The greatest risk of overdose for opioid dependent clients is during admission to residential treatment and at discharge from residential treatment or jail.

Numerous studies have demonstrated that opioid users have the highest drop-out rates of all clients in abstinence-based treatment, and the highest relapse rates of all clients. Moreover, it is well documented that clients leaving jails and residential treatment, that relapse on opioids are at serious risk of overdose due to a decline in drug tolerance that occurs while in jail or residential treatment.

In a 2017 meta-analysis examining 122,885 clients treated with methadone and 15,831 clients treated with buprenorphine, researchers concluded, retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk mortality. Moreover, they found the greatest points of mortality risk were at time of admission (when clients often drop-out and return to opioid use), and when clients leave treatment and then return to opioid use (when their drug tolerance is low).1

Points of High Risk Fatality

- Residential Treatment Admission, where clients often drop-out and return to use
- Discharge from Residential Treatment or Jail, where clients have low tolerance and return to use

The Centers for Disease Control reports there were 70,237 drug overdose deaths in 2017.2 Many of these individuals had prior experiences with addiction treatment services and incarceration. In 2017, Oregon had 416 accidental drug overdose deaths. In Oregon, that’s one overdose death every 21 hours for the entire year. In 2018, Oregon EMS first responders administered naloxone to 2,808 individuals who presented with symptoms of opioid overdose. This number does not include naloxone administered by other first responders, or other individuals (family, friends, behavioral health workers, etc.).3

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Many traditionally abstinence-based residential programs have now adopted Medication Assisted Treatment (MAT), including programs like Hazelden Betty Ford. In 2012, the Hazelden Betty Ford Residential Treatment incorporated buprenorphine into their program. Marvin Seppala, M.D., Chief Medical Officer at Hazelden Betty Ford states, “We started seeing problems in our programs, especially residential treatment programs. Our opioid admissions increased dramatically. People were bringing drugs into the treatment unit, and we were starting to see deaths early after discharge. There was an ethical imperative.” Hazelden Betty Ford launched buprenorphine treatment into America’s oldest 12-step residential treatment program. Within two years, Hazelden found that the percentage of opioid clients who drop out of their 12-step program and relapse fell from 25% to just 5%. Recently Hazelden Betty Ford completed a study, that reveals the efficacy of use of these medications in a 12 Step, abstinence based treatment system with highly favorable outcomes.4

Despite evidence that MAT (medication assisted treatment) works, many behavioral health workers are opposed to the use of medications in addiction treatment. They often object to long-term use of MAT, despite clear research that longer term use is more effective. Even individuals in recovery have unfavorable views toward MAT. The 2018 MHACBO Behavioral Health Workforce Survey (n=1,302) revealed that individuals in recovery from addiction have misunderstandings regarding best practices with MAT. One such mistaken belief involves the “short-term use” of MAT for withdrawal management (tapering). Research is clear that short-term use of MAT is ineffective.

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Staff Resistance & Mistaken Beliefs

1. Mistaken belief: “MAT should only be used for withdrawal management”
Numerous studies have demonstrated that short-term use of MAT (90 days or less) has poor outcomes compared to longer treatment episodes.

- Both SAMHSA and ASAM caution that relapse rates are high among those who drop-out or use MAT short-term, stating, “long-term treatment is often needed.” Moreover, NIDA has recommended that MAT should be used for at least one year.5
- Using MAT only for withdrawal management produces high relapse rates. A 2014 study where clients were given Suboxone (buprenorphine) for 90 days, including stabilization and tapering, showed that over 90% relapsed after tapering.6
- A long-term study of MAT participants showed that among those who used MAT for only 30 days, only 6.6% were abstinent at follow-up, compared to those who used MAT for 3.5 years, where 79.6% were abstinent.7

2. Mistaken belief: “Clients on MAT are using alcohol & other drugs all the time”
Similar to clients in abstinence-based treatment, numerous studies have shown that many clients participating in MAT use other substances. While studies reveal that relapse rates in abstinence-based treatment are slightly lower than methadone maintenance (MMT), there are also studies showing that relapse rates on alcohol are actually higher in abstinence-based treatment.

