AN). Nationally, AIANs had the highest drug related deaths between 2013–2021, compared with other U.S. racial/ethnic groups. AI/AN people experience rates of opioid related overdose death triple that of white Alaskans with 78.2 deaths per 100,000 compared to 24.5 deaths per 100,000 people.[254] Lack of access to medications for opioid use disorder (MOUD) and behavioral health support is still a barrier to accessing care in many rural areas of Alaska.

AI/AN Risk Factors and Protective Factors for Substance Use Disorders

Unique risk factors in AI/AN communities such as historical trauma and socioeconomic challenges have interfered with traditional cultural resilience factors and have increased the risk of addiction in this population. Moreover, communities across Southeastern, Southcentral, and Southwestern coasts of Alaska are more likely to be affected by drug trafficking, and overall exposure to substances for a variety of reasons. AI/AN have for generations lived in

these communities and are vulnerable to this exposure, particularly when treatment is limited.

Connecting AI/AN's with their culture, language, traditions, and heritage through elders and community is protective because these interactions help to develop cultural knowledge, strength, and increase cultural identity. In turn, cultural identification and embracing cultural characteristics, norms, and traditional values can increase community cohesiveness, foster wellness, and reduce distress among AI/AN. Additionally, integrating the continuum of care within communities and occupational industries at risk (such as fishing and canneries) support AI/AN living and working in these at-risk areas and professions. [286]

Barriers to accessing medications for opioid use disorder

Prescribing MOUD for people living in remote villages poses several challenges, including:

- Limited number of addiction medicine specialists.
- Lack of consistent access to onsite licensed medical providers.
- Long distance travel to access specialty care, at high cost, and subject to weather cancellations.
- Access to childcare, time away from work, and lodging required for medical travel.
- Limited pharmacy access with mail delivery of prescriptions subject to delay/interruption.
- Limited local access to behavioral health care.
- Privacy concerns when seeking care at small village clinics.
- Stigma related to substance use disorders (SUDs) and MOUD

Patients who live in remote areas may be able to access buprenorphine through telemedicine services when a local medical provider is not available. Alaska has a well-established telemedicine system through the Alaska Tribal Health System. Nearly every tribal health organization owned village health clinic has telemedicine equipment (such as AFHCAN carts[287]) that can connect via secure video conferencing software to any other Alaska Native clinic or hospital in the state. Most secure telemedicine conferencing applications can also be used with laptops, tablets, and smartphones. Indian Health Service (IHS) tribal encounter reimbursement rates through Medicaid are not reduced for audio-only telemedicine visits, which is important since some AI/AN beneficiaries have limited access to broadband internet. THO village clinics are typically staffed with a community health aide/practitioner (CHA/P) and many villages have behavioral health aide/practitioners (BHA/P), both of whom can provide onsite support and case management services to remote patients.

Currently, the Alaska Native Medical Center (ANMC) lacks a dedicated addiction medicine department that accepts referrals from remote villages for specialized treatment. However, THOs and private rural clinics, including federally qualified health centers (FQHCs), may establish contracts or memorandums of agreement (MOAs) with remote buprenorphine providers when local options are unavailable. These MOAs typically outline the frequency of visits, drug testing protocols, medication counts, and expectations for behavioral health services. It is advisable that these agreements also incorporate staff education on substance use disorders (SUDs) and medication for opioid use disorder (MOUD).

Alaska Native Tribal Health Consortium FREE Provider Consultation Services for Addiction Medicine

Alaska Native Tribal Health Consortium's (ANTHC's) behavioral health department has been offering access to free addiction medicine consultation service for providers as part of its past and present grant funded projects to address opioid use disorder (OUD). Providers can schedule a peer-to-peer curbside consultation meeting with an addiction medicine specialist to help tackle barriers and increase substance use treatment options. Contact behavioralhealth@anthc.org to learn more, subject to grant funded project availability.

Community Engagement

Some rural communities have found it beneficial to hold community education about MOUD to reduce stigma and to encourage community engagement. Experienced buprenorphine prescribers wishing to offer their specialty services to remote tribes should consider meeting with Tribal leaders to address their concerns about introducing MOUD services to their communities. Additionally, MOUD programs serving AI/AN communities should include cultural components that resonate with urban and Tribal

[286] Soto, C., West, A. E., Ramos, G. G., and Unger, J. B. "*Substance and Behavioral Addictions among American Indian and Alaska Native Populations*." International Journal of Environmental Research and Public Health 19, no. 5 (2022): 2974. https://doi.org/10.3390/ijerph19052974.

[287] *AFHCAN Software* https://afhcan.org/documentation/8.0/Cart%20NetHelp/NetHelp/index.html#!Documents/introductiontoafhcansoftware.htm

communities.[288] The California Consortium for Urban Indian Health has various materials and a culturally specific campaign to address the opioid epidemic in Indian Country.

Ordering Medications for Opioid Use Disorders

If the prescriber works within the Alaska Tribal Health System, they can order medications to be mailed to the patient's home or village clinic from the patients local THO pharmacy. It is important to verify that the local pharmacy stocks the formulation of buprenorphine needed. Many commercial pharmacies will also mail sublingual buprenorphine and naltrexone directly to the home address of insured beneficiaries. Long-acting injectable buprenorphine (LIAB) prescriptions for insured beneficiaries can be filled at any authorized specialty pharmacy to be mailed to any clinic that has a licensed provider. ANMC recently added LIAB to its formulary; however, the use may require the recommendation by an addiction medicine consultant or prior authorization. If the patient's local THO pharmacy does not stock LAIB, prescriptions for uninsured beneficiaries should be sent to an authorized specialty pharmacy, and the THO pharmacy should be notified to contact the specialty pharmacy to arrange for payment of the medication.

- Sublocade authorized specialty pharmacies
- Brixadi authorized specialty pharmacies

Naltrexone is typically shipped from the THO pharmacy directly to the tribal clinic where it will be administered.

Tele-MOUD Appointments

If occurring in the village clinic, the local provider, medical assistant or CHA/P collects vital signs, samples for drug testing, and other labs as indicated. The patient is connected via video conference to the MOUD prescriber at the distant site. Concluding the telemedicine session, the prescriber communicates with the local provider regarding the treatment plan and sends a copy of the visit note to the village clinic, with the patient's permission. A telemedicine visit can also be conducted between the patient in their home and the distant buprenorphine prescriber. Some commercial laboratories can mail drug testing collection supplies directly to a patient's home if they are unable to access the local clinic.

If an initial in-person visit is not possible, see the section on Section I Chapter 4 on telemedicine regulations on prescribing without an in-person visit and the Indian Health Services' Internet Eligible Controlled Substance Provider Designation guidance for IHS facilities.

Tele-MOUD for Remote Villages

Southcentral Foundation's Four Directions Program offers MOUD in some of its more rural villages via telemedicine through 3 hub sites located in McGrath, Iliamna, and St. Paul. Providing additional training on MOUD to the village CHAPS helped prepare them to support clients living in these remote villages.Tele-MOUD has helped to reduce barriers and to care and costs by reducing travel to Anchorage. Dr. Isgro maintains her IHS Internet Eligible Controlled Substance Provider Designation (IECSP) designation that is available to all tribal health providers, which has been useful as an adjunct to keep this telemedicine option available regardless of changing telemedicine laws.

Access to Methadone in the Tribal Health System

The Southeast Alaska Regional Health Consortium (SEARHC), based in Juneau, is the first THO in Alaska to operate an Opioid Treatment Program (OTP) with recent OTPs established in Ketchikan, Sitka and Klawock. Given that Alaska Native health consortiums like ANTHC and SEARHC are core providers of health care in rural Alaska, THOs opening OTPs is a crucial and underutilized pathway to increasing access to MOUD in remote areas.

One helpful tool SEARHC utilized to help expand remote and telemedicine methadone access is through asynchronous observed dosing:

Sonara is a HIPAA-compliant, digital health solution that uses a web-based application to support patients who administer methadone at home. Patients scan a patented tamper aware label and are prompted to record a video of themselves taking their medication at home,

[288] Zeledon, I., Telles, V., Dickerson, D., Johnson, C., Schweigman, K., West, A., and Soto, C. 2022. "*Exploring Culturally Based Treatment Options for Opioid Use Disorders Among American Indian and Alaska Native Adults in California.*" Journal of Studies on Alcohol and Drugs 83 (4): 613–620. https://doi.org/10.15288/jsad.2022.83.613.

versus requiring daily travel to a treatment center. The asynchronous video is available for the care team to review, which enables supervision of at-home administration. Remote observation provides a daily touchpoint for our Opioid Treatment Programs to enhance trust with patients, engage in more timely interventions and retain patients in treatment.[289]

See the Section III Chapter 12 on methadone for more information.

Psychosocial Support

Psychosocial support can be offered by a local behavioral health clinician, a Behavioral Health Aide (BHA), by peer support specialists, via phone-in and online mutual support groups (such as AA), and via tele-behavioral health visits.

The Role of Behavioral Health Aides

"A BHA is a counselor, health educator, and advocate. BHAs help address individual and community-based behavioral health needs, including those related to alcohol, drug and tobacco use as well as mental health problems such as grief, depression, suicide, and related issues. BHAs seek to achieve balance in the community by integrating their sensitivity to cultural needs with specialized training in behavioral health concerns and approaches to treatment". BHA's can fill critical roles in remote communities such as collecting information for intakes and assessments, assisting with mutual support group facilitation, providing case management services, assisting with cultural camps, assisting with screening for substance misuse, mental health problems and suicidality and helping patients navigate connection to care.[290]

ANTHC Behavioral Health Aids Program

Tele-Behavioral Health

The ANTHC Behavioral Health Wellness Clinic provides behavioral health through telemedicine to Native beneficiaries across the state, including the following services:

- Behavioral health assessments
- Individual counseling
- Health behavior coaching
- Referral support
- Group counseling, including:
  - For anxiety, depression, & stress
  - ACT on Your Recovery
  - Mindfulness for health and resilience
  - Trauma recovery and empowerment
  - Healthy relationships
  - For grief, loss, and bereavement

Online Support Groups

White Bison Offers Wellbriety twelve-step programs and talking circles for AI/AN people

Tribal Residential Treatment and Medically Supervised Withdrawal Management (not an exhaustive list)

Jake's Place Dillingham, Bristol Bay Area Health Corporation

Chanlyut (short term), Ernie Turner (6 month) Anchorage, Cook Inlet Tribal Council

Ralph Perdue, Fairbanks, Fairbanks Native Association

Women and Children Center for Inner Healing, (women with children) Fairbanks, Fairbanks Native Association

Graf Rheeneerhaanjii (Youth), Fairbanks, Tanana Chiefs Conference

Gateway to Recovery (withdrawal management) Fairbanks, Tanana Chiefs Conference

Dana A Coy, (women and children), Anchorage, South Central Foundation

SCF Withdrawal Management, Anchorage, South Central Foundation

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[289] Southeast Alaska Regional Health Consortium. "Opioid Treatment Program." Accessed September 26, 2024. https://searhc.org/service/opioid-treatment-program/.

[290] Alaska Native Tribal Health Consortium. "Behavioral Health Aide Program." Accessed September 26, 2024. https://www.anthc.org/behavioral-health-aide-program/.

