Medication for Opioid Use Disorder

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Melissa Weimer Disclosures

- Dr. Weimer has received monetary honorarium on one occasion from Indivior related to speaking about opioid dependence and pain only.

*The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.*
Target Audience

• The overarching goal of PCSS-MAT is to make available the most effective medication treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
Educational Objectives

• At the conclusion of this activity participants should be able to:

  ▪ Identify the rationale for using medications to treat opioid use disorder

  ▪ Describe effective medications for treating opioid use disorder

  ▪ Explain the unique properties of methadone, buprenorphine, and naltrexone
Case

- Jane is a 23 year old female with chronic low back pain from a motor vehicle accident at age 16 who presents to your office asking for help to stop using IV heroin.
- She has been using opioids daily for about 4 years. She started using illicit prescription opioids, then switched to IV heroin daily about 2 years ago when she could no longer afford illicit opioid pills.
- She has attempted non-medication-based addiction treatment in the past and quickly relapsed.
- She also drinks approximately 14 alcoholic drinks per week, but has never had alcohol withdrawal symptoms when she stops drinking. She feels that she could easily stop drinking alcohol. She denies other drug use.
- She denies other mental health or medical issues, but has had two opioid overdoses in the past year.
- She lives with her parents who are supportive of her. She is on probation for possession of opioids.
- She reports opioid withdrawal symptoms including anxiety, restlessness, nausea, stomach cramping, and diarrhea. Her vital signs and physical exam are normal except for gooseflesh, dilated pupils, and bilateral upper extremity track marks.
Case Questions

• Is medication for opioid use disorder (OUD) indicated for this patient?

• What additional work up or evaluation is needed to decide upon medication for this patient?

• Which medication to treat OUD is most appropriate for this patient?

• How will you address the concomitant alcohol use?
Substance Use Disorder: A Chronic Relapsing Disorder

Stages of the Addiction Cycle

Stages of Addiction Cycle

Binge and intoxication

Response to drug

Preoccupation and anticipation

Withdrawal and negative affect

Stress and reward

Neuroadaptations

- Neurocircuits
- Synaptic systems
- Molecules
- Epigenetics

<table>
<thead>
<tr>
<th>Stage of Addiction</th>
<th>Shifting Drivers Resulting from Neuroadaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binge and intoxication</td>
<td>Feeling euphoric ➔ Feeling good ➔ Escaping dysphoria</td>
</tr>
<tr>
<td>Withdrawal and negative affect</td>
<td>Feeling reduced energy ➔ Feeling reduced excitement ➔ Feeling depressed, anxious, restless</td>
</tr>
<tr>
<td>Preoccupation and anticipation</td>
<td>Looking forward ➔ Desiring drug ➔ Obsessing and planning to get drug</td>
</tr>
</tbody>
</table>

Behavioral Changes

- Voluntary action ➔ Sometimes taking when not intending ➔ Impulsive action ➔ Relapse
- Abstinence ➔ Sometimes having trouble stopping ➔ Compulsive consumption ➔ Constrained drug taking ➔ Sometimes taking more than intended
Substance Use Disorder: DSM-5
(≥2 items in 12 month period)

1. Failure to fulfill responsibilities ✓
2. Use in physically hazardous situations ✓
3. Legal problems was in DSM-IV but it was replaced with *Craving in DSM-5.*
4. Social/interpersonal problems ✓
5. Use larger amounts/longer than intended ✓
6. Cannot cut down ✓
7. ↑ time spent to get, use, and recover ✓
8. Give up or ↓ other important parts of life ✓
9. Ongoing use despite problems ✓
10. Tolerance* ✓
11. Withdrawal* ✓

