

Implementation of Integrated Medications for Addiction Treatment (MAT) for Opioid Use Disorder (OUD) in a Serious Mental Illness (SMI) Service Setting

INTRODUCTION

This implementation guide is designed to provide guidance to administrative, clinical and/or medical leaders of organizations and programs serving people with serious mental illness (SMI) on how to implement integrated medication for addiction treatment (MAT) services for current clients who have co-occurring opioid use disorder (OUD) and alcohol use disorder (AUD). Medication for AUD (naltrexone and acamprosate) will be discussed as a component of implementation of

medication (buprenorphine and naltrexone) for OUD.

Organizations serving people with SMI are variable in size and scope. This guide describes an implementation process for a “mid-sized” organization with several programs and sites and with a small cohort of prescribers (psychiatrists, advanced practice nurses) covering those sites. The content of the guide can be adapted for smaller and larger organizations.

STEP ONE: ARTICULATE THE RATIONALE

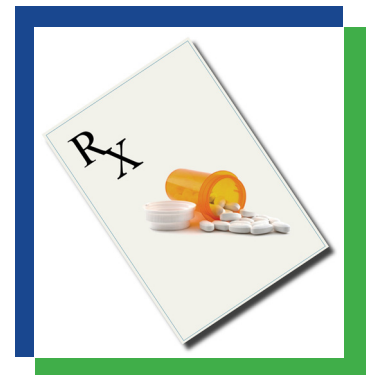
Rationale: MAT (along with other integrated SUD interventions) is an essential service for our SMI population

In any SMI population, co-occurring substance use disorder (SUD) is an expectation, not an exception. For that reason, it is important to provide integrated best practice interventions for co-occurring substance use challenges as a routine part of service provision in all SMI settings (see implementation guides 1-4). Further, in a diverse SMI population, OUD will be more prevalent than in either the general population, or in a population with mental illness other than SMI. Conversely, in an OUD population, SMI (27%) is more prevalent than the general population¹.

Therefore, integration of MAT into a mental health (MH) clinic is essential for the same reason as implementation of MAT in a primary care clinic: that is where the patients are. Individuals with OUD being served in a MH clinic should have access to a full range of medication and psychosocial services integrated into their existing services because, for the most part, they will not easily negotiate referral to another setting. Appropriate treatment, as for anyone with OUD, can make the difference between life and death.

Rationale: MAT is an evidence-based practice, not a “philosophy”

Even today, there will be people at all levels of the MH agency who regard medication for OUD (and even AUD) as a “treatment philosophy” (for example, “harm reduction vs. abstinence”) and may state that they are personally opposed. As a leader, it is important to articulate clearly that MAT is not only an evidence-based practice, it is a treatment of choice for many individuals that the agency serves and that this is not a philosophical debate. Just as for any evidence-based practice, the question for the agency is “how” we provide it, not whether we provide it.



STEP TWO: DEVELOP AN ORGANIZATIONAL APPROACH TO IMPLEMENTATION

Implementation of MAT should not be viewed as a “service off to the side” but instead as an organizational effort to better meet the needs of individuals with co-occurring SUD, including OUD. By the same token, MAT implementation is not the job of the “prescribers” or the “medication clinic” alone. Individuals may be referred internally for MAT interventions from various programs. Identification of the population, coordination of care, consistency of messaging and provision of needed psychosocial interventions are the responsibility of all team members.