Raven's Way, (Youth), Juneau, SEARHC

Old Minto Recovery Camp, North of Fairbanks, Tanana Chiefs

Ayagnirvik Healing Center, Bethel, YKHC

McCann Treatment Center, (Youth) Bethel, YKHC

Cultural Camps (not an exhaustive list)

Culture camps can play an important role in prevention and recovery in SUD and comorbid mental illness by increasing positive mood, feelings of belongingness, and perceived coping of participants.[291]

Aleut Camps

Chugachmiut Recovery camps

Old Minto Tanana Chiefs

White Raven Anchorage

Youth Camps statewide

Alaskan Native Harm Reduction Services (not an exhaustive list)

Iknowmine ANTHC Mail order harm reduction supplies

Yukon-Kuskokwim Health Corporation (YKHC) through Bethel pharmacy

Sobering Centers (not an exhaustive list)

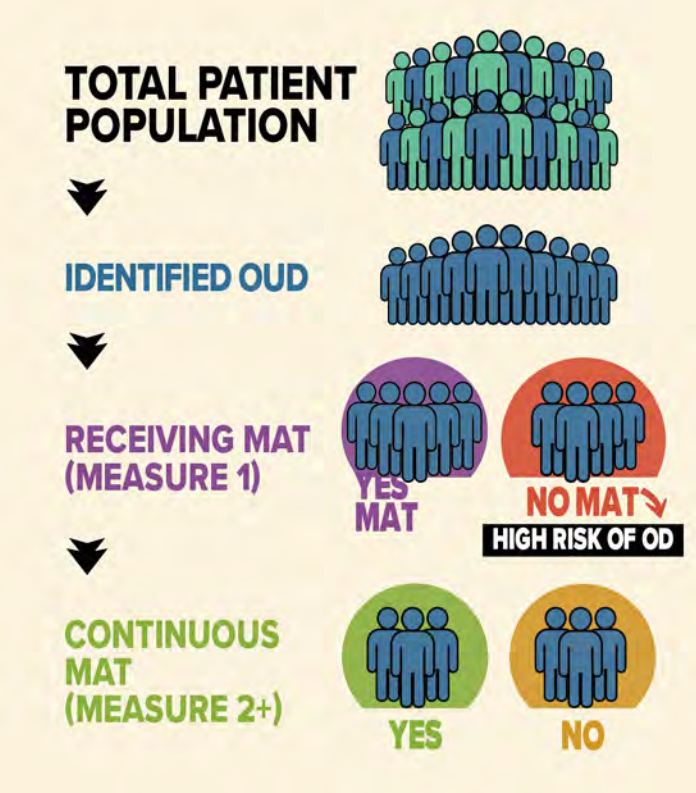
Denardo Center Fairbanks, Tanana Chiefs

Bethel Sobering Center YKHC

Alaska Native Tribal Health Consortium Opioid Dashboard

ANTHC built a dashboard for MOUD on Health Catalyst, a data analytics tool available to Tribal health partners. The Medication Assisted Treatment (MAT) Dashboard uses two measures to help Tribal health providers track MOUD usage and to identify high risk individuals and engage them in care as soon as possible. The first measure is the number of people with an OUD diagnosis who are receiving MOUD. The second measure is MOUD continuity at 90 days and 6 months. For more information, email behavioralhealth@anthc.org .

Figure 16. Example of ANTHC's MAT Dashboard Measures



Tribal Wellness courts, Re-entry Support, and Child Welfare (not an exhaustive list)

Alaska Tribal Justice Resource Center

Henu Wellness Court, Kenaitze Indian Tribe, Kenai

Healing to Wellness Court, Sitka Tribe

Bristol Bay Re-entry Program, Bristol Bay Native Association (BBNA), Dillingham

[291] Barnett, J. D., T. C. Schmidt, B. Trainor, and L. Wexler. "A Pilot Evaluation of Culture Camps to Increase Alaska Native Youth Wellness." Health Promotion Practice 21, no. 3 (2020): 363–371. https://doi.org/10.1177/1524839918824078.

Nome Reentry Coalition, Norton Sound Health Corporation

Alaska Tribal Court Directory

Alaska Office of Children's Services Indian Child Welfare

Tribally-Sponsored Health Insurance Program

Tribally-Sponsored Health Insurance Program (T-SHIP) buys private health insurance coverage for IHS beneficiaries. Having insurance coverage, in addition to IHS benefits, increases care options for sponsored individuals and their entire community.

Tribal Opioid Response Grants and Opioid Settlement funds

Opioid Settlement Funds

New funds are available to federally-recognized Tribes, through the Tribal opioid litigation settlements. These Tribal settlement funds will provide opportunities to support ongoing opioid-related work led by Tribal communities, including prevention, harm reduction, and treatment efforts.[292]

These funds can be used for services that have been previously excluded from other grant funding such as contingency management and harm reduction supplies. For additional guidance, see the Center for Indigenous Health's nationally recognized guidance for Tribal opioid settlement funds, Principles for the Use of Funds From the Opioid Litigation.

Tribal Opioid Response Grants

The purpose of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Tribal Opioid Response Grant (TOR) is to address the opioid crisis in Tribal communities by increasing access to culturally appropriate and evidence-based treatment, including MOUD. The Addiction Technology Transfer Center (ATTC) offers a Tribal Opioid Response Resources page to provide support for grantees.

Culturally responsive SUD treatment

Resources for providing culturally responsive Substance use disorder treatment to Native Alaskan/American Indian Populations include:

- ANTHC MOUD toolkit
- One Sky Center training and technical assistance to American Indian and Alaska Native programs, such as community needs assessment, services planning and collaboration, program development and evaluation, and identification of funding mechanisms and opportunities.
- SAMHSA Tribal Training and Technical Assistance Center provides broad, focused, and intensive TTA to federally recognized tribes and other AI/AN communities
- SAMHSA TIP 61: Behavioral Health Services for American Indians and Alaska Natives
- Opioid Response Network Tribal Team Free education, consulting and technical assistance to tribes
- IHS Tele-MOUD Toolkit
- Implementing Contingency Management Techniques within AI/AN Treatment Populations NWATTC
- ANTHC Harm Reduction Toolkit
- Trainer's Guide to Motivational Interviewing: Enhancing Motivation for Change—A Learner's Manual for the American Indian/Alaska Native Counselor
- Native American Motivational Interviewing: Weaving Native American and Western Practices
- Culturally Responsive Practices in Treatment of Substance Use Disorders: Serving Indigenous Populations

[292] Tribal Opioid Settlements. Accessed September 26, 2024. https://www.tribalopioidsettlements.com/.

Chapter 22: Patients with Pain

Nearly two-thirds of patients with opioid use disorder (OUD) have a comorbid chronic pain condition; therefore, it is critical for providers to understand the appropriate treatment of pain in patients on medications for opioid use disorder (MOUD).[293] Uncontrolled pain can trigger cravings to return to opioid use. The American Society of Addiction Medicine (ASAM) guidelines recommend opioid agonist therapy (with methadone or buprenorphine) as the medications of choice for most patients with chronic pain as they also serve to provide analgesic relief.[294] Since the analgesic response to methadone and buprenorphine only lasts about 6-8 hours, patients may have improved pain control with split dosing of their medication.

All patients with chronic pain should be offered non-opioid pain management options, which have been shown to work as well or better than opioids from chronic pain relief.[295] The Veterans Administration (VA) has an exceptional resource page for holistic chronic pain management. Patients with an untreated OUD who previously responded poorly to non-opioid pain management should be offered these therapies again after being stabilized on MOUD. They may experience an improved response. The VA also offers a free CME course on managing complex patients with chronic pain.

Table 15. Non-opioid medications for chronic pain[296]

Medication	Magnitude of Benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/ pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants (TCAs) and serotonin/ norepinephrine reuptake inhibitors (SNRIs)	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Gabapentin/ pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants (TCAs) and serotonin/ norepinephrine reuptake inhibitors (SNRIs)	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safe than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

[293] Hser YI, MooneyLJ, Saxon AJ, Miotto K, Bell DS, Huang D. *Chronic pain among patients with opioid use disorder: Results from electronic health records data.* J Subst Abuse Treat.2017 Jun;77:26-30. doi.org/10.1016/j.jsat.2017.03.006.

[294] ASAM. "National Practice Guideline". 2020

[295] Agency for Healthcare Research and Quality. "*Opioids for Chronic Pain: Research*." Effective Health Care, June 2023. Accessed September 26, 2024. https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research/. 4o mini

[296] Agency for Healthcare Research and Quality. "*Opioids for Chronic Pain: Research*." Effective Health Care, June 2023. Accessed September 26, 2024. https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research/.

There are many evidenced based non-medication approaches to treating chronic pain which may be more effective at improving quality of life than medications, including movement-based and behavioral health-based interventions. Cognitive Behavioral Therapy (CBT) for pain is a highly effective intervention;[297] however, local access to behavioral health clinicians trained in pain management therapies may be limited in Alaska.

Some resources to access CBT for pain therapy and training from home:

- The VA has a resource page for providers that includes short video tutorials on introducing these techniques to patients
- The Pain Management Workbook, by Dr Rachel Zoffness, is an excellent tool patients can use at home to work through these CBT lessons
- Pain Reprocessing Therapy is an approach that helps patients reframe their perspectives on pain in their daily lives, and medical and behavioral health providers can get online training in this approach
- Explain Pain, a book by David S Butler and G Lorimer Moseley, aims to give clinicians and people in pain the power to challenge pain and to consider new models for viewing what happens during pain. Once they have learned about the processes involved, they can follow a scientific route to recovery
- Curable is a CBT-based app that allows patients to access treatment from their digital devices

Table 16. Evidence based non-pharmacologic approaches to treating chronic pain

Psychosocial Intervention	Complementary and Integrative Health (CIH) Therapies	Rehabilitation Therapies	Exercise
▸ Cognitive-Behavioral Therapy (CBT) ▸ Acceptance and Commitment Therapy (ACT) ▸ Progressive relaxation therapy ▸ Mindfulness-based Therapies ▸ Pain School ▸ Behavior groups	▸ Acupuncture ▸ Massage ▸ Chiropractic therapy ▸ Ice and heat therapy ▸ Meditation	▸ Physical therapy ▸ Occupational therapy	▸ Stretching ▸ Tai chi ▸ Swimming ▸ Hiking ▸ Walking ▸ Yoga ▸ Chair exercises

Patients with Acute Pain taking Buprenorphine

When a patient experiences an acute pain event, they may benefit from a temporary increase in their buprenorphine dose. A patient who is taking 16 mg of buprenorphine daily and has a minor outpatient surgical procedure will likely have adequate analgesia by increasing their buprenorphine dose to 24-40 mg a day, divided every 6-8 hours, along with scheduled NSAIDS plus acetaminophen. Stopping buprenorphine prior to surgical procedures is no longer recommended, although some patients may choose to reduce their buprenorphine dose to 8-12 mg in the 24 hours prior to surgery to increase opioid receptor availability. The day of surgery buprenorphine should be continued, and in addition to multimodal non-narcotic pain management strategies, high dose IV opioid analgesics (typically fentanyl or hydromorphone) may be used in the inpatient setting to manage severe acute pain. The dosage of full agonist required may be more than triple that utilized typically and should be titrated to effect while monitoring for oversedation. The outpatient use of full opioid agonists should be done cautiously with close monitoring and with a safety plan in place to address risks of relapse and overdose. Multimodal perioperative pain management includes utilizing non-opioid interventions

[297] Sanabria-Mazo, J. P., Colomer-Carbonell, A., Fernández-Vázquez, Ó., Noboa-Rocamora, G., Cardona-Ros, G., McCracken, L. M., Montes-Pérez, A., Castaño-Asins, J. R., Edo, S., Borràs, X., Sanz, A., Feliu-Soler, A., & Luciano, J. V. "*A Systematic Review of Cognitive Behavioral Therapy-Based Interventions for Comorbid Chronic Pain and Clinically Relevant Psychological Distress*." Frontiers in Psychology 14 (2023): 1200685. https://doi.org/10.3389/fpsyg.2023.1200685.

such as scheduled NSAIDS and acetaminophen, topical analgesics, gabapentinoids, low-dose ketamine, and regional anesthetic blocks.

