Opioid Use Disorder Screening & Medication Assisted Treatment

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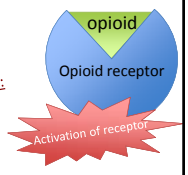
No disclosures to report

- This presentation outlines possible options and does not favor any specific treatment plan
- Presenter and all places of employment do NOT receive any financial or other incentives to prescribe any specific medications or promote any specific treatment programs

- Opioids activate receptors in the brain and nervous system – may relieve pain and produce pleasurable effects



Potential problems with opioid receptor activation:
- Physical Dependence
- Tolerance
- Overdose
- Addiction
- Withdrawal
- Opioid Induced Hyperalgesia

- Recognition of national epidemic
- The paradigm shift: opioid medications have high risk in short and long term use
- CDC recommendations released March 2016 to guide prescribing of opioids outside of active cancer treatment, palliative care, and end-of-life treatment

"We have to stop treating addiction as a moral failing, and start seeing it for what it is: a chronic disease that must be treated with urgency and compassion."

- Dr. Vivek H. Murthy, United States Surgeon General 2016

Opioid Use Disorder

Problematic pattern of opioid use leading to clinically significant impairment or distress, manifested by at least 2 of the following, occurring within a 12-month period:

1. Opioids taken in larger amounts or longer period than intended.
2. Persistent desire or unsuccessful efforts to cut down.
3. Time spent in activities necessary to obtain the opioid or use the opioid.
4. Craving or urge to use opioids.
5. Opioid use resulting in a failure to fulfill obligations at work, school, or home.

Opioid Use Disorder (continued)

6. Continued opioid use despite having recurrent social or interpersonal problems caused by effects of opioids.
7. Social, occupational, or recreational activities are given up because of use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is due to opioids.
10. Tolerance, as defined by either (a) need for markedly increased amounts of opioids to achieve desired effect or (b) diminished effect with continued use of the same amount of opioid.
11. Withdrawal, as manifested by either (a) opioid withdrawal syndrome or (b) opioids taken to relieve withdrawal symptoms.

Severity of Opioid Use Disorder

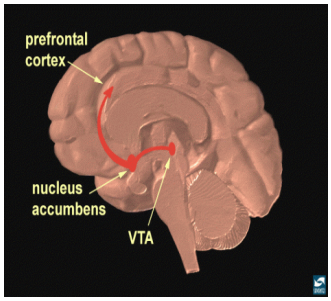
- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 or more symptoms

Screening for Opioid Use Disorder

- Substance Use History:
  - Types of substances used – prescription and nonprescription
  - Frequency and amount, routes of use
  - Problematic consequences of use
  - Treatment history
  - Recent use history
- Medical, Psychiatric, Family history

The reward circuit

- Flooding of the reward center with Dopamine
- Leads to repeating of activities which are creating pleasure/reward



- Addiction: ongoing pursuit of reward despite negative consequences.

Discussion with patients

- Ability to establish a helping alliance
- Good interpersonal skills
- Nonpossessive warmth
- Friendliness
- Genuineness
- Respect
- Affirmation
- Empathy
- Supportive style
- Patient-centered approach
- Reflective listening

https://www.ncbi.nlm.nih.gov/books/NBK64237/

Examples

- "How has heroin use affected your life?"
- "How has hydrocodone affected your life?"
- "In the past, what factors have helped you stop using?"
- "What specific concerns do you have today?"