- **Engage the agency leadership team.** There needs to be clear discussion of the rationale, and a commitment of all involved to support moving forward. There are multiple clinical, administrative and fiscal operational details that will have to be addressed, and a team effort is essential. Not everyone will be equally enthusiastic, but those who are not excited must agree to be helpful and not undermine the effort. If the medical director, for example, is not a champion, he or she must agree to designate a champion and help that person be successful.
- **Communicate the vision and direction through the agency.** Implementation of MAT is part of an organizational culture that welcomes individuals and families with co-occurring substance use and prioritizes the need to provide integrated interventions to those individuals. Systematically communicating that individuals with co-occurring substance use are welcomed for care, including those who are choosing to continue to use, is foundational. Within the organizational culture, provision of MAT is one of the essential best practice interventions that will be implemented step by step in the agency. Communication should occur routinely through leadership messaging, large staff meetings and, importantly, team meetings throughout the organization. Communicating the vision once is never enough.
- **Identify one or more change leaders.** Because many operational details need to be addressed, identifying a change leader (or small team of change leaders) with authority and investment will make the process much smoother. Designating one of the medical leaders as one of the change leaders is extremely helpful.
- **Provide training and orientation.** Introductory trainings to all staff, and specifically to prescribers, help explain the rationale for the whole approach, including for MAT. One goal of the introductory trainings is to identify individuals who may want to be formally identified as “champions.”
- **Identify a representative team of champions to start meeting regularly to begin the process.** In any organization, there are individuals who will be excited about implementing MAT, those who are neutral and those who are resistant. The best approach to change is to organize and empower the “front runners” to help bring along the “middle” and not to struggle with those who are most negative. The change leaders can identify a team of individuals who represent different segments of the agency to be on the “team of champions” for implementation of MAT. These should include at minimum:
 - o Prescriber (could be someone who already is waived to prescribe buprenorphine)
 - o Nurse
 - o Clinician and/or case manager who enjoys working with people with COD
 - o Person with lived experience of co-occurring disorders who supports MAT
 - o Representation of different sites or divisions within the agency
 - o Representative from administration or quality who can help with policies, data, EHR and billing



STEP THREE: PREPARE FOR INITIAL LAUNCH

Operational Motto: Big Vision – Small Steps

At this stage, the change leaders and the team of champions might articulate a “big vision.” For example:

All prescribers will be providing MAT, and all programs will have capacity to deliver the full array of integrated SUD treatment including MAT.

But it is necessary to proceed in small, achievable steps to make progress. Any step that proves to be too difficult or that engenders significant resistance should be avoided. Always find the easiest way to take the next step forward, without letting go of the “big vision.”

Here are examples of small steps:

- **Collect data to identify the scope of need:** The target of the MAT service is on INTERNAL referrals: “clients who are already there who need this service from us.” It is helpful to gather some type of baseline data to quantify the scope of the need. Ask each program to identify anyone they already know with definite or possible OUD, as well as anyone on prescribed opioids. Those on prescribed opioids can be given the Opioid Risk Tool (ORT) to gauge level of risk. Some agencies will pilot using an SUD screening tool (e.g., NIDA, modified ASSIST) on a sampling of new and/or existing clients to identify potential SUD, including OUD, and use this information to estimate and quantify need across the agency, and by site. Knowing where there is most obvious need can help to identify the best starting place focus for the service.
- **Review federal and state program and billing regulations.** State regulations for how to deliver and bill for MAT, as well as which medications can be paid for, are amazingly variable. Some states require prior authorization through MCOs, and others do not. Some states cover long acting naltrexone under Medicaid, others only pay for oral. Some states pay for a wide variety of buprenorphine preparations; other formularies are more limited. Carefully review all the details, as a team, ahead of time, to know how to set up a legitimate and functional service, and to generate realistic estimates of cost and revenue based on your existing payer mix. For assistance in your state, you can contact the *Opioid Response Network* by submitting a request at www.opioidresponsenetwork.org. The *Opioid Response Network* is a SAMHSA grant-funded initiative created to provide education and training at a local level to provide evidence-based practices in the prevention, treatment and recovery of opioid use disorders.
- **Identify the first “MAT team” and the easiest starting place to pilot implementation.** The first step is to set up an initial “MAT service” within the agency that may serve multiple clients from multiple programs, just as you might set up a “clozapine clinic.” It is helpful if there is a prescriber who is already waived in a location where there are already clients, space and helpful team members. That may not always be the case, but the goal is to make getting started easy, and to not have perfection be the enemy of progress. The team should consist of a prescriber, a nurse and a “coordinator” who can be a clinician, case manager or peer. A peer who is trained in Medication Assisted Recovery Support (MARS) can be a valuable asset.
- **Start small, with a continuous quality improvement framework.** It is helpful to start with a small cohort of clients who are not necessarily the most challenging individuals—maybe 5-10 clients. The goal is to work out the “kinks” in the operation before expansion.