Patients with Acute Pain taking Methadone

Hospitalized patients taking methadone should be continued on their current dose, which should be verified with their opioid treatment program (OTP). Maintenance doses may be split; however, providers should not administer additional doses of methadone for acute pain management as peak serum levels will take days to occur, risking overdose. Instead, short acting, high dose full agonists, such as hydromorphone, should be utilized. The dosage of full agonist required may be more than triple that utilized typically, and analgesics should be titrated to effect while monitoring for oversedation. The outpatient use of full opioid agonists should be done cautiously with close monitoring and with a safety plan in place to address risks of relapse and overdose. As noted above, a full multimodal analgesic approach is most effective.

Addressing Perioperative pain in patients taking buprenorphine

1. Continue buprenorphine in the perioperative or acute pain period for patients with OUD;
2. Use a multimodal analgesic approach;
3. Pay attention to care coordination and discharge planning when making an analgesic plan for patients with OUD treated with buprenorphine; and
4. Use an individualized approach founded upon shared decision-making.[298]

Patients with acute pain on Naltrexone

Managing acute pain in patients on naltrexone presents challenges due to its potent opioid blockade. If opioid use is required for a planned surgical procedure, oral naltrexone should be discontinued at least 3 days before surgery, and extended-release injectable naltrexone should be stopped at least 30 days prior. However, for patients early in naltrexone treatment, discontinuation is not recommended. In emergency situations, health care providers should prioritize non-opioid strategies such as high-dose NSAIDs, local nerve blocks, conscious sedation, nitrous oxide, and ketamine. If pain remains inadequately controlled, providers may consider using high-dose, high-potency opioids to attempt to overcome the opioid blockade, with careful cardiorespiratory monitoring.

Utilizing Buprenorphine for Chronic Pain Management in patients without opioid use disorder

Since the Centers for Disease Control and Prevention (CDC) released its guidelines on safe opioid prescribing in 2016, many healthcare providers have significantly reduced their opioid prescribing practices. In some cases, this has involved tapering or discontinuing opioid therapy for patients on high doses, or declining to accept new patients currently using opioids. As a result, individuals who have been on long-term, high-dose opioid therapy for chronic pain may suddenly find that their prescriber is no longer willing to continue treatment—or that they are unable to find a new provider willing to do so. These patients, sometimes called "opioid refugees,"[299] are at risk for severe opioid withdrawal if their medications are reduced abruptly, which can lead to hospitalization and increase risk of overdose and suicide.[300] The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain have attempted to address this problem by clarifying that abrupt tapering or discontinuation of opioids is not recommended, and decisions on the risks and benefits of chronic opioid therapy should be individualized to each patient. In recommendations numbers 5 and 12, the CDC encourages providers to consider prescribing buprenorphine for chronic pain management for patients in whom the risks of their current opioid therapy outweigh the benefits but are unable to tolerate tapering. Some advantages to using buprenorphine for chronic pain include reduced overdose risk, reduction in escalating opioid tolerance and possible reduced risk of opioid-induced hyperalgesia.[301]

[298] Buresh, M., Ratner, J., Zgierska, A., Gordin, V., & Alvanzo, A. "*Treating Perioperative and Acute Pain in Patients on Buprenorphine: Narrative Literature Review and Practice Recommendations*." Journal of General Internal Medicine 35, no. 12 (2020): 3635–3643. https://doi.org/10.1007/s11606-020-06115-3

[299] New Hampshire Public Radio. "*How Fixes for N.H.'s Opioid Crisis May Be Hurting Those with Chronic Pain*." The Exchange, January 22, 2018. Accessed September 26, 2024. https://www.nhpr.org/the-exchange/2018-01-22/how-fixes-for-n-h-s-opioid-crisis-may-be-hurting-those-with-chronic-pain.

[300] Fenton, Joshua J., Elizabeth Magnan, Ioanna E. Tseregounis, Guibo Xing, Alicia L. Agnoli, Diana J. Tancredi. "*Long-term Risk of Overdose or Mental Health Crisis After Opioid Dose Tapering*." JAMA Network Open 5, no. 6 (2022): e2216726. https://doi.org/10.1001/jamanetworkopen.2022.16726.

[301] Dalal, Shalin, Aravind Chitneni, Andrew A. Berger, Victor Orhurhu, Baraa Dar, Brian Kramer, Amy Nguyen, Jeremy Pruit, Charles Halsted, Alan D. Kaye, and Jessica Hasoon. "*Buprenorphine for Chronic Pain: A Safer Alternative to Traditional Opioids*." Health Psychology Research 9, no. 1 (2021): 27241. https://doi.org/10.52965/001c.27241.

The VA now recommends in its 2022 Use of Opioids in the Management of Chronic Pain that buprenorphine should be the drug of choice when prescribing chronic opioid therapy for pain management.

Although there are two formulations of buprenorphine that are approved by the Food & Drug Administration (FDA) to treat chronic pain (Butrans transdermal patch and Belbucca buccal film), these medications are not available as generics and may be unaffordable for some. Also, these formulations are low-dose and thus only appropriate for patients with lower levels of opioid tolerance. Butrans and Belbucca may NOT be used to treat OUD. Chronic pain patients with higher levels of tolerance (>50-100 MME) may need sublingual buprenorphine tablets or films to meet their analgesic needs. It is legal to prescribe sublingual buprenorphine off label for chronic pain; however, insurance coverage may require prior authorization. Combination products (with naloxone) may have lower diversion and abuse risk and may be suitable to use in patients with pain. Although Belbucca and Butrans offer conversion tables to assist with planning the switch over from full agonists, there is no validated formula to calculate morphine equivalency for buprenorphine. Providers should take time to carefully plan the transition with patients and prescribe a one- to two--day supply of low-dose buprenorphine, with daily follow up to rapidly titrate up to an effective dosage. Low-dose overlapping starts are a popular approach to starting buprenorphine in patients with chronic pain taking high-dose full agonists. See Section II, Chapter 6 for more information.

Comprehensive Pain Management (SEARHC)

SEARHC in Juneau offers a comprehensive pain management program that offers, medical, procedural, and behavioral health interventions to improve the quality of life for people with chronic pain. A unique service they offer through behavioral health is Pain Reprocessing Therapy (PRT), a system of psychological techniques that retrains the brain to interpret and respond to signals from the body properly, subsequently breaking the cycle of chronic pain. This intervention has been shown to dramatically improve pain in over 2/3 of patients. Access to BH clinicians trained in pain management is limited statewide; however, training is available online to help providers expand their capacity to offer this care.

Chapter 23: Patients with Co-Occurring Mental Health Disorders

Co-occurring disorders (COD) are defined as concurrent substance use and physical or mental disorders. Other terms used to describe co-occurring disorders include dual diagnosis and comorbid disorders.[302] Per American Society of Addiction Medicine (ASAM), use of the term co-occurring does not identify which disorder is primary which is secondary, which disorder occurred first, or whether one disorder caused the other.[303] Sometimes it can be difficult to differentiate a substance-induced mood or thought disorder from a primary mental illness, and when possible, definitive psychiatric diagnosis is made after the patient is abstinent from substances for a month. Treatment that integrates addiction and mental health care is the most effective for COD; however, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of an opioid use disorder with appropriate medication management.

Co-occurring mental health conditions are frequently seen in patients with substance use disorder (SUD).[304] Nearly 40% of patients with SUD also have a mental health disorder, and nearly two thirds of patients with OUD have experienced mental illness in the past year.[305] Providers benefit from knowing the signs and symptoms of common mental health disorders. Depressive disorders and anxiety disorders (including post-traumatic stress disorder) are the most common co-occurring conditions, although ADHD and personality disorders are often encountered across the range of substance use disorders.[306] Mental health and SUD have common risk factors such as adverse childhood events and genetic vulnerabilities, and patients with mental health disorders may use substances to self-medicate. Some experts favor explaining addiction as "ritualized compulsive comfort seeking" as a common response to the adversity experienced in past trauma.[307] Patients with mental health disorders experience challenges that can result in lower rates of retention in SUD treatment programs and may need more support services to succeed.[308]

Assessment for mental health disorders should occur at the onset of medications for opioid use disorder (MOUD) treatment; however, the completion of the assessment should not delay or preclude starting MOUD. Pharmacotherapy for individuals with COD is optimally delivered by providers in a context of a broad range of treatment and services to address the needs of the individual. These services may include psychosocial treatment, recovery support, and case management. See Section II, Chapter 7 for more information. Providers may not have all these resources; therefore, it is recommended that providers develop partnerships with behavioral health agencies and recovery support systems to refer patients with COD.[309]

Patients with OUD generally respond to medications for mental health diagnoses at rates similar to those without opioid use disorders. The same core medications used in

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[302] Substance Abuse and Mental Health Services Administration. "*Co-Occurring Disorders*." Accessed September 26, 2024. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders#:~:text=The%20coexistence%20of%20both%20a,affected%20by%20a%20mental%20illnes

[303] American Society of Addiction Medicine. "*National Practice Guideline*." Accessed September 26, 2024. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guide

[304] National Institute on Drug Abuse. *"Co-Occurring Disorders and Health Conditions."* Last modified September 30, 2024. Accessed March 11, 2025. https://nida.nih.gov/research-topics/co-occurring-disorders-health-conditions.

[305] Jones, C. M., and E. F. McCance-Katz. "*Co-occurring Substance Use and Mental Disorders Among Adults with Opioid Use Disorder*." Drug and Alcohol Dependence 197 (2019): 78-82. https://doi.org/10.1016/j.drugalcdep.2018.12.030.

[306] Renner Jr, J. A. "*Module 15: Managing Common Psychiatric Conditions in Patients with Substance Use Disorders*." Boston University School of Medicine. Providers Clinical Support System. Released July 26, 2019. Accessed January 13, 2021. https://pcssnow.org/courses/15-managing-common-psychiatric-conditions-in-primary-care/.

