Medication First Model

for the treatment of Opioid Use Disorder

Introduction

The Medication First (or low-barrier maintenance pharmacotherapy) approach to the treatment of Opioid Use Disorders (OUD) is based on a broad scientific consensus that the epidemic of fatal accidental poisoning (overdose) is one of the most urgent public health crises in our lifetimes. Increasing access to buprenorphine and methadone maintenance is the most effective way to reverse the overdose death rate. Increased treatment access will best be achieved by integrating buprenorphine induction, stabilization, maintenance, and referral throughout specialty addiction programs as well as primary care clinics and other medical settings throughout the mainstream healthcare system[1].

Parallels to Housing First

The name and principles of "Medication First" are borrowed from the Housing First approach to homelessness. The National Alliance to End Homelessness explains: *Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed. This approach prioritizes client choice in both housing selection and in service participation[2].*

Not Treatment as Usual

Maintenance pharmacotherapy with buprenorphine and methadone can reduce fatal opioid overdose rates by 50-70%, reduce illicit drug use, and increase treatment retention [3-4]. However, in traditional treatment programs for addiction, the vast majority of patients are offered no ongoing medical treatment. Those who do receive medical care often face intensive psychosocial service requirements that make treatment both burdensome and costly.

4 Principles of the Medication First Model:

1. People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
2. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
3. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
4. Pharmacotherapy is discontinued only if it is worsening the person's condition.

Medication *first* ***does not mean*** Medication *only*

Like the Housing First approach, the Medication First model provides a crucial, stabilizing resource—OUD pharmacotherapy—without conditioning the receipt of medical treatment on other service requirements. However, all participants should be **offered** a full menu of psychosocial services be engaged in an individualized manner. In this way, "meeting people where they are" is a mantra of both Motivational Interviewing and Medication First. Once stable on anti-craving medication, people may choose to re-engage in normal life activities rather than invest many hours per day or week in group therapy and education. Medication First is consistent with the Substance Abuse and Mental Health Services Administration's working definition of recovery which prioritizes this form of self-determination: *Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential[5].*

"10 Do's and Don'ts of Medical Treatment for OUD"

1. Do not initiate a taper or discontinuation of buprenorphine or methadone in response to any client infraction (e.g., missing therapy sessions).
2. (Other side of #1) Do not mandate participation in individual or group counseling as a requirement for continued medical treatment. See #10.
3. Do not set a time limit for maintenance medical treatment.
4. Do not encourage rapid buprenorphine taper protocols with the goal of transitioning to antagonist medications or no medications at all.
5. Do not discharge a client based on positive drug test results for illicit substances.
6. Do not discharge a client from a residential setting without enough medication to supply them to their first outpatient physician visit.
7. Do not withhold medical treatment if the treatment provider does not have staffing capacity to provide psychosocial services at the time the client presents.
8. Do not switch a client from injectable to oral naltrexone solely for cost saving purposes.
9. **Do individualize dose decisions based on individual client factors, particularly craving intensity and environmental support** (i.e., be wary of underdosing – most clients do best when stabilized between 16mg-24mg of buprenorphine per day).
10. If and when adherence to treatment protocols becomes disrupted by client behaviors described above, **do increase client accountability measures** (e.g., drug testing, frequency of medication/dosing visits) **without discontinuing the needed medications**. Use motivational interviewing and make clear the rationale for the recommendation of individualized psychosocial supports. Peer support services can also be effective in helping people engage in needed services.

References:

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For more resources about the medical treatment of OUD, please visit: MissouriOpioidSTR.org/treatment