https://www.ncbi.nlm.nih.gov/books/NBK64237/

- Do you use opioid medications either prescribed to you or obtained from the street?
- Resource for assessment questions:

http://www.kap.samhsa.gov/products/manuals/index.htm

Available screening tools

- Drugs: – COWS (Clinical Opiate Withdrawal Scale) (Wesson et al. 1999) – SOWS (Subjective Opiate Withdrawal Scale) (Bradley et al. 1987; Gossop 1990; Handelsman et al. 1987) – DAST-10 (Drug Abuse Screening Test) (Skinner 1982) – CINA (Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms) (Peachey and Lei 1988) – CAGE-AID (CAGE Adapted to Include Drugs) (Brown and Rounds 1995) – Narcotic Withdrawal Scale (Fultz and Senay 1975)
- Alcohol: – CAGE (Maisto and Saitz 2003) – AUDIT (Alcohol Use Disorders Identification Test) (Babor et al. 2001) – MAST (Michigan Alcohol Screening Test) (Selzer 1971) – SMAST (Short Michigan Alcohol Screening Test) (Selzer et al. 1975)

Approach to Treatment

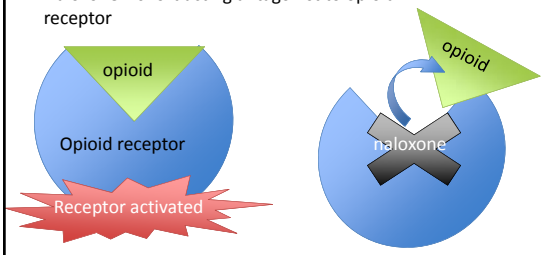
- Harm reduction
  - Surgeon General Dr. Vivek Murthy highlights the role of harm reduction by acknowledging that harm reduction programs meet the *"needs of those who are not yet ready to participate in treatment"* and those *"who may not be ready to stop substance use – offering individuals strategies to reduce risks while still using." -2016*
    - https://addiction.surgeongeneral.gov
- Risk reduction
- Treatment options

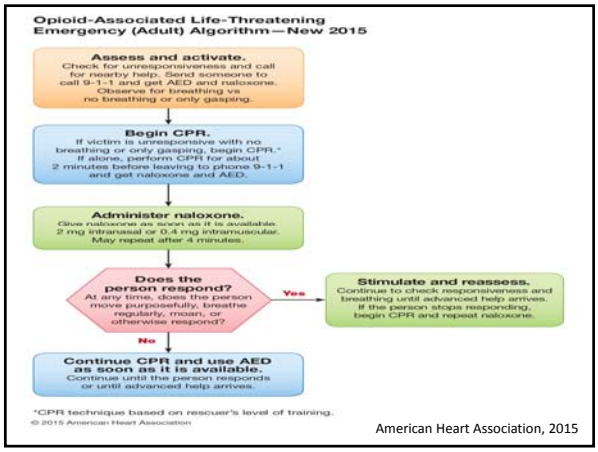
Risk Reduction

- Safe use practices
- Syringe service programs – www.harmreduction.org
- Offer Naloxone to patients in case of overdose
- Counsel regarding co-use with other substances – esp benzodiazepines, alcohol
- Screening labs – CBC, CMP, HIV, Hepatitis B, Hepatitis C, TB screening, Syphillis, other based on medical history
  - US Preventative Services Task Force

Overdose Treatment

Naloxone – short acting antagonist to opioid receptor





American Heart Association, 2015

Naloxone

- Now available without prescription at Walgreens and CVS in Nevada as well as Community Health Centers – Community Health Alliance and Northern Nevada HOPES
- Short acting
- Cost and Coverage

Treatment Options

- Opioid Agonist
  - Methadone
  - Buprenorphine
- Opioid Antagonist
  - Naltrexone
  - Naloxone (short acting, overdose treatment)
- Nonmedication treatment options
- Psychosocial treatment modalities recommended regardless of treatment option

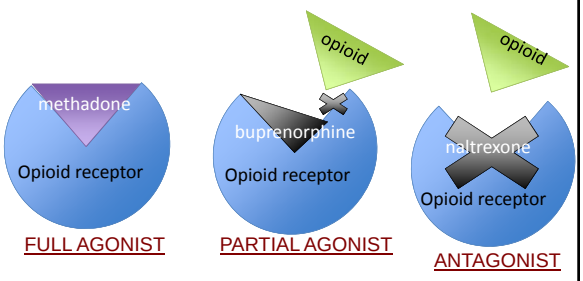
Medications for Opioid Use Disorder

Detox
- Inpatient or outpatient
  - Buprenorphine
  - Methadone

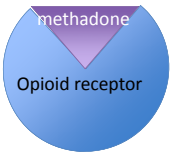
Maintenance
- Medication Assisted Treatment: 3 FDA approved medications
  - Methadone
  - Buprenorphine
  - Naltrexone