[307] Stevens JE. *Addiction docsays: It's not the drugs. It's the ACEs…adverse childhood experiences*. ACES Too High News. https://acestoohigh.com/2017/05/02/addiction-doc-says-stop-chasing-the-drug-focus-on-aces-people-can-recover/. Published May2,2017. Accessed January13,2021

[308] Krawczyk N, Feder KA, Saloner B, Crum RM, Kealhofer M, Mojtabai R. *The association of psychiatriccomorbidity with treatmentcompletion among clients admitted to substance use treatment programs in a U.S. national sample*. Drug Alcohol Depend.2017;175:157-163. doi.org/10.1016/j.drugalcdep.2017.02.006

[309] Substance Abuse and Mental Health Services Administration. *General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occuring Mental and Substance Use Disorders*. HHS Publication No. SMA12-4689, Rockville, MD: Substance Abuse and Mental Health Services Administration, https://library.samhsa.gov/sites/default/files/sma12-4689.pdf

the general population (such as SSRIs), are used in patients on MOUD, with a few special considerations:

- Avoid the use of medications with a potential for misuse whenever possible.[310]
- Methadone has many drug-drug interactions, especially with certain antipsychotic medications.
- Patients on naltrexone should be monitored for adverse events, as increased rates of depression and suicidality have been reported.
- Long-acting injectable medication formulations may be useful in patients with comorbid mental health disorders who have difficulty adhering to daily dosing.
- Patients with mania or psychosis related to amphetamine use may show complete or partial resolution of these symptoms with cessation of use, although symptoms may be prolonged for weeks or months in some patients. Unstable patients or those with bipolar disorder or schizophrenia may require treatment with mood stabilizers or antipsychotics. Psychiatric consultation can be helpful in cases of persistent psychosis.
- For patients with attention deficit disorders (such as ADHD), non-amphetamine treatments such as atomoxetine, bupropion, and guanfacine are preferred. Amphetamines carry the risk of misuse and addiction, especially in patients with stimulant use disorders. Stable patients with ADHD who require prescription amphetamines for school or work performance should be closely monitored for treatment effectiveness and medication misuse.
- Non-benzodiazepine medications for anxiety (such as SSRIs, SNRIs, buspirone, mirtazepine, hydroxyzine, propranolol, and clonidine) and insomnia (doxepin, trazodone, melatonin, TCAs) are preferred to the use of benzodiazepines. Cognitive behavioral therapy for insomnia (CBT-I) is the most effective treatment for sleep disorders.[311]
- Initiation of benzodiazepines should be avoided whenever possible due to risk of misuse and association of increased overdose mortality when combined with opioid agonists. Patients taking chronic or illicit benzodiazepines should not be denied treatment with methadone or buprenorphine. Rapid benzodiazepine discontinuation has been associated with increased risk of harm[312], so patients who are stable on chronic benzodiazepines and for whom the benefits outweigh the risks may be best served by continuing their benzodiazepine therapy while they are on MOUD. Although studies examining outcomes in patients taking benzodiazepines with buprenorphine have shown some increase in mortality, they also have shown improved retention on MOUD in patients taking benzodiazepines.[313] Patients taking benzodiazepines should be monitored closely due to increased overdose risk should the patient return to illicit opioid use. If it is determined that the patient is likely to benefit from the discontinuation of the benzodiazepine, it is important to remember that sudden discontinuation of benzodiazepines in physically dependent individuals can result in life-threatening seizures. A slow benzodiazepine taper should generally be followed, and if a rapid taper is required, it should generally be performed in the inpatient setting. For an excellent brief guide, use Helping Patients Taper from Benzodiazepines. See Section IV Chapter 16 on comorbid benzodiazepine use for more information.
- Periodic reassessment is necessary when working with patients with COD. After a patient has been medically stabilized on MOUD, it is common for symptoms of mood disorders to improve, especially in the first four weeks, and patients should be reassessed when stable. Ongoing uncontrolled symptoms of mental health disorders may be a trigger to return to use, therefore patients should be offered appropriate pharmacotherapy and psychosocial therapy for their mental illness.

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[310] "*Module: Medication-Assisted Treatment for Opioid Use Disorder.*" American Medical Association. Accessed September 26, 2024. https://edhub.ama-assn.org/pcss-moud/module/2821520.

[311] Qaseem, A., Kansagara, D., Forciea, M. A., Cooke, M., Denberg, T. D., and Clinical Guidelines Committee of the American College of Physicians. "*Management of Chronic Insomnia Disorder in Adults: A Clinical Practice Guideline From the American College of Physicians.*" Annals of Internal Medicine 165, no. 2 (2016): 125–133. http://annals.org/article.aspx?doi=10.7326/M15-2175.

[312] Maust, Dawn T., Kelsey Petzold, Jessica Strominger, Hye Min Kim, and Alison S. B. Bohnert. "*Benzodiazepine Discontinuation and Mortality Among Patients Receiving Long-Term Benzodiazepine Therapy.*" JAMA Network Open 6, no. 12 (2023): e2348557. https://doi.org/10.1001/jamanetworkopen.2023.48557.

[313] Park, Tae Woo, Marc R. Larochelle, Richard Saitz, Nengliang Wang, Debra Bernson, and Alexander Y. Walley. "Associations Between Prescribed Benzodiazepines, Overdose Death and Buprenorphine Discontinuation Among People Receiving Buprenorphine." Addiction 115, no. 5 (2020): 924–932. https://doi.org/10.1111/add.14886.

Patients with Suicidal Ideation

A comprehensive assessment including evaluation of mental health status and suicide risk helps determine whether the patient is psychiatrically stable. Patients with suicidal or homicidal ideation should be referred immediately for crisis intervention services and possible hospitalization. Patients with a history of suicidal ideation or attempts should have their medication adherence for the treatment of their OUD and mental health disorder monitored more closely. MOUD may need to be started in the inpatient setting, if appropriate.

Patients at risk for crisis should be given information to contact the crisis hotline. Dialing or texting 988 provides a direct connection to compassionate care and support for anyone experiencing suicidal thoughts, who is at risk of suicide, or who is struggling with emotional distress. 988 is free and confidential, with operators who treat callers with respect, listen without judgment, and can provide short counseling sessions for people in acute emotional distress.

Resources

- Substance Abuse and Mental Health Services Administration's (SAMHSA's) TIP 42: Substance Use Treatment for Persons with Co- Occurring Disorders
- General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders
- This two-minute video from SAMHSA Screening and Treatment for Co-occurring Mental Health and Substance Use Disorders shows how providers and patients are seeing success with the latest in integrated treatment.
- University Alaska Anchorage operates and ECHO program Co-occurring Behavioral Health, Opioid and Stimulant Use Disorders ECHO (soon to be renamed Treating SUD in Alaska) is a virtual learning network focused on the establishment of a multi-disciplinary community of practice that will help to reduce unmet treatment needs and opioid-related overdose deaths in Alaska and increase the knowledge of Food & Drug Administration (FDA) approved medications for the treatment of co-occurring and SUD including OUD and stimulant misuse and use disorders. Register here.

Chapter 24: Pregnant Women, Parents, and Guardians

The incidence of opioid use in pregnancy and rates of newborns affected by prenatal opioid exposure have escalated dramatically, paralleling the epidemic observed in the general population. Although 31% to 47% of pregnancies in the United States are unintended, research suggests that for women with opioid use disorder (OUD), the proportion of unintended pregnancies is higher than 85%.[314] Pregnancy provides an important opportunity to identify and treat women with substance use disorders (SUDs).[315]

Stigma towards pregnant women with Substance use disorder

Pregnancy provides an important opportunity to identify and treat women with SUDs. However, pregnant women with SUDs are likely to face more intense stigma compared to women who are not pregnant. Pregnant women with a SUD are often reluctant to seek help due to fear of negative judgment or hostile reactions from caregivers.[316] Addressing stigma in health care and creating a safe and welcoming clinic environment is critical to the development of a therapeutic alliance with the patient. For more information about stigma regarding pregnant women with SUD, the article Substance Use in Pregnancy: Identifying Stigma and Improving Care is a great resource.

"ASAM strongly supports reforms to reverse the punitive approach taken to substance use and SUD during and after pregnancy and respond to the shared interests of the parent-newborn dyad by providing ethical, equitable, and accessible, evidence-based care."[317]

Child Welfare and substance use

Alaska has higher rates of child removal due to SUD than nationwide averages, with over 60% of removal cases involving parental substance use.[318]

From 2004-2015, 38.7% of Medicaid-enrolled infants with neonatal opioid withdrawal syndrome (NOWS) in Alaska were temporarily or permanently placed in protective custody by the Office of Children's Services (OCS) within 28 days of birth[319]. In 2015–2016, among infants admitted into Alaska Regional Hospital's Neonatal Abstinence Evaluation Support Treatment (NEST) Unit: 50% were discharged into OCS custody; 24% had OCS review with a safety plan outlined before discharge to the parents; 20% had OCS notification without action, and 6% had no OCS referral.[320]

American Indian/Alaska Native (AI/AN) children are overrepresented in state foster care systems nationwide, meaning that higher percentages of AI/AN children are found in the state foster care systems than in the general U.S. population. Alaskan Native families are twice as likely to be investigated, twice as likely to have allegations of abuse or neglect substantiated, and four times more likely to have children placed in foster care than Caucasian/White children.[321]

The National Indian Child Welfare Association published this Disproportionality in Child Welfare Fact Sheet, which explores some of the root causes of this problem.

The Administration for Children and Families guide, Resources Specific to American Indian/Alaskan Native (AI/AN) Communities lists extensive resources to learn

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[314] Heil SH, Jones HE, Arria A, et al. *Unintended pregnancyin opioid-abusing women. J Subst Abuse Treat.*2011;40(2):199-202. doi.org/10.1016/j.jsat.2010.08.011.

[315] American College of Obstetricians and Gynecologists and American Society of Addiction Medicine. *ACOG Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy. No. 711.* August2017. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy. Accessed January13,2021.

[316] Olszewski D, Giraudon I, Hedrich D, MontanariL. *EMCDDA thematic paper– women'svoices: experiences and perceptions of women who face drugrelated problems in Europe.* European Monitoring Centre for Drugs and Drug Addiction. Office for Official Publications of the European Communities; Luxembourg:2009. www.emcdda.europa.eu/publications/thematic-papers/womens-voices_en

[317] American Society of Addiction Medicine. "*2022 SUD Pregnant and Postpartum Statement*." Accessed September 26, 2024. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2022-sud-pregnant-postpartum.pdf?sfvrsn=61e2c93a_7.

[318] National Center on Substance Abuse and Child Welfare. "*Number of Children Who Entered Out of Home Care with Parental Alcohol or Drug Abuse as a Condition Associated with Removal, by Age in the United States, 2021.*" Last modified October 1, 2024. https://ncsacw.acf.hhs.gov/research/child-welfare-statistics/interactive-statistics-series/7-enter-out-of-home-care-age-at-removal-aod/

[319] Newby-Kew, A., and J. W. Parrish. "*Understanding child protective services involvement among medicaid enrolled infants with neonatal abstinence syndrome.*" Alaska Department of Health and Social Services (2018).

[320] Singleton, R., Slaunwhite, A., Herrick, M., Hirschfeld, M., Brunner, L., Hallas, C., Truit, S., Hanson, S., Young, M., & Rider, E. (2019). *Research and policy priorities for addressing prenatal exposure to opioids in Alaska.* International journal of circumpolar health, 78(1), 1599275.

