PCSS O TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Opioid Therapies

Role of Medication in the Treatment of Opioid Use Disorders

Carolyn Baird, DNP, MBA, RN-BC, CARN-AP, CCDPD, FIAAN
International Nurses Society on Addictions (IntNSA)
August 24, 2015

Disclosures

- Carolyn Baird, DNP, MBA, RN-BC, CARN-AP, CCDPD, FIAAN
  - None

Target Audience

- The overarching goal of PCSS-O is to offer evidence-based trainings on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction.
- Our focus is to reach providers and/or providers-in-training from diverse healthcare professions including physicians, nurses, dentists, physician assistants, pharmacists, and program administrators.

Educational Objectives

- At the conclusion of this activity participants should be able to:
- Discuss the American Society of Addiction Medicine National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use.
- Describe the properties of the common medications used in pharmacotherapy.
- Identify the special populations and the evidence based approaches for treatment.

Qualifier

- The focus for this webinar is on the additional knowledge and skills specific to medication-assisted treatment.

Background

- Average12 % illicit drug users become dependent (10% cannabis – 50% heroin).
- Opioid epidemic in United States
  - 2 million meet criteria due to prescription opioid use
  - 0.5 million meet criteria due to heroin use.
- Deaths from opioid overdoses now comparable to vehicle crash deaths.
- Opioid misuse estimated to cost society more than $55 billion per year.

Background

- Opioid use disorder or “addiction involving opioid use”
  - Fundamental neurological disease
  - Affects brain reward, motivation, memory, and related circuitry
- Specific receptors and neurotransmitter systems impacted.
- Pharmacological agents (medications) act via these systems and receptors.

Background

- Medications have been researched and documented as effective clinical interventions.
- Address the withdrawal and craving without creating euphoria.
- Less than 30% of treatment programs offer medications.
- Less than half of eligible patients in those programs receive medications.

Things to Consider

- Evidence-based treatment recommendations support the use of medication.
- Practice guidelines exist to assist clinicians in clinical decision making and patient management.
- Guidelines are only effective if followed as outlined.
- Outcomes are impacted by lack of patient understanding and adherence.
- Are only recommendations so federal and state regulations supersede.

Content

- Assessment and diagnosis of opioid use disorder.
- Treatment options.
- Treating opioid withdrawal.
- Methadone.
- Buprenorphine.
- Naltrexone.
- Psychosocial treatment.

Content

- Special Populations
  - Pregnant women.
  - Individuals with pain.
  - Adolescents.
  - Individuals with co-occurring psychiatric disorders.
  - Individuals in criminal justice system.
- Naloxone.

Assessment

- Comprehensive assessment.
- Special attention to
  - Urgent or emergent medical or psych issues
  - Complete history of opioid use
  - History of other substance related disorders and other substances used, including tobacco
  - Physical exam should include CBC, liver function, EKG, and pregnancy for females
  - Social and environmental factors as this is a bio-psycho-social-spiritual illness.

Diagnosis

- Patient provided history and comprehensive assessment primary method.
- Should confirm diagnosis on individual referrals.
- Withdrawal symptoms measured with validated clinical scales,
  - Objective opioid withdrawal scale (OOWS)
  - Subjective opioid withdrawal scale (SOWS)
  - Clinical opioid withdrawal scale (COWS)
- UDS, baseline and during treatment according to pt's stability, type & setting of treatment.

Treatment Options

- ASAM criteria for level 1 general outpatient, level 2 IOP or partial, level 3 residential, or level 4 hospital.
- Shared decision with consideration for
  - Patient preferences
  - Past treatment history
  - Treatment setting
- Consider venue
  - Daily supervised (OTP)
  - Weekly or monthly (OBOT)
- Evaluate adherence level.

Treating Opioid Withdrawal

- Medication for withdrawal management decreases risk of developing strong cravings.
- Standalone use of medication is not treatment and carries safety concerns and risk of relapse.
- Methadone
  - Should be in OTP or inpatient
  - Short-acting opioids begin 20-30mg per day
  - Taper should be completed in 6-10 days.

Treating Opioid Withdrawal

- Buprenorphine
  - Short-acting opioid wait 12-18 hrs last dose and long-acting wait 24-48 hrs.
  - Dose to suppress WD sx (4-16mg per day)
  - Tapering schedule can be as short as 3-5 days or as long as 30 days or more.
- (Research) buprenorphine + low dose oral naltrexone to manage withdrawal & facilitate use of long acting injectable naltrexone.
- (Off label) clonidine orally or transdermally 0.1-0.3mg q 6-8hr. Limit 1.2mg daily.