- **Develop the first set of policies and procedures and then continually revise and update as needed. You do not have to reinvent the wheel.** Start with existing policies and protocols from another MAT provider in your area or another MH agency in your state. Here is a check list of items:
 - **Internal referral procedure:** Low threshold for identifying potential referrals.
 - **Screening and assessment:** Procedure for initial screening of referrals, and then scheduling an assessment. Telehealth assessments may be facilitative and scheduled when clients are attending existing services. Existing screening and assessment forms may have to be modified for MAT.
 - **Scheduling:** It is helpful at the beginning to set aside a block of time for the team to be together and to schedule the first cohort of clients.
 - **Electronic Health Record:** All aspects of the program need to be imported into the record, including clinical formats, program coding, regulatory requirements and billing. Again, find the easiest starting places.
 - **Client materials:** Welcome the client to the MAT service and describe the policies and procedures that are used to achieve a safe and successful outcome. Include a client agreement to participate. Do NOT write the client agreement in a punitive manner, as if every client were intending to misuse medication. DO write the agreements to communicate that the team and the client will be working as partners to find the best approach to help them.
 - **Program policies:** Induction procedures, indications for buprenorphine, naltrexone and long acting preparations of either, prescribing procedures, refill procedures, lost prescription guidelines, urine screening, access to care coordination, counseling and groups. These policies should promote engagement and continuity of care, rather than punishment and extrusion from treatment. This will be discussed further in the next section.
 - **Communication and releases of information:** This includes communication within the agency (no release required), and releases for communicating with any outside prescribers, particularly those who might be prescribing pain medication. Emphasize that it is the expectation that there will be regular communication with existing treaters within the agency, including current prescribers, and the expectation that ALL treaters are working toward assisting the client with OUD. Communication must be regular (weekly at first) and bilateral.
 - **Billing and documentation guidelines for staff.** This includes details like which billing codes to use, where to document in the record, when and how to obtain prior authorizations, etc.
 - **Urine Screening:** How is it done, when is it done, where is it done, how does it get to the laboratory, what happens to the results, when do we have confirmation testing. For more detailed information on various approaches to drug testing in MAT services, consult the Providers Clinical Support System's module on Lab Testing in Assessment of Substance Use Disorders. Visit <https://learning.pcssnow.org/p/LabTestinginSUD>.



- **Develop a functional clinical and operational team.** The success of the service at the beginning is built upon the successful functioning of the team. Ensure the following:
 - **Team huddles:** Investment in team time to discuss cases is important, even if they are not billable. The more that the team learns to function well together, and to communicate as a helpful team with the rest of the agency, the better the service will grow.
 - **Administrative and clinical support:** Clinical leadership of the agency (often the change leader) needs to be actively involved in the beginning making sure that the new service gets off the ground successfully. This means helping negotiate boundary issues between this service and other services that are referring or sharing clients. Emphasize that this is a step by step process, and there will be glitches that need to be worked out over time.
 - **Regular supervision, consultation, and case conferencing:** Providing clinical consultation on a proactive basis is highly recommended. This can be provided by someone outside the agency with expertise in MAT, provided that the consultant is also familiar with serving individuals with SMI. Alternatively, joint consultation by a MAT expert and an internal clinical leader can be helpful.
- **Identify and implement starting steps for the rest of the agency.** Although the MAT “service” is starting small, it is part of a larger vision. In addition, it is helpful for the service not to be isolated from the rest of the organization to encourage further development, learning and growth. Ideally, the same psychiatrist will manage the psychiatric meds for the SMI and MAT. If the clinic has a few psychiatrists who provide specialized MAT, they can provide that through internal referral while the client retains his or her relationship with their existing MH prescriber. The choice of totally transferring care can be considered on a case by case basis, according to which approach is best for the patient. The following suggestions may be helpful strategies:
 - **Engage ALL prescribers in making progress toward being waived:** Although the first services are delivered by change leaders, it is reasonable for all providers to be waived, even if they do not in the short run intend to provide MAT regularly. Also, all providers may need to be able to cover the service in the event of an emergency or absence. Develop a mentoring program for the newly waived so they can shadow a more experienced provider; take on some maintenance patients; work up to inductions, etc.
 - **All prescribers should be expected to provide medications for Alcohol Use Disorders to their SMI clients as a routine best practice.** Each prescriber might start with ONE client as an expectation, and then expand from there. This can be subject of routine peer review and quality improvement across the whole agency.
 - **Include case conferencing on MAT as part of agency wide case discussions and peer review.** Do not wait for something to go wrong. Use these discussions to illustrate successes for the purpose of expanding learning and engagement among staff.
 - **Continue expecting all programs and staff to slowly improve their ability to provide integrated interventions for all co-occurring SUD, including OUD.** Welcoming, screening, strength identification, stage-matching, and skill-building are good foundational interventions.
 - **Develop expertise (tools, groups) in helping people with SMI (and often longstanding trauma) to manage chronic pain without opioids or without medication misuse.** It is appropriate to refer patients for pain management consultations to specialists who appreciate working with the population, but the patient’s own care team should have access to tools to help as well. This type of resource is a helpful



complement to MAT and can/should be provided as a routine part of supporting health and wellness within recovery and rehabilitation services for SMI.