[321] National Indian Child Welfare Association. "*Disproportionality Fact Sheet.*" December 2021. Accessed April 28, 2025 https://www.nicwa.org/wp-content/uploads/2025/03/NICWA_11_2021-Disproportionality-Fact-Sheet.pdf.

about historic trauma and trauma informed care, as well as providing culturally appropriate child welfare services.

> "Equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons' engagement with health care services."
> —American Society of Addiction Medicine (ASAM)

Alaska statute 47.17.024 for mandatory reporting in substance exposed newborns states:

(a) A practitioner of the healing arts involved in the delivery or care of an infant who the practitioner determines has been adversely affected by, or is withdrawing from exposure to, a controlled substance or alcohol shall immediately notify the nearest office of the department of the infant's condition.

(b) In this section,

(1) "controlled substance" has the meaning given in AS 11.71.900, but does not include a substance lawfully taken under a prescription from a health care provider who is authorized to prescribe the substance;

(2) "infant" means a child who is less than 12 months of age.

thus, it is NOT mandatory to report patients to OCS who are in recovery taking medications for opioid use disorder (MOUD). Moreover, Alaska Statute 47.17.020 Persons Required to Report, indicates that:

(i) This section does not require a person required to report child abuse or neglect under (a)(7) of this section to report the resumption of use of an intoxicant as described in AS 47.10.011 (10) so long as the person does not have reasonable cause to suspect that a child has suffered harm as a result of the resumption.[322]

For more information about the historical context of the child welfare system and patient centered strategies to reduce family separation see this report by The Movement for Family Power.

Urine drug testing in Pregnant Women

The debate surrounding universal urine drug testing during pregnancy is complex and multifaceted. While it aims to identify potential substance use and facilitate intervention, it also raises legitimate concerns about privacy, stigma, and the potential for unintended consequences. Pregnant women fear the involvement of Child Welfare Services (CWS) and associated risks of family separation, stigmatizing labels that may impact their interactions with the health care system, and the looming threat of legal repercussions. Such fears can deter individuals from seeking timely prenatal care, which poses risks to both maternal and fetal health.[323] Moreover, the lack of conclusive evidence on the benefits or harms of such screening underscores the need for further research to inform policy and practice.[324]; [325]

When ordering and interpreting drug testing results, it is critical to understand that the presence of a substance in a biological sample tells nothing about the frequency, quantity, or timing of substance use, nor does it provide any information about the circumstances or motivation behind the use. Biological samples such as hair or infant meconium, or cord blood testing, can show positive results for any substances used over the period of detection (which can exceed ninety days), and a positive result cannot be equated with the diagnosis of a use disorder. Additionally, confirmatory testing can take over a week to result, which in many cases does not add value to the clinical management of the newborn or patient and thus may not be medically necessary.

In alignment with American College of Obstetricians and Gynecologists (ACOG) recommendations, urine drug testing should be conducted with the explicit consent of the patient.[326] Drug testing should only be performed when medically necessary to guide treatment decisions. Moreover, a positive test result should not serve as a deterrent to receiving care, nor should it be the sole basis for withholding coverage or initiating family separation. However, navigating these principles in real-world scenarios remains challenging, as the potential consequences of a

[322] Alaska State Legislature, *Alaska Statutes, Section 47.17.020: Persons Required to Repor*t, accessed [December 18, 2024], https://www.akleg.gov/basis/statutes.asp#47.17.020.

[323] Weber, A., B. Miskle, A. Lynch, S. Arndt, and L. Acion. "*Substance Use in Pregnancy: Identifying Stigma and Improving Care*." Substance Abuse and Rehabilitation 12 (2021): 105–121. https://doi.org/10.2147/SAR.S319180.

[324] Chin, Jennifer M., et al. 2022. "*Urine Drug Screening on Labor and Delivery*." American Journal of Obstetrics & Gynecology MFM 4, no. 6: 100733. https://doi.org/10.1016/j.ajogmf.2022.100733.

[325] Price, Heather R., Collier, Adam C., and Wright, Theodore E. 2018. "*Screening Pregnant Women and Their Neonates for Illicit Drug Use: Consideration of the Integrated Technical, Medical, Ethical, Legal, and Social Issues*." Frontiers in Pharmacology 9:961. https://doi.org/10.3389/fphar.2018.00961.

[326] American College of Obstetricians and Gynecologists. "*Substance Use Disorder in Pregnancy*." ACOG. Accessed October 7, 2024. https://www.acog.org/advocacy/policy-priorities/substance-use-disorder-in-pregnancy.

positive test can extend beyond health care to legal and social realms. As society grapples with balancing the need for intervention with the preservation of individual rights and dignity, continued research is imperative to elucidate the true impact of urine drug screening during pregnancy, including its effects on stigma and access to care.[327]

Guidelines for treating opioid use disorder in Pregnancy

The ACOG has recommendations about care for pregnant women with an OUD, including screening for SUDs, the use of opioid agonist pharmacotherapy, modifying some elements of prenatal care as appropriate, and access to adequate postpartum psychosocial support services.[328]

Prior to initiating treatment, all women of childbearing age should be tested for pregnancy, and when testing is negative, asked about their desire for pregnancy in the coming year. Among women who do not want to become pregnant, guidance on effective contraception should be offered as soon as feasible. Women of childbearing age commonly underestimate their risk of pregnancy. Each woman's treatment plan should support her understanding of her risk for conception in the context of her need for MOUD. ACOG supports reliance on a tandem approach of focusing on preventing unintended pregnancy with access to voluntary reversible long-acting contraception and provision of MOUD.[329] A study of patient perception of contraception found that "Interventions should reduce barriers to contraceptive access, particularly long-acting reversible contraceptives (LARCs), and establish counseling strategies that use open, nonjudgmental communication, acknowledge the continuum of reproductive needs, explore perceived susceptibility to pregnancy, and utilize peer educators."[330]

MOUD with opioid agonist treatment has multiple benefits in pregnancy, including reduced overdose risk, improved engagement in prenatal care, increased access to SUD counseling and social services, and reduced risk of obstetrical complications.[331] Per the ASAM Guide for the Treatment of Opioid Use Disorder, treatment with methadone or buprenorphine is recommended and should be initiated as early as possible during pregnancy. Medically supervised withdrawal is not recommended in pregnancy due to high risk of return to use (50-90%).[332] Return to use jeopardizes both mother and baby with heightened potential to overdose, infectious disease exposure, lack of prenatal care, and pregnancy complications such as preterm birth.

Medications for opioid use disorder selection in pregnancy

Although methadone historically has been the first line OUD treatment in pregnancy, buprenorphine is becoming much more widely used due to its availability and research demonstrating that neonatal opioid withdrawal syndrome may be less severe.[333] Due to increases in blood volume and renal clearance in pregnancy, MOUD dose increases, and split dosing may be required. Buprenorphine mono-product (Subutex) has been historically preferred in pregnancy, rather than the combination buprenorphine/naloxone product to avoid the infant exposure to naloxone. However, absorption of naloxone sublingually is very low, and maternal drug levels are not felt to be clinically significant. Recent reviews of the use of the combo product (buprenorphine/naloxone) in pregnancy has shown it to be safe and may be a better choice for some women than the mono product.[334] It is important to warn women that there is increased risk of precipitated withdrawal with the

[327] Weber et al., "Substance use in pregnancy..."

[328] American College of Obstetricians and Gynecologists. "*Opioid Use and Opioid Use Disorder in Pregnancy.*" ACOG, August 2017. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy.

[329] Patrick, Stephen W., and Davida M. Schiff; Committee on Substance Use and Prevention, "*A Public Health Response to Opioid Use in Pregnancy,*" Pediatrics 139, no. 3 (March 2017): e20164070, https://doi.org/10.1542/peds.2016-4070.

[330] Stancil, S. L., M. K. Miller, A. Duello, S. Finocchario-Kessler, K. Goggin, R. P. Winograd, and E. A. Hurley. "*Long-Acting Reversible Contraceptives (LARCs) as Harm Reduction: A Qualitative Study Exploring Views of Women with Histories of Opioid Misuse.*" Harm Reduction Journal 18, no. 1 (2021): 83. https://doi.org/10.1186/s12954-021-00532-1.

[331] Reddy, Usha M., Uma M. Reddy, Robert M. Silver, Michael W. Varner, George Saade, Brian Casey, Hyagriv Simhan, et al. "*Opioid Use Disorder and Pregnancy Complications in U.S. Hospitals, 1997–2014.*" Addiction 116, no. 9 (2021): 2539–2549. https://doi.org/10.1111/add.15582.

[332] Jones, Hendrée E., Kevin E. O'Grady, Deesha Malfi, and Michelle Tuten. "*Methadone Maintenance vs. Methadone Taper During Pregnancy: Maternal and Neonatal Outcomes.*" The American Journal on Addictions 17, no. 5 (2008): 372–386. https://doi.org/10.1080/10550490802266276.

[333] Anbalagan, Sujatha, David M. Falkowitz, and Maria D. Mendez. "*Neonatal Abstinence Syndrome.*" Last modified April 1, 2024. In StatPearls. Treasure Island, FL: StatPearls Publishing, 2024. https://www.ncbi.nlm.nih.gov/books/NBK551498/.

[334] Ordean, Alice, and M. Tubman-Broeren. "*Safety and Efficacy of Buprenorphine-Naloxone in Pregnancy: A Systematic Review of the Literature.*" Pathophysiology: The Official Journal of the International Society for Pathophysiology 30, no. 1 (2023): 27–36. https://doi.org/10.3390/pathophysiology30010004.

combination product if women misuse their medication – through intravenous, insufflated, and smoking routes – which could cause fetal stress.

According to ASAM: "While the evidence on the safety and efficacy of naloxone in pregnant women remains limited, the combination buprenorphine/naloxone product is frequently used, and the consensus of the guideline committee is that the combination product is safe and effective for this population."[335]

For most pregnant women, buprenorphine can be initiated at home. Hospitalization during the initiation of methadone or buprenorphine may be an option for those with comorbid medical or psychosocial issues resulting in a high-risk pregnancy, especially in the third trimester. Naltrexone is not preferred for use in pregnancy since there is less data on naltrexone use in pregnancy, and careful consideration of both potential benefits versus risks must be considered for each individual patient. If a woman becomes pregnant while she is receiving naltrexone, providers should discuss the risks and benefits of continuing naltrexone or switching to another form of MOUD.[336]

Both currently available brands of monthly long-acting injectable buprenorphine (LAIB) contain the solvent N-Methyl-2-pyrrolidone (NMP), which may cross the placenta. Limited studies in rodents given doses equivalent to triple that used in humans suggest possible increase in teratogenic effects. The weekly formulation of LAIB (Brixadi weekly) does not contain this solvent, so has been the long-acting formulation of choice in pregnancy in some countries outside the United States. Although there are no studies of the use of LAIB in pregnancy, for some women with severe OUD who are not able to meet their treatment goals with the use of sublingual buprenorphine, the use of LAIB in pregnant women may be considered after a risk-benefit discussion with the patient.[337]

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS), is a result of the sudden discontinuation of fetal exposure to substances (including both illicit substances and legal ones like nicotine) and medications (which include controlled substances as well as non-narcotic medications such as antidepressants) that were used by the mother during pregnancy.[338] It is a treatable condition occurring in 30-80% of substance exposed infants during the first two weeks of life.[339] The current recommended approach to treating NAS is the Eat, Sleep, Console method which is shown to significantly reduce the need for medications to treat NAS and decrease the number of days until infants required hospitalization, without increasing specified adverse outcomes.[340]

The Eat, Sleep, Console method supports newborns in:

- Eating: The baby is able to feed normally for his or her age.
- Sleeping: The baby can sleep for at least one undisturbed hour.
- Consoling (being soothed): The baby can be soothed within ten minutes.