*Mild=2-3
Mod=4-5
Severe=6+

*10 and 11 do not count if opioid is prescribed
Purpose of Medication for OUD

- Allow reestablishment of homeostasis of the reward pathways in the brain away from substances
- Restore emotional and decision-making capacities
- Control symptoms of opioid withdrawal
- Suppress opioid cravings
- Block the reinforcing effects of ongoing opioid use
- Promote and facilitate patient engagement in recovery-oriented activities
- Coupled with behavioral interventions
  - Enhance the salience of natural, healthy rewards
  - Reduce stress reactivity and negative emotional state
  - Improve self-regulation
  - Increase avoidance of relapse triggers

Volkow, et al, NEJM. 2016
ASAM National Practice Guideline, June 1, 2015.
Goals of Medication for OUD

- Reduce mortality
  - All cause and drug-related
- Reduce associated morbidity
  - Transmission of blood-borne viruses
  - Infectious complications from IV drug use
- Reduce and/or discontinue opioid use
- Increase retention in addiction treatment
- Improve general health and well-being
- Reduce drug-related crime

Volkow, et al, NEJM. 2016
Access to medication remains a key barrier to reduction in mortality from opioid use.

Annual deaths (1,000's) from AIDS (left) and opioid overdose (right), USA

Arrows indicate year of FDA approval of specified medications
*HAART = Highly active antiretroviral therapy
*OBOT = Office based outpatient treatment of opioid use disorder (OUD)
*XR-NTX = Extended release naltrexone
Data reflect approximations adapted from the Centers for Disease Control and Prevention

Adjusting for heroin purity and the number of methadone patients, there was a statistically significant inverse relationship between heroin overdose deaths and patients treated with buprenorphine (P = .002).

Schwartz et al AJPH 2013
Medication for OUD

- Methadone
  - Opioid Treatment Program

- Buprenorphine
  - Office-Based
  - Opioid Treatment Program

- Naltrexone
  - Office-Based
  - Opioid Treatment Program

- Counseling mandatory for methadone; ability to refer to counseling necessary for buprenorphine; optional for naltrexone but encouraged.

- All medical modalities require medication management
Opioid (mu) Receptor Activity for Medications treating Opioid Use Disorder

Medication Dose

- Full Agonist: Methadone
- Partial Agonist: Buprenorphine
- Antagonist: Naltrexone

% Mu Receptor Intrinsic Activity

- no drug
- low dose
- high dose
### Medication Efficacy for Opioid Use Disorder

<table>
<thead>
<tr>
<th></th>
<th>All cause Mortality</th>
<th>Treatment Retention</th>
<th>Any Opioid Use</th>
<th>HIV or HCV Transmission</th>
<th>Criminal Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methadone</strong></td>
<td>↓ (n=4)(^a,c)</td>
<td>↑ (n=6)(^a)</td>
<td>↓ (n=6)(^a)</td>
<td>↓ (n=34)(^b)</td>
<td>↓ (n=2)(^a)</td>
</tr>
<tr>
<td><strong>Buprenorphine</strong></td>
<td>↓ (n=2)(^a,c)</td>
<td>↑ (n=4)(^a)</td>
<td>↓ (n=2)(^a)</td>
<td>↓ (n=6)(^b)</td>
<td>↓ (n=2)(^a)</td>
</tr>
<tr>
<td><strong>Oral Naltrexone</strong></td>
<td>No data</td>
<td>↑ (n=3)(^d)</td>
<td>↓ (n=3)(^d)</td>
<td>No data</td>
<td>↓ (n=2)(^d)</td>
</tr>
<tr>
<td><strong>Extended Release Naltrexone</strong></td>
<td>↓ (n=1)(^e)</td>
<td>(n=6)(^e-j)</td>
<td>↓ (n=6)(^e-j)</td>
<td>No data</td>
<td>↓ (n=1)(^g)</td>
</tr>
</tbody>
</table>

Methadone

- Developed in 1930s during WWII as an alternative to morphine
- In 1947, approved in US as analgesic and antitussive
- In 1960s, first utilization as medication to treat OUD by Dr. Vincent Dole of Rockefeller University
- 1971, first federal program for methadone maintenance treatment
Methadone

