Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
INTERPRETIVE STATEMENT

Discouraging Medication for Opioid Use Disorder Treatment Termination Due to Return to Use

July 31, 2024

Summary

In June 2023, revised Substance Use Disorders (SUD) Service Program Administrative Rules from the Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Community and Health Systems went, into effect.

The revised rules require licensed programs to have policies and procedures in place that govern "discharge, including aftercare." Specifically, the policy and procedures "may not allow discharge of a recipient due to a return to [substance] use as long as the recipient reengages in treatment and complies with program policies and treatment protocol prospectively" [R 325.1331(1)(e)]. This interpretive statement will assist licensed programs with the development of clinical protocol that complies with this requirement.

General Principles to Guide Clinical Protocol Development

1. Treatment may not be involuntarily discontinued because of a patient's continuing substance use and/or return to substance use (i.e., "relapse").

2. Purpose and expectations regarding drug testing should be communicated with the patient.

3. Drug testing practices should focus on supporting patient wellness and recovery. Drug screening results should never be the sole basis for a treatment decision.[1]

4. Patient (re)engagement in treatment should be defined expansively and flexibly to adapt to the patient's needs.

Background

A substance use disorder is a chronic illness and returning to substance use (i.e., "relapse") is a normal and expected part of the treatment process. Even so, some programs nationally maintain zero tolerance policies that result in involuntary dismissal from treatment when a patient returns to use. This approach is inconsistent with evidence-based practice and federal recommendations such as the recent *Advisory on Low Barrier Models of Care* created by the Substance Abuse and Mental Health Services Administration (SAMHSA).[2]

While there are risks to the continuation or resumption of active disordered use of substances, there are also serious risks associated with stopping patient access to lifesaving treatment. When a patient's treatment with buprenorphine is terminated – especially early in treatment – they experience a high risk of return to use.[3] In a large, randomized, multi-site study, when patients receiving buprenorphine treatment were tapered off the medication after 12 weeks, there was a 90% rate of unsuccessful outcomes. On the other hand, when patients receiving buprenorphine were stabilized on buprenorphine treatment over a longer period, they had much better opioid use-related outcomes.

The clinical response to a patient's ongoing use or return to use must be stigma-free and patient centered. Where a treatment plan requires adjustment, this should be done in active collaboration with patients. Finally, practitioners should understand that "reducing substance use and harm mitigation are acceptable goals" for treatment relative to total abstinence.[2]

How Practitioners Observe Continued Substance Use or Return to Use

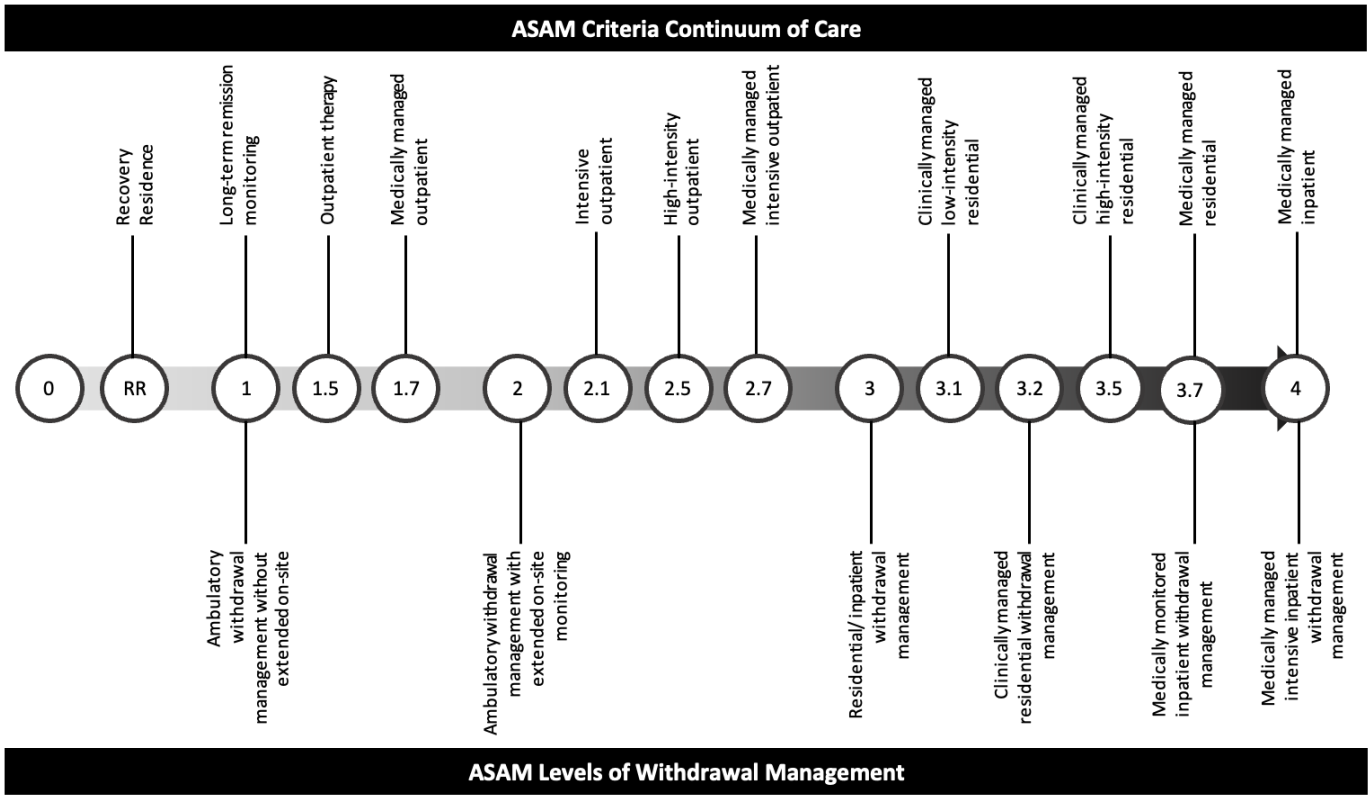
Assessing a patient's current substance use and adherence to medication for opioid use disorder treatment regimen can be important for monitoring and adjusting patient treatment plans to reduce the risk of overdose and other adverse events. For example, a patient that takes benzodiazepines while in treatment for opioid use disorder should be counseled on the risk of central nervous system depression when multiple substances are used simultaneously.[1] When the purpose and expectations of treatment participation are clear, patients should understand that assessment of current substance use is not a surveillance mechanism.