This approach also helps to encourages keeping the infant in the parent's room whenever possible and supports parents in developing skills they need to care for and comfort their newborns.

The Neonatal Abstinence Evaluation Support Treatment (NEST) program at Alaska Regional Hospital utilizes Eat, Sleep Console with a high nurse-to-patient ratio for medically controlled withdrawal management in an environment that simulates a home nursery with low lighting and reduced sound. Each private space includes sleeping accommodations for one parent.

Breastfeeding

Unless otherwise contraindicated, mothers receiving methadone or buprenorphine for treatment of OUD

[335] ASAM National Practice Guideline.

[336] ASAM National Practice Guideline

[337] Towers, C. V., and H. Deisher. "*Subcutaneous Extended-Release Buprenorphine Use in Pregnancy*." Case Reports in Obstetrics and Gynecology 2020 (2020): 3127676. https://doi.org/10.1155/2020/3127676.

[338] American Academy of Pediatrics. "*Neonatal Opioid Withdrawal Syndrome*." Pediatrics 146, no. 5 (2020): e2020029074. https://doi.org/10.1542/peds.2020-029074.

[339] ACOG. "*Opioid use and opioid use disorder in pregnancy*".

[340] Zhou, Xue, Brian K. H. Chan, Michael J. Kim, Christine L. T. N. Huang, B. M. L. C. Mak, K. T. H. Lam, and A. T. F. Y. Wong. "*Opioid Use in Pregnancy and Neonatal Outcomes*." New England Journal of Medicine 388, no. 1 (2023): 21–30. https://doi.org/10.1056/NEJMoa2214470.

are generally encouraged to breastfeed.[341] Very little medication is transferred through breastmilk, and most studies have shown no statistical difference in development to age five in babies exposed to MOUD.[342] Generally, breastfeeding is not recommended in mothers who continue to use illicit drugs. For specific breastfeeding recommendations, given the complexity of breastfeeding in mothers with SUD, individualized care plans should be created in partnership with the patient and multidisciplinary team with appropriate clinical support and follow-up.[343]

Naloxone for overdose reversal

Naloxone is recommended for use in pregnant women to reverse life-threatening opioid overdose. All pregnant women with OUD should receive overdose response training and a naloxone kit.

Continuity of care after hospital discharge

The discharge plan for infants treated for NAS may include home visits and services, such as parenting support and links to home nurses and social workers. The plan may also include referrals to health care workers who know about NAS and are available to the family immediately after discharge. The American Academy of Pediatrics recommends this simple checklist to help with discharge planning and proper care after leaving the hospital.

- Discharge checklist for infants with opioid exposure
- No significant clinical signs of withdrawal for 24–48 hours
- Parent education about neonatal opioid withdrawal syndrome (NOWS) and routine newborn care, emphasizing safe sleep
- Pediatrician or primary care provider follow-up visit scheduled within 48 hours of discharge
- Early intervention services referral
- Home-nurse visitation referral
- Hepatitis C testing follow-up, including referral to pediatric infectious disease when appropriate
- Plan of safe care, coordinating with child welfare as appropriate
- Developmental-behavioral pediatrician referral as appropriate

Overdose risk for pregnant women and parents peak during the post-partum period, especially around six to nine months postpartum, which is a major driver of increasing rates of pregnancy related mortality.[344] Continued monitoring and support during the postpartum year is to help postpartum women continue MOUD uninterrupted is critical to reduce overdose risk.

Residential SUD treatment programs that accept pregnant women as well as parents with their children

- Dana A Coy, (women and children), Anchorage, Southcentral Foundation
- Women and Children Center for Inner Healing, (women with children) Fairbanks, Fairbanks Native Association
- Set Free (Palmer-women and children, Homer-men and children)

Provider resources:

- SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants
- SAMHSA A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders
- ACOG Opioid Use and Opioid Use Disorder in Pregnancy
- CDC Treatment for Opioid Use Disorder Before, During, and After Pregnancy

[341] Academy of Breastfeeding Medicine. *Clinical Protocol #21: Substance Use Disorders in Pregnancy and Lactation. Revised 2022. Accessed October 7, 2024.* https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/ABM%20Clinical%20Protocol%2021%20SUD_English.pdf.

[342] ACOG. "*Opioid Use and Opioid Use Disorder in Pregnancy*"

[343] *Breastfeeding Recommendations for People Who Use Substances*: AWHONN Practice Brief Number 16 Journal of Obstetric, Gynecologic & Neonatal Nursing, Volume 52, Issue 1, e1 - e4

[344] Han, Bing, Wilson M. Compton, Elizabeth B. Einstein, Erin Elder, and Nora D. Volkow. "*Pregnancy and Postpartum Drug Overdose Deaths in the U.S. Before and During the COVID-19 Pandemic*" JAMA Psychiatry 81, no. 3 (2024): 270–283. https://doi.org/10.1001/jamapsychiatry.2023.4523.

Patient resources:

- ACOG FAQs Opioid Use Disorder and Pregnancy
- The Perinatal Health Program under the Alaska Division of Public Health has a NAS Patient Booklet that the provider may give to pregnant patients and their families.
- Eat, Sleep, Console for NAS
- A Short Guide to Breastfeeding and Substance Use

Justice-involved Individuals

A substantial portion of the prison population in the United States is convicted for drug-related offenses. The exact rates of inmates with substance use disorders (SUDs) is difficult to measure; however, some research shows that an estimated 49% percent of the United States state prison population has an active SUD.[345]

Inmates with opioid use disorders (OUDs) face increased challenges but also have increased opportunities for intervention. During time in prison, untreated inmates may experience a reduced tolerance to opioids due to withdrawal and abstinence. Upon release, many will return to opioid use, and having lost their tolerance, face increased risk of overdose and death. Overdose death rates for recently incarcerated individuals not on medications for opioid use disorder (MOUD) are up to 120 times higher than the general population[346].

Forcing opioid tapering and withdrawal during incarceration can have dire consequences upon release into the community. Initiating or continuing MOUDs during incarceration reduces the risk for opioid use and overdose upon release by maintaining opioid tolerance, reducing return to illicit use and increasing community treatment engagement.[347]

Long-acting injectable formulations of buprenorphine (LAIB) (Sublocade and Brixadi) and long-acting injectable naltrexone (Vivitrol), may have multiple advantages for patients involved in the criminal justice system. When SUD treatment is court mandated, long-acting injectable MOUD allows easy documentation of patient adherence and avoids any concern about medication diversion. Additionally, if a patient is re-incarcerated in the future, LAIB can offer extended opioid agonist effects lasting beyond the typical one-month duration. This prolonged effect may help reduce the risk and severity of withdrawal symptoms and lower the likelihood of returning to illicit drug use during or after incarceration. It is important to note; however, that patients who have stopped their LAIB injections may test positive for buprenorphine in their urine for over a year, a fact that should be communicated to people subject to mandatory drug testing, and those who are monitoring test results. When clinically indicated, serial confirmatory urine or serum buprenorphine levels can be tested to track changes over time.

Failure to continue MOUD for an incarcerated individual in recovery is an Americans with Disabilities Act (ADA) violation and should be reported. See Section I, Chapter 4 on ADA regulations for more information.

Clinics should offer individual treatment plans for patients who are referred to treatment through probation, child protective services, therapeutic courts, or other court orders. Patients with legal involvement may be required to provide proof of participation in medical and behavioral health care. Additionally, therapeutic courts may recommend a highly structured treatment plan that includes regular appointments and frequent drug testing. When state and federal agencies mandate drug testing, they also provide those services, so medical providers should only order the drug testing as clinically indicated to monitor medication adherence and substance use. Some patients may prefer monthly injectable medication to avoid concerns about medication adherence. Alternatively, offering directly observed dosing of sublingual products—whether through video chat, in-person visits, or secure directly observed therapy apps—can help patients demonstrate adherence. Monthly injectable buprenorphine may be preferred to daily dosing for patients who are at risk for return to incarceration, to reduce risk of acute withdrawal due to medication interruption. Patients with legal involvement are often court-ordered to receive behavioral health assessment and support. All patients should be asked to sign releases of information to enable communication with probation or parole officers, the Office of Children's Services (OCS), and lawyers to verify their participation in treatment. However, it is crucial to remember that no records, including drug test results, can be shared with any outside entity without the patient's explicit written consent

[345] Prison Policy Initiative. "*Punishing Drug Use*." Prison Policy Initiative Blog, January 30, 2024. https://www.prisonpolicy.org/blog/2024/01/30/punishing-drug-use/.

[346] Binswanger, Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release from Prison — A High Risk of Death for Former Inmates." New England Journal of Medicine 356, no. 2 (January 11, 2007): 157–65. https://doi.org/10.1056/NEJMsa064115.

[347] Cates, L., and A.R. Brown. "*Medications for Opioid Use Disorder during Incarceration and Post-Release Outcomes*." Health and Justice 11, no. 4 (2023). https://doi.org/10.1186/s40352-023-00209-w.

or a court order. The referring state agency has protocols in place to perform their own random forensic drug testing for monitoring compliance. Regular communication between the state agencies and the medical case manager are critical to ensure that medical and behavioral health treatment plans align with any legal requirements of court ordered treatment. Patients who fail to fulfill requirements of their court mandated treatment plan should still be offered low threshold care and harm reduction services to reduce morbidity and mortality.

Alaska Department of Corrections

The Alaska Department of Corrections (DOC) processes approximately 29,000 remands annually throughout the state. On any given day there are approximately 5,000 offenders housed within thirteen facilities statewide. It is estimated that approximately 15% of offenders assessed within DOC use opioids as their drug of choice. DOC offers continuation of MOUD that is aligned with evidenced-based treatment practices for individuals entering the correctional setting with a diagnosed OUD who are currently on MOUD. DOC has a comprehensive screening, assessment, intervention, and education model available to all incarcerated individuals. The following is a brief description of the MOUD intervention and treatment options the department offers:

- Screening of all individuals entering a DOC facility for substance use and use disorders.
- SUD assessments as needed to further determine treatment needs.
- Methadone and buprenorphine bridging for up to 30 days for all individuals remanded with a verified community prescription.
- For individuals expected to be incarcerated for more than thirty days, a long-term treatment plan is created for patients with the consultation of addiction medicine specialists when needed.
- Pregnant women with an OUD will be offered the opportunity to start and to continue MOUD and pharmacotherapy for as long as therapeutically necessary.
- DOC provides resources for individuals while incarcerated and when returning to the community (education, counseling, help with housing, connection to government benefits, etc.).
- Extended-release naltrexone is available to all inmates meeting criteria prior to being released back into the community.
- All individuals released back into the community are offered a naloxone rescue kit.

DOC facilities are not currently offering initiation of MOUD other than for pregnant women.

