Guidelines for Managing Relapse in Primary Care Practices

Overarching comments

Relapse is part of recovery. During the long-term management of any chronic disease there will be periods of time when things are relatively well controlled and periods of time when there is poor control. Use of alcohol, illicit substances, or prescribed drugs taken other than how they are prescribed may happen while someone is taking pharmacotherapy for opioid use disorder. Follow these steps or reach out to a clinical contact/provider mentor with any concerns.

If a patient is open about a relapse and is forthright about what happened, generally a lower-level intervention is required than when a patient is not being honest (e.g., using other people's urine or doctoring their own).

In managing relapse, individual programs have to determine where they fall on a spectrum from complete harm reduction to absolute abstinence. From a harm-reduction perspective, it is best for patients to continue their buprenorphine as long as possible if there are not clear safety concerns.

Initial non-opioid relapse or rare occasional relapse over time

Suggested guidelines:

- See patients more often (ideally weekly) and order urine toxicology screen at every visit
- Increase psychosocial support (attending recovery meetings more often, connecting with a peer or sponsor, and participating in individual therapy)
- Problem solving in clinic around what triggered relapse and how to avoid in future

First opioid relapse or multiple non-opioid relapses in short period of time

All of the steps above, plus:

- Referral to CASAC
- Consider additional urine toxicology screens in between visits
- Referral to higher level of care *(**Note:** Have contact information for providers at local substance use disorder treatment organizations readily available, with names/direct numbers, to expedite referrals.)*

In case of failure to comply with above recommendations

Options include:

- Give timeframe for compliance such as 2-4 weeks, after which no further prescription will be written *(Note: The provider can stop writing a prescription without a taper in this scenario. From a harm-reduction perspective, it is best for patients to continue their buprenorphine, meeting more frequently with the pharmacotherapy provider, until they engage in a higher level of care.)*
- See patients very often (every day or every other day; can be done in collaboration with nursing visits if clinician is not available daily)
- Decrease dose of buprenorphine

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