NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

Standards for Person-centered Medication Treatment at OASAS Certified Programs

The purpose of this document is to provide guidance to medical directors and medical providers at programs implementing updated OASAS regulations, and should be used collaboratively with other OASAS guidance provided on the website. This memorandum highlights topics related to medication treatment within the guidance document, "Standards for OASAS Certified Programs," released on July 9, 2019, and thereby sets standards of care for medication treatment per recently revised OASAS programmatic regulations. Questions should be directed to addictionmedicine@oasas.ny.gov.

To provide medication treatment for addiction in a person-centered manner, medical directors at OASAS certified programs should update medical policies and protocols in accordance with the following principles, and medical providers working in programs should provide care in alignment with the guidance for each principle:

Access to medication-assisted treatment: Medication-assisted treatment (MAT) for opioid use disorder and other substance use disorders is evidence-based and life-saving.[1] Therefore, any individual who chooses to engage in MAT should be offered this service. *Programs must accept clients on all forms of MAT, and admission should happen on the same day that a client presents requesting MAT services.* This includes people seeking treatment with poly-substance use (e.g., benzodiazepines, fentanyl, cannabis, etc.). For clients not on MAT but for whom it would be helpful and appropriate, providers should educate them on all appropriate MAT options as well as the risks of not choosing MAT, and ensure that they can access the form they choose, either directly from the treatment program or via a linkage agreement with another treatment program (e.g., access to methadone from a partnering Opioid Treatment Program (OTP)).

Psychosocial treatment and counseling: Psychosocial interventions, supports, and counseling are extremely helpful for many people working towards recovery from addiction. However, MAT is effective and life-saving even for individuals who are unwilling and/or unable to engage in psychosocial services.[1,2,3] Furthermore, many individuals who are initially unwilling to engage in counseling may be easier to engage in such services after a period of stabilization on MAT. *Therefore, MAT services must be offered to clients regardless of their ability or willingness to engage in psychosocial treatment.* This means that admission cannot be denied and clients cannot be discharged solely on the basis of refusal or inability to engage in psychosocial treatment and counseling. The onus is then on programs to engage clients in any services deemed necessary, including by using peer services, rather than programs making MAT services contingent upon patient engagement in psychosocial services.

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[1] Martin SA, Chiodo LM, Bosse JD, Wilson A. The Next Stage of Buprenorphine Care for Opioid Use Disorder. Ann Intern Med.2018; 169:628–635. doi: 10.7326/M18-1652

[2] Substance Abuse and Mental Health Services Administration. Medications to Treat Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63. https://store.samhsa.gov/system/files/sma18-5063fulldoc_0.pdf

[3] Implementing Transmucosal Buprenorphine for Treatment of Opioid Use Disorder: https://www.oasas.ny.gov/legal/documents/BestPractices.pdf

Continued substance use and poly-drug use: Even in the context of continued substance use and/or poly-drug use (including non-prescribed benzodiazepines), evidence shows that it is safer and leads to better outcomes long-term, including decreased mortality, if clients remain on MAT.[4] *Therefore, MAT should not be discontinued and clients should not be administratively discharged solely on the basis of continued substance use and/or poly-drug use. Also, policies that summarily exclude individuals from being admitted because of poly-substance use are not permitted.* Rather, providers should work with clients over time to engage them in addressing their on-going substance use, using harm reduction principles and motivational interventions. Providers should continue using clinical judgment to withhold individual doses of full opioid agonist medications for intoxication and/or sedation.

Prescribed medications: Clients are often prescribed medications that have the potential to interact with continued drug use and/or MAT in an unsafe manner (e.g., opioid pain medications, benzodiazepines). However, the Food and Drug Administration recently clarified that it is better practice and safer for clients to start and/or continue MAT in this context rather than leave the substance use disorder untreated, because "the harm caused by untreated opioid addiction can outweigh these risks."[5] *Therefore, programs cannot refuse to admit clients or discharge clients solely because they are on another medication that confers increased risk of overdose or other adverse outcomes.* Rather, providers should work with clients and coordinate care with their outside prescribers over time to move towards safer medication regimens.

Toxicology screening/testing: *Toxicology screens should be used as a clinical tool rather than a surveillance mechanism.*[4] The results should be used to inform the treatment plan. Results should be discussed with the patient from a supportive, clinical perspective, as opposed to a punitive one.

Transition planning/post-treatment planning (formerly discharge planning): There are times when providers will determine that a client needs a different level/type of care to have the best chances of success in their recovery. Examples include but are not limited to: a client who would benefit from an intensive outpatient program, a person with significant psychiatric symptoms who would benefit from an integrated treatment program, an individual who is on buprenorphine or long-acting injectable naltrexone but would benefit from a methadone trial, or a client who has been found to be diverting buprenorphine and would therefore benefit from observed dosing in an OTP. *In all but the rare exceptions mostly involving serious staff/client safety concerns, programs should not administratively discharge clients or taper MAT, and should continue to treat clients (including with MAT) while they are being referred to a different setting/program and while making every effort to coordinate a warm handoff to the receiving treatment team.* Even when a person declines referral to a different treatment setting, programs should continue to provide treatment while attempting to engage the person in transitioning to the recommended level of care.

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[4] Martin SA, Chiodo LM, Bosse JD, Wilson A. The Next Stage of Buprenorphine Care for Opioid Use Disorder. Ann Intern Med.2018; 169:628–635. doi: 10.7326/M18-1652

[5] FDA https://www.fda.gov/Drugs/DrugSafety/ucm575307.htm