Urine drug testing is often used to detect a patient's continued substance use and utilization of prescribed medications for opioid use disorder; however, drug testing is only one piece of information in a broader and more complex picture of a patient's health. Practitioners should consider other factors, including the patient's own self-report, as well as other indicators of stability and wellness. If a patient declines drug testing, the practitioner should review the purpose and expectations around drug testing and its importance to developing the optimal treatment plan. Whatever the circumstances, toxicology testing should be used to "prioritize patient safety rather than punishment."[2]

Recommendations

<u>How to Respond to Evidence of Resumption of Substance Use</u>

- Investigate the patient's goals for treatment and their self-reported needs to meet those goals.
- Provide risk-reduction information and counseling where appropriate.
- Refine the treatment plan with the following questions in mind:
    - Does the patient need a higher dosage of medication or a different formulation?
    - Is the patient interested in increasing the frequency of their visits or receiving other kinds of outreach or check-ins between appointments?
    - Does the patient require supports, e.g., housing or treatment for other medical needs?
    - Consider whether a higher level of care may be appropriate and explore options with the patient. The ASAM Continuum of Care and Levels of Withdrawal Management is included below for reference.



How to Assess Reengagement in Treatment and/or Program Compliance

- Patient expresses interest in reengagement in treatment.
- Patient reviews and contributes to developing a new treatment plan.
- Clinical judgment indicates that the benefits of continuing treatment outweigh the significant risks of discontinuing treatment, which includes an increased risk of overdose.

How to Reengage Patients in Treatment

- Integrate the Principles of Low Barrier Care into the patient's treatment planning. The principles include the following:
    - Person-centered care,
    - Harm reduction and meeting the person where they are,
    - Flexibility in service provision,
    - Provision of comprehensive services,
    - Culturally responsive and inclusive care, and
    - Recognize the impact of trauma.
- Rapidly re-initiate care if there is a disruption.

*Please note that this resource contains recommended considerations for the development of policies and procedures for facilities providing medications for opioid use disorder. This document is not intended to be an official guideline for clinical protocol development. It is recommended that qualified practitioners work collaboratively to develop clinical protocols that promote high quality patient care, suits their practice needs, and conforms with generally accepted standards of medical practice. The information included above is intended for informational purposes only and does not constitute legal advice or state regulatory guidance.

Citations

1. *A patient-centered, rapid access approach to substance use disorder*. Bridge to Treatment. (2023, April 17). https://bridgetotreatment.org/resource/a-patient-centered-rapid-access-approach-to-substance-use-disorder/.
2. Low barrier models of care for substance use disorders. (n.d.). https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-for-substance-use-disorders-pep23-02-00-005.pdf.
3. Weiss RD, Potter JS, Fiellin DA, Byrne M, Connery HS, Dickinson W, Gardin J, Griffin ML, Gourevitch MN, Haller DL, Hasson AL, Huang Z, Jacobs P, Kosinski AS, Lindblad R, McCance-Katz EF, Provost SE, Selzer J, Somoza EC, Sonne SC, Ling W. Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: a 2-phase randomized controlled trial. Archives of general psychiatry. 2011. 68(12):1238–1246.