- A 2002 study of opioid dependent clients, comparing those who participated in abstinence-based treatment compared to methadone maintenance (MMT) showed that those participating in MMT experienced fewer relapses on alcohol compared to the abstinence-based treatment group.8

3. Mistaken belief: “MAT is just substituting one opiate for another”
Substitution is actually the goal! Numerous studies show that MAT medications work differently in the brain than illicit opiates such as heroin. This is especially true of buprenorphine and Vivitrol.

- Methadone is an opioid agonist, which means it activates the opiate receptors in the brain much like prescription opioids and heroin. However, methadone’s long acting properties reduce cravings and ease withdrawal symptoms without producing much euphoria.9
- Buprenorphine is an opioid partial agonist that both activates the opioid receptors and at the same time blocks other opioids from attaching to the receptors thus limiting their euphoria producing abilities. Additionally, buprenorphine has a ceiling effect which makes respiratory depression unlikely.9
- Methadone and Buprenorphine create dependence vs. addiction. Highly abusable opiates/opioids like heroin and fentanyl produce euphoria, tolerance and significant life impairment. When individuals stabilize on methadone or suboxone, they no longer experience ever increasing tolerance. Rather, they may be on the same dose for several years. Moreover, many of their impairments go into remission and clients become more functional, evidenced by increasing employment, housing, self-care and reducing new arrests and recidivism.

4. Mistaken belief: “Clients in MAT will be on maintenance medications forever”
Methadone and Buprenorphine are safe for long-term use or the dose can be gradually tapered in preparation for abstinence. The U.S. average length of stay for MAT is about two years (TEDS).

According to a 2019 Harvard study, 25% of patients will obtain complete abstinence from MAT medications, and 50% will become abstinent but may return to MAT if there is a relapse. These recovery rates are comparable to long-term total abstinence rates in abstinence-based treatment.

5. Mistaken belief: “People on MAT are nodding off all the time”
Sometimes individuals taking methadone will experience drowsiness approximately 3 hours after taking their dose. This drowsy period can last 30-90 minutes. Programs should monitor this drowsy period and time dispensing of medication to optimally accommodate the client’s participation in services. Clients are not, “nodding off - all the time”. While some clients, (not most) will have a drowsy period of about one hour per day, staff should avoid exaggerating these symptoms in client records.

11. DATOS.org

Best & Promising Practice Checklist!

- Preparation
  Find a prescriber and train residential staff on MAT effectiveness, best & promising practices.

- Admission
  Residential clients should be screened for Opioid Use Disorders (OUD’s) at admission. Screening should include assessment of withdrawal with a screening tool such as the COWS (Clinical Opiate Withdrawal Scale). Clients should receive legitimate, informed consent and choice, educating them about the risk, efficacy and benefits of MAT options [methadone, burprenorphine (Sublocade, Probuphine, Suboxone, Subutex), naloxone, naltrexone, and naltrexone injectable (Vivitrol)].

- Security
  MAT medication must be stored in locked cabinets. Residential programs should develop policies and practices to prevent diversion of any prescribed medications, including MAT. Programs should implement procedures for over-seeing self-administration of MAT medications.

- Maintenance
  Medications should be taken daily, at the same time, as prescribed. Residential staff should monitor medication effects at peak (approx 3 hours after dosing). This is when clients may experience drowsiness. Staff should have up-to-date care coordination with the prescriber and be able to report clients’ responses to medication. Programs should implement routine testing to ensure receipt of the prescribed dosage of medication. This may include weekly/monthly UDS’s to check for medication levels.

- Education & Therapy
  Residential programs should develop educational curricula to educate all clients regarding myths and stigmatization regarding those who participate in MAT. Programs should be vigilant to protect the rights of those participating in MAT and should intervene on stigmatizing abuse of clients by other residents and view such incidences as educational opportunities for the milieu. Effective residential and jail-based MAT programs often offer adjunctive groups to clients participating in MAT. These groups are typically offered 1-2 times weekly within the residential milieu for MAT clients to receive advanced education regarding MAT and to share their experiences and offer support to each other.

- Discharge
  Residential programs should implement transitional planning to facilitate moving the client to outpatient services and potentially another prescriber. Part of this transitional planning should include engagement of the client’s family and support system in both MAT education and their role of support in discharge planning.

12. Jail-based Medication Assisted Treatment, Promising Practices, Guidelines and Resources for the field, October 2018