Overdose
  - Naloxone

At the Receptor



Methadone (schedule II)



AGONIST: long acting activation

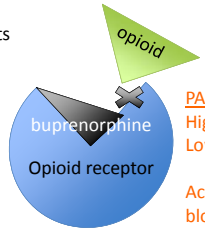
- Regulation: strict federal guidelines dictate eligibility for methadone maintenance
- Benefit: prevents withdrawal symptoms, detox, reduces cravings, reduces euphoria of subsequent opioid use, efficacy in opioid use disorder, cost effective
- Risk: possible overdose risk, misuse, tolerance, hyperalgesia, cardiac arrhythmias, dependence

Buprenorphine (schedule III)

Regulation: required certification; patient limits in treatment

Benefits:
Detox
maintenance therapy
craving reduction

daily oral or (new) long-acting implant



PARTIAL AGONIST: Higher affinity with Lower activity

Activates receptor plus blocks activation of receptor by other opioids

Prescribing Buprenorphine

- Requires waiver to prescribe and dispense
- 30 pts in first year – 100 in 2nd year – recent increase to 275 pts with criteria
- Available trainings (approx 8 hours)
  - American Academy of Addiction Psychiatry
  - American Psychiatric Association
  - American Society of Addiction Medicine
  - American Osteopathic Academy of Addiction Medicine

Buprenorphine limitations

- Partial agonist
  - When used in monotherapy has abuse potential
  - Naloxone added in combination as an abuse deterrent
    - Available combination formulations: buprenorphine/naloxone, Suboxone, Zubsolv, Bunavail
  - Buprenorphine/Naloxone generic
- Street value/diversion
  - Highly effective in detox help
- Potential dependence/ addiction
- May induce withdrawal with recent use of opioids
  - Higher affinity for opioid receptor

Probuphine

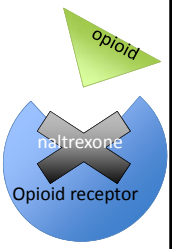
- Buprenorphine implant
- 6 month duration
- Requires prescribing and insertion training

- Buy and bill system
- Must have active buprenorphine license
- Office procedure

Naltrexone (prescription, not controlled)

Benefits:
prevents opioid intoxication and dependence
reinforces abstinence
efficacy in opioid and alcohol use
no addiction/dependence potential

Oral daily dose vs. long acting injection



Naltrexone limitations

- Requires completed withdrawal from opioids- will induce withdrawal if taken with opioids in the system
  - Requires motivated patient
  - cannot aid with detox
- Risk: may have increase risk of death from overdose due to decrease in tolerance with receptor blockade (depending upon dose of opioid used in relapse)

Vivitrol (long acting Naltrexone)

- 28 day duration
- IM injection

Increasing success

- Create a collaborative, harm reduction based plan with patient – explain rationales for treatment plans
  - Frequent visits for follow up
- Integrated model with behavioral health, case management – monitoring compliance
- Awareness of controlled substance regulation/diversion
  - *Observed* Urine Drug Screening
  - Random call-ins for medication counts between scheduled visits
  - Reviewing Prescription Monitoring Program – Nevada and California access
  - Limiting prescriptions to short supply
  - Updated treatment contract on each patient
  - Supervised/observed dosing
- Extrinsic motivations
- Insurance coverage/cost – working with prior authorizations to maintain medication coverage
- Community effort– support across levels of care – detox, inpatient, outpatient, medication assisted, nonmedication, psychosocial

References

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  - www.uptodate.com

Thank you

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