Methadone

- Has been a treatment option since 1965.
- Patient picture
  - Physiologically dependent
  - Able to give informed consent
  - No contraindications from assessment
- Initial doses range from 10-30mg with reassessment in 3-4 hours for persistent WD symptoms.
- First day may give 2nd dose of up to 10mg.
- Reach usual daily dose 60-120 mgs by 5-10mg increases not less than 7 days apart.

Methadone

- Administration is monitored to prevent misuse and diversion.
- Non-monitored dosing is based on pt's clinical response and behavior.
- Psychosocial treatment including strategies for relapse prevention should be integral part.
- If relapse occurs once no longer in treatment, MAT should be restarted.

Methadone

- Reasons to switch are intolerable side effects or not able to attain or maintain treatment goals.
- Methadone to buprenorphine- 30-40mg per day or less.
- Methadone to oral or extended release injectable naltrexone- completely withdrawn or participating in naltrexone facilitated opioid withdrawal.
- Warn of risks for opioid overdose and increase risk of death after discontinuing treatment.

Buprenorphine

- First dose is 2-4mg and is given after mild to moderate withdrawal occurs.
- Increases are in increments of 2-4mg.
- Average dose 8mg per day.
- If opioid use continues increase by 4-8mg per day up to 12-16mg or higher.
- FDA limit is 24mg per day.
- Limited evidence that higher doses lose effectiveness and increase diversion potential.

Buprenorphine

- Induction usually observed but some research supports home induction.
- Experienced patients and prescribers only.
- Frequent office visits (weekly at first) to gauge response and reduce diversion.
- UDS for buprenorphine, metabolites, other substances and prescription drugs.
- Psychosocial treatment.
- Prescription Drug Monitoring Program (PDMP)
- Recall visits for pill counts.

Buprenorphine

- No recommended time limit.
- Discontinuation slow process of several months.
- Monitor closely plus ongoing monitoring.
- Buprenorphine to naltrexone requires 7-14 days between last dose and first dose.
- Buprenorphine to methadone requires no delay
  - Partial to full agonist no adverse reaction.
- Warn that discontinuing treatment & resuming opioid use increases risk of overdose and death.

Naltrexone

- Recommended to prevent relapse.
- Oral effective where adherence is supervised or enforced in daily 50mg doses or 3 x a week of 100mg x2 and 150mg.
- Extended release injectable q 4weeks, deep intramuscular in gluteal muscle, 380mg.
- Research supports concurrent psychosocial tx.
- No recommended length of treatment.
- Use clinical judgment patient circumstances.
- Can be stopped abruptly with no withdrawal.

Naltrexone

- Naltrexone to buprenorphine or methadone planned, considered, monitored.
- No physical dependence with antagonist
  - Doesn't precipitate withdrawal.
  - Need to lower naltrexone level - day for oral, month injectable.
  - Initial doses low.
- Discontinuing antagonist & resuming opioid use has increased risk of overdose & death.

Comparison

Drug	Methadone	Buprenorphine	Naltrexone
Action	Full Agonist	Partial Agonist	Antagonist
Route	Oral	Oral	Oral & Injectable
Dosing	Daily	Daily	Daily, 3 x a Wk, Monthly
Pregnancy	Yes	Monoproduct only	No
Cost	$1.00 a day	$4.00 to $30.00 a day	$700 to $1000 per dose

Psychosocial Treatment

- Recommended with all pharmacologic products
  - Assessment
  - Supportive counseling
  - Links to family supports
  - Referrals to community services
- Treatment planning collaborative to determine optimal type and intensity, set parameters for non adherence.

Special Populations

Pregnant Women

- ID urgent or emergent medical conditions.
- Provide medical exam and psychosocial assessment.
- Test for HIV, hepatitis B & C, liver function.
- If hepatitis serology negative - offer vaccine (A&B).
- Be aware of risk of late initiation of prenatal care, missed appointments, poor weight gain, signs of intoxication or withdrawal.

Pregnant Women

- Educate gynecologists & obstetricians re: opioid use disorders.
- Get releases signed so care can be co-managed.
- Start pharmacologic treatment early
- Should be methadone or buprenorphine monoproduct.
- Hospitalization for induction advisable especially late in pregnancy.

Pregnancy

- Methadone – 20-30mg to start with 5-10mg increases after 3-6 hrs to treat withdrawal.
- Increases are 5-10mg a week to level that controls withdrawal & minimizes craving.
- Advancing pregnancy affects drug metabolism with decreased plasma levels and increased clearance.
- Increased or split dosing more effective with less side effects as dose increases.
- Adjust doses after child birth.