- Full opioid agonist indicated to treat opioid use disorder
- Long and variable elimination half-life
  - 15-150 hours
- Federal regulation requires dispensing in a licensed opioid treatment program (OTP)
  - Exceptions: hospitals
- OTPs integrate counseling into the treatment paradigm
- Specific Eligibility Criteria
- Typical effective dose range is 60-100mg per day, may need to be higher in some patients
Methadone

>40 years of data support \(^1,^2\)
- Safety
- Sustained opioid abstinence
- Treatment retention
- Reduced IV Drug Use risk behaviors
- Reduced transmission of HIV and HCV

But…
- Requires careful monitoring
- Increased risk of mortality in first 2 weeks of treatment due to unique and complex pharmacokinetics
- Prolongs QTc\(^3,^4\)
  - 23% of patients by 16 weeks of treatment\(^4\)
- Multiple drug-drug interactions\(^5\)

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\(^1\) Kreek Addict Dis 2010
\(^2\) Mattick Cochrane Rev 2014
\(^3\) Chou, J Pain 2014
\(^4\) Wedam Arch Intern Med 2007
\(^5\) McCance-Katz Am J Addict 2009
Mortality Risk During and After Methadone Treatment

Mortality rates/1000 person years (95% CI)

**Methadone: Contraindications and Precautions**

<table>
<thead>
<tr>
<th>Contraindications</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypersensitivity</td>
<td>Concurrent use of other CNS depressants including alcohol, other opioids, benzodiazepines</td>
</tr>
<tr>
<td>Respiratory depression (e.g. severe COPD, severe OSA, etc)</td>
<td>Liver disease</td>
</tr>
<tr>
<td>Hypercapnia</td>
<td>Drug interactions with medications metabolized by cytochrome p450 -CYP34A, CYP2B6, CYP2C19, CTY2C9, CYP2D6</td>
</tr>
<tr>
<td>Paralytic ileus</td>
<td>Electrocardiogram (ECG) QTc &gt; 450ms*</td>
</tr>
<tr>
<td>ECG QTc &gt; 500ms*</td>
<td></td>
</tr>
</tbody>
</table>

*Pretreatment and annual ECG screening recommended*
Buprenorphine/Naloxone Film or Tablet (4:1 combination)

- First FDA approval in 2002 for OUD treatment
- Partial opioid agonist, Schedule 3
- Transmucosal film or tablet
- Dosing
  - Once daily
  - Alternative dosing: every other day or thrice weekly also effective
  - Off label: twice daily or three times daily
- 24mg/day usually the highest effective dose
- Ceiling Effect* with lower opioid overdose risk
- Office based prescribing by MDs, DOs, PAs, or NPs with DEA waiver or “X license”
  - Treat up to 30 patients the first year, then up to 100 patients
  - Can apply to prescribe up to 275 patients if certain requirements met

*Ceiling effect does not apply to children where unintentional exposure can lead to death
Rationale for Buprenorphine/Naloxone Combination

- Naloxone present in attempt to decrease misuse or diversion
- Naloxone is mostly inactive unless injected
  - Very low bioavailability of naloxone when medication used sublingually
  - If patient opioid dependent and not in opioid withdrawal, injection of buprenorphine/naloxone can precipitate withdrawal
  - If patient in opioid withdrawal, injection of buprenorphine/naloxone can have euphorogenic or opioid withdrawal relieving effects

## Commercially Available Transmucosal Buprenorphine Formulations for the Treatment of OUD

<table>
<thead>
<tr>
<th>Formulation</th>
<th>Buprenorphine/Naloxone</th>
<th>Suboxone®</th>
<th>Buprenorphine</th>
<th>Zubsolv®</th>
<th>Bunavail®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dosages Available</td>
<td>SL Tablets</td>
<td>SL Film</td>
<td>SL Tablets</td>
<td>SL Tablets</td>
<td>Mucous Membrane Film</td>
</tr>
<tr>
<td></td>
<td>2/0.5mg, 4/1mg, 8/2mg</td>
<td>2/0.5mg, 8/2mg, 12/3mg</td>
<td>2mg, 8mg</td>
<td>1.4/0.36mg, 2.9/0.71mg, 5.7/1.4mg, 8.6/2.1mg, 11.4/2.9mg</td>
<td>2.1/0.3mg, 4.2/0.7mg, 6.3/1mg</td>
</tr>
<tr>
<td>Concomitant Naloxone</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

