

CHAPTER 2: Treatment Components

Key Takeaway(s)

- Treatment settings or programs that offer the greatest number of evidence-based components (medications, behavioral therapies, and recovery support services) tend to have the greatest likelihood of facilitating recovery.
- Primary care plays a fundamental role in treating opioid use disorders because it can be more convenient than visiting a specialty provider for patients; carries less stigma; and has the unique ability to concurrently address other comorbid medical issues. Yet, few primary care practitioners have been trained or adequately incentivized to provide addiction care. Primary care-centered interventions that have strong research evidence demonstrating their effectiveness in treating alcohol and opioid use disorders include: team-based modules; hospital-to-primary-care linkages; expanding nurses' scope of practices and prescribing capacity; primary-to-specialty care linkages; and physician-to-physician support systems.
- There is very strong research support for the effectiveness of several FDA-approved medications, including methadone, buprenorphine, and extended-release naltrexone in the treatment of opioid use disorder (Wakeman et al., 2020). Despite this, fewer than half of facilities providing addiction treatment offered any medications for opioid use disorder in 2019, and only four percent offered all three FDA-approved medications (amfAR, 2019).
- There is strong research support for the effectiveness of several forms of behavioral therapy, such as Cognitive Behavioral Therapy and Marital and Couples Therapy, in helping individuals sustain recovery from a substance use disorder.
- There is strong research evidence for the effectiveness of addiction counseling provided in individual sessions; but only modest research evidence for the effectiveness of addiction counseling provided in group settings.
- There is well supported research evidence for the effectiveness of several recovery support services in the treatment of substance use disorders, including: drug-free housing; self-help/mutual support groups; childcare; and case management.

Recommendations

- There is no research evidence supporting time-limited treatment (e.g. 30 days, 24 visits, etc.) for substance use disorders. Further, there is very little research supporting programmatic care (i.e., where all patients in a program receive essentially the same schedule of services). Substance use disorders should be treated like other chronic medical disorders and tailored to the individual. Regardless of the setting, level, or approach to addiction care, all addiction treatment providers should offer a personalized set of evidence-based medications, behavioral therapies, and recovery support services with the goal of engaging patient participation, initiating clinically-managed recovery and supporting transition to self-managed recovery.
- Continuity of care across the various types of addiction treatment settings is essential to maintain patient motivation and participation toward the goal of self-managed recovery. Providers should be connected to a network of care that facilitates referrals and coordination.
- Both counseling and behavioral therapy should be made available in all addiction treatment settings that serve patients with opioid use disorder. However, patients' receipt of medications should not be contingent on participation in counseling or therapy.

Case studies/models/research findings

- A number of large systematic reviews, large population studies, and randomized controlled trials demonstrate that, when compared to those who receive no treatment, patients with opioid use disorder who receive medication experience:
 - Fewer overdoses (Degenhardt et al., 2011; Schwartz et al., 2013; Wakeman et al., 2020).
 - Less injection drug use (Dolan et al., 2003; Gowing et al., 2011; Woody et al., 2014).
 - Reduced risk for HIV/HCV transmission (Dolan et al., 2005; Marsch, 1998; Mattick et al., 2003; Sees et al., 2000; Woody et al., 2014).
 - Improved social functioning (Bart, 2012; Kakko et al., 2003; Mattick et al., 2003).
 - Decreased criminal activity (Marsch, 1998; Mattick et al., 2003; Schwartz, et al., 2009, 2011).
 - Lower rates of illicit opioid use (Mattick et al., 2009; Fudala et al., 2003; Johnson et al., 1995; Thomas et al., 2014).
 - Better treatment retention rates (Mattick et al., 2014).

Implementation considerations (policy, costs, scaling, etc.)

- Access to and quality of treatment for opioid use disorders are seriously restricted by an inadequate workforce. Few primary care physicians or nurse practitioners offer care for opioid use disorder due to inadequate education and training, as well as restrictive prescribing regulations and inadequate reimbursement rates. These significant barriers to care must be addressed in order to engage this professional workforce.
 - Providing adequate access to research-supported behavioral therapies for patients in treatment for substance use disorders is a sound investment but will require system-wide training of existing personnel, hiring additional qualified providers and offering adequate salaries. Nonetheless, the costs are justified by the outcomes and no greater than for comparable support services currently available to patients in treatment for all other chronic illnesses.
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