Pregnancy

- Provide psychosocial counseling and discuss implications of UDS results and treatment.
- Naltrexone has risks if become pregnant
  - Explain risks
  - Encourage to discontinue
  - If relapse or concerns of relapse consider methadone or buprenorphine monoproduct.
- Naloxone not recommended except life threat.
- Should be encouraged to breastfeed.

Individuals with Pain

- First steps
  - Correct diagnosis and target for treatment.
  - Acetaminophen and NSAIDS.
  - Opioid agonists if untreated opioid use disorder.
  - Pharmacotherapy and psychosocial treatment.
- On methadone for opioid use disorder
  - Additional opioids for acute pain & surgery.
  - Higher doses due to tolerance.

Individuals with Pain

- Buprenorphine and mild acute pain temporary increase.
- Buprenorphine and severe pain
  - Discontinue and use high potency opioid.
  - Monitor carefully.
  - Regional anesthesia may be necessary.
- Buprenorphine and surgery
  - Surgeon & anesthesiologist consult.
  - To discontinue stop 24-36hrs ahead.
  - Resume once full agonist analgesia not needed.

Individuals with Pain

- Response not the same on naltrexone.
- Naltrexone
  - Mild pain – NSAIDS
  - Moderate to severe pain – ketorolac (Toradol) short term.
  - Surgery – discontinue oral 72hrs prior, extended release 30 days prior.

Adolescents

- Concurrent pharmacological and psychosocial treatment.
- Include education on interventions for sexual risk reduction & comprehensive treatment.
- Consider agonist and antagonist.
- Under 18 need to observe federal law and obtain FDA approval.
- May benefit from multidimensional services in specialized facilities.

Co-occurring Psychiatric Disorders

- Pharmacotherapy and psychosocial treatment.
- Evaluate mental health status for severity of symptoms, suicidality, homicidal thoughts.
- Suicidal or homicidal ideation require immediate intervention, reduction of risk, attention to underlying factors, monitoring and follow up.
- Identify potential drug drug interactions.
- Co-occurring schizophrenia may need more assertive community treatment.

Criminal Justice

- Pharmacotherapy and psychosocial appropriate for prisoners and parolees.
- Length of sentence not at issue.
- May use agonist and antagonist therapy. Evidence doesn't support one over another.
- Treatment should be initiated at least 30 days prior to release.

Naloxone

- Should be given in event of overdose.
- Can and should be given to pregnant women in life threatening situations.
- Consensus opinion
  - Patients and family member should be given prescriptions and trained in use.
  - First responders (EMS, police, firefighters) should be trained and authorized to use.

Methadone, buprenorphine or naltrexone?

Case 1	Case 2	Case 3
30yo female	35yo male	21yo male
Pregnant	Incarcerated for 2 years with no meds	High school drop out
MBA with executive position in high stress job	To be released on probation within 24hours	Started using heroin in his teens
Uses heroin to 'manage' stress	Hx of bipolar disorder, back injury with chronic pain	Has had at least one overdose
Family wants her 'clean and sober' for baby's sake	Abusing prescription opiates prior to jail	Just 'hangin' out'

QUESTIONS

References

- American Society of Addiction Medicine (ASAM). (2015, May 27).The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (Practice Guideline). Retrieved from http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/national-practice-guideline.pdf?sfvrsn=18.
- Dennis, B. B., Naji, L., Bawor, M., Bonner, A., Varenbut, M., Daiter, J., Plater, C., Pare, G., Marsh, D. C., Worster, A., Desai, D., Samaan, Z., & Thabane, L. (2014). The effectiveness of opioid substitution treatments for patients with opioid dependence: a systematic review and multiple treatment comparison protocol. *Systematic Reviews, 3:* 105. Published online 2014 September 19.
- United Nations Office on Drugs and Crime (UNODC). (2012, June). *World Drug Report 2012* (United Nations publication, Sales No. E.12.XI.1). Retrieved from http://www.unodc.org/documents/data-and-analysis/WDR2012/WDR_2012_web_small.pdf.

PCSS-O Colleague Support Program

- PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.
- PCSS-O Mentors comprise a national network of trained providers with expertise in **addiction medicine/psychiatry and pain management.**
- Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available at no cost to providers.

For more information on requesting or becoming a mentor visit:
www.pcss-o.org/colleague-support

- **Listserv:** A resource that provides an "Expert of the Month" who will answer questions about educational content that has been presented through PCSS-O project. To join email: pcss-o@aaap.org.

P C O TRAINING
S S

PROVIDERS' CLINICAL SUPPORT SYSTEM
For Opioid Therapies

PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

For more information visit: www.pcss-o.org
For questions email: pcss-o@aaap.org

Twitter: @PCSSProjects

Funding for this initiative was made possible (in part) by Providers' Clinical Support System for Opioid Therapies (grant no. 1H79TI025595) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.