SL = Sublingual

Belbuca®, Buprenex®, and Butrans® are not indicated for treatment of opioid dependence or opioid use disorder.
# Buprenorphine: Contraindications and Precautions

<table>
<thead>
<tr>
<th>Contraindications</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypersensitivity</td>
<td>Concurrent use of other CNS depressants including alcohol, other opioids, benzodiazepines</td>
</tr>
<tr>
<td>Patient not already on buprenorphine and undergoing a procedure where full agonist treatment is needed*</td>
<td>Precipitated withdrawal due to full agonist opioid use</td>
</tr>
<tr>
<td></td>
<td>Severe liver impairment</td>
</tr>
</tbody>
</table>

*Patients can have acute pain addressed while on buprenorphine treatment. Refer to [PCSS Core Pain Curriculum](#) for more information.
Buprenorphine Implant (Probuphine®)

- FDA approved in 2016
- Indication: Treatment of OUD in patients who have been clinically stabilized on transmucosal buprenorphine 8 mg/day or less.
- Medication consists of 4 implants (80mg/implant) surgically inserted into the subdermal region of the upper arm that release buprenorphine for 6 months.
- At steady state (after 4 weeks), comparable to trough buprenorphine plasma levels produced by daily sublingual buprenorphine doses of 8mg or less.
- To prescribe, insert or remove medication, providers must complete a live training program.

Buprenorphine Implant
Probuphine®

- 177 randomized; 166 completed (93.8% retention)

<table>
<thead>
<tr>
<th>Responder Rate</th>
<th>Implant</th>
<th>SL B/X</th>
<th>P Value</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Analysis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 4 of 6 month without illicit opioid use</td>
<td>81/84 (96.4%)</td>
<td>78/89 (87.6%)</td>
<td>&lt;0.001</td>
<td>11.4</td>
</tr>
<tr>
<td><strong>Secondary Analysis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 month illicit opioid abstinence</td>
<td>72/84 (85.7%)</td>
<td>64/89 (71.9%)</td>
<td>0.03</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Buprenorphine Depot Injection (Sublocade®)

- FDA approval obtained November 2017
  - Moderate to severe OUD treatment
- Monthly subcutaneous abdominal injection
  - Minimum 7 days of transmucosal buprenorphine treatment first
- Two doses
  - 300mg/1.5mL and 100mg/0.5mL
- Two dosing options based on current evidence
  - 300mg/1.5mL x 6 months
  - 300mg/1.5mL x 2 months, followed by 100mg/0.5mL x 4 months
- Peak buprenorphine concentrations occur ~24 hrs after injection
- Steady state achieved in 4 to 6 months
- After discontinuation, patients may have detectable plasma levels for 12 months or longer

Buprenorphine Depot Injection (Sublocade®)

• One Phase 3 trial completed¹

• Low proportion of people with significant adverse effects

• Primary endpoint = mean % abstinence¹
  ▪ 41-43% treatment arm vs 5% for placebo (p<0.0001)

• Secondary endpoint = treatment success (80% urine samples free of opioids)¹
  ▪ 28-29% treatment arm vs 2% placebo (p<0.0001)

¹Late-Breaking Research Oral Session at CPDD 79th Annual Scientific Meeting 2017.  http://cpdd.org/meetings/2017-meeting-information/
Treatment Retention: Buprenorphine Detoxification vs. Maintenance