STEP FOUR: STEADILY IMPROVE AND EXPAND BY ADAPTING SERVICES TO THE POPULATION

All the policies and procedures must be continuously adapted and improved to meet the needs of the clients, the team, the agency and external regulators/funders. This is common to all types of new services. There are some common themes however that are worth noting for MAT services within SMI service settings.

- **Engagement is the biggest challenge.** More experienced providers of MAT recognize that the most important priority in terms of improving outcomes and reducing harm is to keep people engaged in treatment. As much as that is true for a non-SMI population, it is even more true for an SMI population, for which adherence to strict rules and requirements may be even more challenging. MAT services in SMI settings often begin by being relatively conservative in their expectations, but this is seen as a way of helping the staff get comfortable and get the team processes organized. Over time, the services must be “excessively low barrier,” and the goal is to keep people engaged even if they are continuing to use and not adhering to recommendations. **As a rule, if clients are having a hard time, monitor them more closely and provide more support, do not kick them out of care.**
- **Avoid absolute contraindications for entry.** For example, benzodiazepines are a contraindication to buprenorphine prescribing, but what many SMI providers have found is that people on well managed long standing benzodiazepine prescriptions who have OUD are better served with MAT than by being extruded from service, or by being forced to withdraw from the benzodiazepines in order to gain access. These types of decisions require case by case clinical flexibility and peer review but tend to provide better results in the end.
- **Diversion is usually less of a challenge than people think.** Although many programs and teams will develop policies that are focused on avoiding diversion, and diversion is indeed a concern, the experience of agencies serving SMI is that diversion is not as common as is feared, and the bigger concern is that excessive rigidity will drive away clients who need to remain engaged. It is important to be alert for diversion, but not to remain flexible at the same time.
- **Provide care coordination and flexible access to both individual and group counseling, but do NOT mandate groups as a condition to receive medication.** Individuals with SMI receiving MAT can certainly benefit from all types of counseling, but it should not be “required” as a condition of receiving MAT. Many individuals can receive integrated interventions in the context of their current SMI services. Further, attendance at the MAT “clinic” for prescribing should be organized as to incorporate routine access to care coordination, peer support and “drop-in” groups. Those who are struggling can be asked to engage in more individual and group services as part of receiving larger prescriptions. As the team gains experience, it will become more artful at balancing flexibility with structure and expectations that are individualized to promote success, without leading to unnecessary treatment dropout.
- **Urine screening is a helpful tool.** Because clients often have a hard time disclosing what substances they are using, urine screening is regarded as a helpful tool to facilitate conversation and intervention, not as a reason for negative consequences or punishment. Always make it easy for clients to feel rewarded for having the courage to tell the truth about their use.
- **Build collaborative partnerships with community methadone programs.** While buprenorphine or naltrexone can be used successfully in the treatment of OUD for many individuals in SMI settings, there are individuals whose severity and complexity of OUD and other SUD will be better served within the structure of a methadone program. SMI agencies often do not consider methadone programs to be a resource for their clients, and



methadone programs are often not organized to easily manage people with very severe psychiatric disabilities. Building a good partnership, with helpful cross consultation (we each help each other with challenging patients) can facilitate better care transitions and outcomes for the small numbers of clients that will have this higher level of need.

- **Expand services slowly across the organization.** Once the first “MAT team” develops expertise and comfort, it is likely to be a good time to launch one or more additional “service teams” at the same or different locations in the agency. Building on the successful experience of the “pilot” team is helpful, but it is important to keep in mind that each team has to go through its own “growing pains.” Further, the second and third wave teams are usually a bit more nervous than the front runners, so it is important to recognize that they too will need careful support and nurturance to get off the ground successfully. Testimonials from patients and prescribers can be powerful. Once there is access to MAT services in each location, additional prescribers may be asked to begin to take on small numbers of clients if needed, and be able to use the support of the existing team structure to help them develop confidence.

REFERENCES

Jones CM, McCance-Katz EF. Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug and Alcohol Depend*

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