Justice-involved individuals should be encouraged to disclose MOUD treatment during the intake screening process, so that treatment may be continued and withdrawal symptoms avoided.

Alaska Therapeutic Courts

The Alaska Therapeutic Courts (TC) follow a policy that incorporates evidence-based practices for drug courts. This approach includes using medications for addiction treatment alongside counseling and behavioral therapies to offer a comprehensive, whole-patient strategy for addressing substance use disorders. TCs are shown to reduce return to drug use and recidivism.[348]

The therapeutic model is not an “easy way out” of a felony or misdemeanor, but rather an alternative justice approach. In this model, a collaborative court team—comprising a supervising judge, district attorney, defense counsel, probation officer, and substance use or behavioral health treatment provider—closely monitors participants who opt for treatment instead of incarceration. The court team meets weekly to review their progress, and to suggest incentives or sanctions that may best encourage the participants’ success. When individuals are accepted into a TC, participants are required to:

- Have an assessment conducted by a contracted SUD treatment provider.
- Be screened for need for OUD and if appropriate, the participant will be referred to a provider for a medical assessment for MOUD therapy.
- Attend court status hearings weekly, bi-monthly, or monthly depending on their stage in the program.

The court team relies on the medical provider’s treatment plan and recommendations for MOUD. Pharmacotherapy may be included as a condition of the participant’s participation in the therapeutic drug court. If a participant refuses to comply with the medical recommendations, it may result in a participant’s discharge from the TC program.

[348] Center for Court Innovation. "*Incorporating Medication in Opioid Courts*." Center for Court Innovation, 2023. https://www.innovatingjustice.org/publications/incorporating-medication-opioid-courts.

TCs exist in Anchorage, Bethel, Fairbanks, Juneau, Kenai, and Palmer. Visit the Alaska Therapeutic Courts website for more information.

Reentry Services

Reentry case managers offer direct assistance and reentry planning for Alaskans returning to their communities after incarceration. Additionally, peer mentors—individuals with lived experiences of incarceration and/or substance use—provide invaluable support, including reentry planning, housing and employment assistance, access to treatment and recovery services, transportation, and various forms of support such as peer support, faith-based initiatives, cultural programs, and family assistance.

The Alaska Reentry Partnership is a coalition of individuals, reentry coalitions and centers, family members, case managers, community providers, local businesses, and public agencies that promote success for justice-involved Alaskans.

Resources for individuals with justice involvement

- Alaska Native Justice Center
- Alaska Reentry Partnership
- Incorporating Medication in Opioid Courts
- Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings SAMHSA
- Guidelines for Managing Substance Withdrawal in Jails Department of Justice
- Reporting ADA violations for Prisoners

Chapter 26: Youth

Substance use by adolescents has an enormous impact on their health and well-being. It impairs healthy growth and development, is associated with risky behaviors such as unprotected sex, dangerous driving, and contributes to the development of many other health problems.[349] National Survey on Drug Use and Health from 2022 indicates that just 7.5% of those younger than 18 identified as having opioid use disorder (OUD) are prescribed medications, and 10% of 18-25 year olds identified as having OUD receive medications for opioid use disorder (MOUD).[350]

The American Academy of Pediatrics (AAP) recommends that providers offer medications for MOUD to adolescents with OUDs or discuss referrals to other providers for this treatment.[351] Training for treating SUDs in adolescents is offered by the AAP.

When prescribing medications for OUD in adolescents, providers need to be familiar with the clinical practices unique to adolescents. For example, providers need to be comfortable providing family-based overdose prevention education, have knowledge of effective treatment engagement strategies based on adolescent development, and have a strong understanding of the confidentiality practices regarding minors.[352]

Pharmacotherapy in Youth

Buprenorphine: Approved for use in ages 16 and older. Due to reduced medication compliance seen in adolescents, monthly injectable buprenorphine may result in better adherence.

Naltrexone: Approved for use in ages 18 and older. However, a provider may choose to use it off-label for an adolescent if it is the best available treatment option. Naltrexone may be the medication of choice in youth with mild OUD or who have less than one year of opioid dependence. Naltrexone, which also reduces alcohol cravings, may be a good therapeutic option for adolescents and young adults with co-occurring alcohol use disorder (AUD).

Methadone: Because of various restrictions, including the requirement for written consent from a parent/guardian, methadone is infrequently used in adolescents under 18 years of age.[353]

Retention in Treatment

Adolescents and young adults typically have poor retention in treatment. Keeping young people engaged in their medical care is crucial to long-term recovery success. Programs that actively engage youth through parental involvement, active outreach via text messaging, and rewarding medication compliance with incentives have demonstrated much higher medication compliance and lower dropout rates than treatment as usual.[354]

Minor Patients and Confidentiality

Providers working with youth need to be familiar with confidentiality laws for minors. This includes Alaska state statutes, the Health Insurance Portability and Accountability Act (HIPAA), and 42 CFR 2.14. This guide cannot deliver legal advice, and providers who have questions about minor patients and confidentiality should seek legal counsel.

In general, a health care provider may not provide health care to a minor (under age 18) without the consent of the minor's parent or legal guardian; however, there are

[349] Adams, Gerald, Anne Marie Cantwell, and Shawn Matheis. "*Substance Use in Adolescence*." In Adolescent Behavior Research: Advances and Future Directions, edited by Gerald Adams, Anne Marie Cantwell, and Shawn Matheis. Taylor & Francis, 2016. https://www.taylorfrancis.com/chapters/edit/10.4324/9781315783154-1/substance-use-adolescence-gerald-adams-anne-marie-cantwell-shawn-matheis

[350] Substance Abuse and Mental Health Services Administration (SAMHSA). *2023 National Survey on Drug Use and Health Detailed Tables: Section 5, Mental Health Services*. Last modified 2023. https://www.samhsa.gov/data/sites/default/files/reports/rpt47100/NSDUHDetailedTabs2023/NSDUHDetailedTabs2023/2023-nsduh-detailed-tables-sect5pe.htm.

[351] Committee on Substance Use and Prevention. "*Medication-Assisted Treatment of Adolescents with Opioid Use Disorders*." Pediatrics 138, no. 3 (2016): e20161893. https://doi.org/10.1542/peds.2016-1893.

[352] Pacek, Lauren R., Marc L. Copeland, Li-Tzy Wu, and Bradley N. Gaynes. "*Prevalence of Psychiatric Comorbidity among Methamphetamine Users in the United States: Findings from the 2015–2016 National Survey on Drug Use and Health*." Journal of Studies on Alcohol and Drugs 80, no. 4 (2019): 393–398. https://doi.org/10.15288/jsad.2019.80.393.

[353] David C. Chang, Jan Klimas, Evan Wood, and Nadia Fairbairn, "*Medication-Assisted Treatment for Youth with Opioid Use Disorder: Current Dilemmas and Remaining Questions*," American Journal of Drug and Alcohol Abuse 44, no. 2 (2018): 143-146, https://doi.org/10.1080/00952990.2017.1399403.

[354] National Institutes of Health (NIH). "*Youth Opioid Recovery Support: How Digital Tools Can Help*." Helping to End Addiction Long-Term (HEAL) Initiative, September 20, 2022. https://heal.nih.gov/news/stories/Youth-Opioid-Recovery.

several important exceptions to this rule. See AS 25.20.025 Examination and Treatment of Minors for some of these exceptions.

HIPAA generally allows a parent to have access to a child's medical records as the minor child's personal representative, as long as the access is not inconsistent with state or other laws (see AS 25.20.025 for state laws). For more information about HIPAA and minor consent, visit the U.S. Department of Health and Human Services' Health Information Privacy webpage.

42 CFR Part 2.14 specifically addresses confidentially with substance use treatment as it relates to minor patients. It covers three topics: state law not requiring parental consent to treatment, state law requiring parental consent to treatment, and minor applicant for services lacks capacity for rational choice.

Another helpful resource is the handout Confidentiality Laws, Alaska-Specific. This is part of the Spark Training developed by the Adolescent Health Initiative at Michigan Medicine; February 2019; Ann Arbor, MI.

Alaska-Specific Resources for Youth with Substance Use Disorders

Behavioral Health Youth Roadmap

This roadmap forms the basis of a statewide plan that can be implemented over multiple years to achieve the expansion of provider services necessary to complete the continuum of care. This is intended to build upon existing studies, models, and work already underway. The intent is that this roadmap provides a focused path to:

1. create a shared vision for behavioral health services in Alaska;
2. align funding opportunities and requests with service delivery needs;
3. identify barriers, including regulatory, fiscal, technology, or other issues not fully addressed; and
4. ensure unique regional and cultural needs are cared for and local solutions leveraged as much as possible.

HelpMeGrow-Alaska

HelpMeGrow-Alaska is a program out of the All Alaska Pediatric Partnership "dedicated to promoting healthy child development statewide by providing support and information to individuals and organizations who care for and about children and young adults."[355] It is for parents, providers, teachers, and caregivers giving assistance through navigators.

Overview of Alaska's Behavioral Health System of Care for Children

2023 report by the State of Alaska that outlines the current efforts to improve access to care and address deficits cited in a 2022 U.S. Department of Justice report on state services.

Partnership Access Line – Pediatric Alaska

The Partnership Access Line – Pediatric Alaska (PAL-PAK) offers immediate support to pediatric care providers (doctors, nurse practitioners, and physician assistants) in Alaska who have questions about child and adolescent mental health care, such as diagnostic clarification, medication adjustment, or treatment planning. PAL-PAK is available to any prescriber caring for children or teens in Alaska. The consultation service is state- and grant-funded, so there is no charge for calling the consultation line. Providers may call about any pediatric patient (ages 0-19), regardless of the patient's insurance type.

Consultations can be patient-specific or can be general questions related to child psychiatry. The phone consultation is covered by HIPAA, section 45 CFR 164.506; no additional release of patient information is required to consult by phone. Call 855-599-7257 (toll-free), Monday through Friday, 7 a.m. to 4 p.m. Alaska time, to be directly connected to a child and adolescent psychiatrist.

To find youth outpatient SUD/mental health treatment providers go to FindTreatment.gov.

[355] Help Me Grow Alaska, *About Help Me Grow Alaska*, accessed [December 18, 2024], https://a2p2.org/help-me-grow-alaska/about/.

Chapter 27: Elderly

While illicit drug use typically declines after young adulthood, nearly 1 million adults aged 65 and older live with a substance use disorder (SUD). Admissions to substance use treatment facilities between 2008-2018 increased 190%.[356] Aging could possibly lead to social and physical changes that may increase vulnerability to substance misuse.[357] Older adults typically metabolize substances more slowly, and their brains can be more sensitive to drugs. Older adults may be more likely to experience mood disorders, lung and heart problems, or memory issues; all of which can be worsened by substance use. Additionally, the effects of some drugs—like impaired judgment, coordination, or reaction time—can result in falls and other accidents. Many elderly experience polypharmacy, increasing the risk of drug-drug interactions. Elderly patients who misuse substances can be at elevated risk of suicidal ideation. Risk factors for substance use disorders in older adults can include: chronic pain, physical disabilities or reduced mobility, transitions in living or care situations, loss of loved ones, forced retirement or change in income, poor health status, chronic illness, and polypharmacy. Little is known about the best models of care for treating SUD in the elderly, but research shows that older patients have better results with longer durations of care. See Substance Abuse and Mental Health Services Administration (SAMHSA) Resources for Treating Older adults for more information.

[356] Lin, Jen-Yuan, Miriam Arnovitz, Nabil Kotbi, and others. "*Substance Use Disorders in the Geriatric Population: A Review and Synthesis of the Literature of a Growing Problem in a Growing Population*." Current Treatment Options in Psychiatry 10 (2023): 313–332. https://doi.org/10.1007/s40501-023-00291-9.

[357] National Institute on Drug Abuse (NIDA). "*Substance Use in Older Adults DrugFacts*." Last modified July 9, 2020. Accessed October 20, 2024. https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts.

Chapter 28: Veteran Services

Substance use disorders (SUDs) are a significant problem among military veterans. One study of military personnel found that about 30% of completed suicides were preceded by alcohol or drug use, and an estimated 20% of high-risk behavior deaths were attributed to alcohol or drug overdose.[358] A number of environmental stressors specific to military personnel have been linked to increased risk of the development of SUDs among military personnel and veterans, including deployment, combat exposure, and post-deployment civilian/reintegration challenges.[359] Access to care, particularly mental health services, is problematic for veterans residing in rural areas. Another challenge to treatment that is sometimes encountered by veterans is the stigma associated with seeking SUD treatment. Veterans with SUDs commonly meet criteria for co-occurring mental health disorders, such as PTSD, depression, anxiety, and adjustment disorder. Among Afghanistan and Iraq veterans, 63% diagnosed with an SUD also met criteria for PTSD.[360]

Alaska Veterans Affairs SUD treatment centers

- Chris Kyle Patriots Hospital, Anchorage, Inpatient withdrawal management and residential treatment for veterans
- Banyan Veterans Outpatient Addiction Treatment, Wasilla

Provider Resources

- VA/DoD Clinical Practice Guidelines for Management of Substance Use Disorder (SUD) (2021)
- Identifying and Managing Opioid Use Disorder (OUD): A VA Clinician's Guide
- Overdose Education for Veterans: Learning to Use Naloxone
- OUD Academic Detailing Services - Educational Materials

Veteran Resources

- Substance Use Treatment for Veterans Resource Page
- VA Mental Health Related Support Groups for Veterans 907-563-6966
- The Veterans Crisis Line 1-800-273-8255 and press 1, or text 838255
- Alaska's Healing Hearts is a national organization offering year-round outdoor recreational opportunities for America's brave wounded warriors and their families.
- Wounded Warrier Project Peer Support Groups that connect veterans with each other in their communities
- Alaska Women Veteran Resources
- 907 Vets Inc.'s goal is to combat suicide, depression, and loneliness by building camaraderie through drug and alcohol-free activities 907-756-8387

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[358] Larson, Mary Jo, Nicole R. Wooten, Rebecca S. Adams, and Elizabeth L. Merrick. "*Military Combat Deployments and Substance Use: Review and Future Directions*." Journal of Social Work Practice in the Addictions 12, no. 1 (2012): 6–27. https://doi.org/10.1080/1533256X.2012.647586.

[359] Seal, Karen H., Genna Cohen, Alexandra Waldrop, Beth E. Cohen, Shira Maguen, and Lillian Ren. "*Substance Use Disorders in Iraq and Afghanistan Veterans in VA Healthcare, 2001–2010: Implications for Screening, Diagnosis, and Treatment*." Drug and Alcohol Dependence 116, no. 1-3 (2011): 93–101. https://doi.org/10.1016/j.drugalcdep.2010.11.027.

[360] Teeters, Jennifer B., Cynthia L. Lancaster, Denise G. Brown, and Sudie E. Back. "*Substance Use Disorders in Military Veterans: Prevalence and Treatment Challenges*." Substance Abuse and Rehabilitation 8 (2017): 69–77. https://doi.org/10.2147/SAR.S116720.

Chapter 29: Unhoused Individuals

Homelessness and opioid use disorder (OUD) are distinct, although often interrelated, public health crises in the United States. These crises have been worsened by the effects of the COVID-19 pandemic, which has had a negative impact on mental health, substance use, housing stability, and economic stability for many.

"Homelessness is a key driver of poor health, but homelessness itself results from accumulated adverse social and economic conditions…The social determinants of homelessness and health inequities are often intertwined, and long-term homelessness further exacerbates poor health." Stafford & Wood, 2017[361]

A recent study looking at data between 2004 and 2018 revealed that opioid overdose is the leading cause of death among individuals experiencing homelessness in Boston, Massachusetts. Alarmingly, one in four adults over the age of eighteen in this demographic has died from an overdose.[362] Access to medications; however, varies by community in systemically marginalized populations—such as people without homes. Among people experiencing homelessness, additional barriers include a lack of insurance, income, and transportation; rigid program and scheduling requirements; lack of childcare and family-centered care options; isolation and disconnection; and the need to navigate multiple systems. Often people with OUD as well as those experiencing homelessness face additional co-occurring physical and mental health conditions, which complicate treatment and recovery.

The United States Interagency Council on Homelessness created a resource that defines and describes four core areas of best practices for effective street outreach:

Street outreach efforts are systematic, coordinated, and comprehensive.

Street outreach efforts are housing focused.

Street outreach efforts are person-centered, trauma-informed, and culturally responsive.

Street efforts emphasize safety and reduce harm.

Key highlights from Opioid-use disorder treatment for people experiencing homelessness: A scoping review

- People experiencing homelessness (PEH) sub optimally engage with treatment for OUD.
- Pharmacotherapy outcomes do not substantially differ between PEH and non-PEH.
- Programs should encourage pharmacotherapy for PEH rather than detoxification alone.
- Medications for opioid use disorder (MOUD) clinics should adopt flexible policies to improve engagement among PEH.
- Housing may improve OUD treatment outcomes for PEH but more research is needed.

Resources for caring for patients experiencing homelessness

- Alaska DBH Homelessness and Health
- SAMHSA Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder: A Toolkit Part 1
- SAMHSA Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder: Toolkit Part 2
- National Health Care for the Homeless Council SUD Resource Page
- VA HUD Resource Guide for Permanent Housing and Clinical Care

[361] Stafford, Amanda, and Lisa Wood. 2017. "*Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants*" International Journal of Environmental Research and Public Health 14, no. 12: 1535. https://doi.org/10.3390/ijerph14121535

[362] Fine, Daniel R., Kelsey A. Dickins, L. Darin Adams, and others. "*Drug Overdose Mortality Among People Experiencing Homelessness, 2003 to 2018.*" JAMA Network Open 5, no. 1 (2022): e2142676. https://doi.org/10.1001/jamanetworkopen.2021.42676.

APPENDICES

Appendix One: Abbreviations

ANTHC	Alaska Native Tribal Health Consortium
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
BHA	Behavioral Health Aide
BUP-XR/LIAB	Extended-release/ long-acting injectable buprenorphine
CFR	Code of Federal Regulations
CHAP	Community Health Aide Practitioner
CLIA	Clinical Laboratory Improvement Amendments
COD	Co-Occurring Disorder
COWS	Clinical Opiate Withdrawal Scale
CM	Contingency management
CPT	Current Procedural Terminology
DEA	Drug Enforcement Administration
DBZ	Designer Benzodiazepines
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DTx	Digital Therapeutics
EC	Electronic Cigarettes
FDA	Food & Drug Administration
HIPAA	Health Insurance Portability and Accountability Act of 1996
IMF	Illegally Manufactured Fentanyl
LAIB	Long-acting Injectable Buprenorphine
LOC	Level of Care
MOUD	Medications for Opioid Use Disorder
MRO	Medical Review Officer
OBOT	Office-Based Opioid Treatment
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
QAP	Qualified Addiction Professional
QHP	Qualified Health Plans
PA	Prior Authorization or Physician Assistant
PCSS	Provider Clinical Support System
PDMP	Prescription Drug Monitoring Program
PrEP	Pre-exposure prophylaxis (HIV)
PW	Precipitated Withdrawal
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SLBUP	Sublingual Buprenorphine
SOTA	State Opioid Treatment Authority
SUD	Substance Use Disorder
StUD	Stimulant Use Disorder

Appendix Two: Finding Substance Use Disorder Treatment in Alaska

Below are some links for SUD treatment in Alaska. These links are for approved Alaska Department of Health, Division of Behavioral Health programs. Many other programs exist in the state, but they do not fall under the state's purview since they are not state funded and/or are not billing Medicaid through the state.

Outpatient & Residential SUD Providers in Alaska

- ASAM Alaska Provider Locator
- FindTreatment.gov
- Residential Substance Use Disorder Treatment Bed
- Opioid Treatment Programs in Alaska
- SAMHSA's Buprenorphine Practitioner Locator for Alaska
- DOH Directory of Private Substance Abuse Treatment Agencies Approved by DBH to Receive ASAP and other Criminal Justice Referrals

Appendix Three: MAT Resources

Alcohol

- Medications for the Treatment of Alcohol Use Disorder: A Brief Guide
- SAMHSA Medication Assisted Treatment of Alcohol Use Disorder: Pocket Guide
- ASAM Clinical Guideline on Alcohol Withdrawal Management
- The American Psychiatric Association Practice Guideline for The Pharmacological Treatment of Patients With Alcohol Use Disorder

MOUD Provider Trainings

- Bridge to Treatment- Resources
- SAMHSA Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings
- Providers Clinical Support System (PCSS) Medication for Opioid Used Disorder Training
- Providers Clinical Support System (PCSS) SUD 101 Core Curriculum (2023)
- Buprenorphine Quick Start Pocket Guide
- ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using Fentanyl

Drug Testing

- Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document, Pocket Guide and App

For Patients, Family, and Friends

- SAMHSA Decisions in Recovery: Treatment for Opioid Use Disorder
- ASAM Opioid Addiction Treatment: A Guide for Patients, Families and Friends
- Recovery Research Institution Guide for Family Members
- MAT Handouts for Patients and Family Members

General Resources

- ASAM National Practice Guidelines for the Treatment of Opioid Use DIsoder-2020 Focused Update full guideline, pocket guise and patient guide
- SAMHSA TIP 63: Medications for Opioid Use Disorders
- Providers' Clinical Support System (PCCS)
- BRIDGE to Treatment
- National Harm Reduction Coalition
- Center for Care Innovations
- Opioid Response Network
- Continuing Education Options on Opioids, Pain Management and Addiction for Alaska
- Drugs of Abuse: 2024 Edition of Drugs of Abuse Resource Guide
- Addictionary

Buprenorphine

- Buprenorphine Initiation A Patient's Guide to Starting Buprenorphine at Home
- ED BRIDGE Buprenorphine Self-Start Guide
- ED BRIDGE to treatment Blueprint for Hospital Opioid Use Disorder Treatment
- ED BRIDGE to treatment Starting Buprenorphine with Microdosing and Cross Tapering

Naltrexone

- Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide
- XR-Naltrexone: A Step-by-Step Guide

Methadone

- 7 AAC 70.125 Additional requirements for providing opioid use disorder treatment services
- Federal Guidelines for Opioid Treatment Programs
- ED BRIDGE to Treatment Methadone Hospital Quick Start Guide

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