Maintenance: 75% Abstinent at 1 year
0% mortality

Detoxification: 0% Abstinent at 1 year
20% mortality

HR = 58.7, p .0001

Kakko, Lancet 2003
Mortality Risk During and After Buprenorphine Treatment

Mortality rates/1000 person years (95% CI)

- Buprenorphine - all cause mortality
- Buprenorphine - overdose risk

Buprenorphine vs. Methadone
Treatment Retention

Percent Retained

0 20 40 60 80 100

Study Week

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

73% High dose methadone (60-100mg)
58% Buprenorphine
20% Low dose methadone (20mg)

Johnson NEMJ 2000
Buprenorphine vs. Methadone
Opiate Urine Results

Mean % Negative

Study Week

100
80
60
40
20
0

1 3 5 7 9 11 13 15 17

40% Buprenorphine
39% High dose methadone
19% Low dose methadone

Johnson NEMJ 2000
Oral Naltrexone

- Opioid antagonist: blocks all opioid receptors
- Two formulations: Oral and Intramuscular
- Oral Naltrexone FDA approved in 1984 for blockade of effects of administered opioids
  - Dose is 50mg daily
  - Alternative dosing = dose three times a week with two 100mg-doses followed by 150mg dose
  - Not widely used to treat OUD because low rates of patient acceptance, difficulty with initiation, and high rates of medication nonadherence
  - Cochrane Review did not find oral naltrexone superior to placebo or no medication in treatment retention and illicit opioid use

Extended-Release (XR) Naltrexone: Intramuscular Injection

- FDA approved 2010 for treatment of opioid use disorder following medically supervised withdrawal
- 380mg administered intramuscularly once every 4 weeks
  - Some people may metabolize quickly and need injection in 21 days
- Consider in
  - Patients who have failed agonist treatment
  - Patients confined to environments that do not allow for medication treatments
  - Patients who do not have access to agonist treatment
  - Patients with high risk of diversion
  - Patients who are highly motivated and willing to taper off opioid agonists
  - Patients who do not want to be treated with an agonist
  - Patients with concomitant opioid and alcohol use disorder

ASAM The National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use.
XR-Naltrexone

- Requires patient to be fully abstinent from opioids
  - Short acting opioids = 5-7 days abstinent
  - Long acting opioids = 7-10 days abstinent
  - Confirm opioid abstinence with urine drug test and/or naloxone challenge*
- Few drug-drug interactions
- Induction delays and non-adherence may reduce overall effectiveness

*Naloxone Challenge:
Use to assess lack of physical opioid dependence
Usually involves injection (IV, IM, or SQ) of
Short-acting NAloxone to test opioid abstinence
See TIP 63 for more information
XR-Naltrexone

- Efficacious for opioid abstinence compared to placebo
  - **Comer**: 60 U.S. people who use heroin at 8 weeks\(^1\)
  - **Krupitsky**: 250 Russian people who use heroin at 24 wks\(^2\)
    - % Opioid Abstinent XR-Naltrexone 45 (35.7%) vs Placebo 25 (22.8%)
    - RR 1.58, 95% CI (1.06 – 2.36), \(p = 0.0224\)
    - NNT 7.8
    - Fair quality study, high attrition, young white males only

\(^1\) Comer Arch Gen Psych 2006
\(^2\) Krupitsky Lancet 2011
XR-Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders

- Open-label, randomized, controlled effectiveness trial
- Compared six monthly injections of XR-NTX with usual treatment (brief counseling and referrals for community treatment programs)
- Study population: adult ex-prisoners who had a history of opioid dependence
- Primary endpoint: opioid relapse

XR-Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders

Kaplan–Meier Curves for Relapse-free Survival

After 6 months
Time to relapse:
10.5 weeks Naltrexone
5.0 weeks Usual Treatment

Opioid Relapse Event:
43% Naltrexone
64% Usual Treatment

Overdoses:
0 Naltrexone
7 Usual Treatment

# XR-Naltrexone: Contraindications and Precautions

<table>
<thead>
<tr>
<th>Contraindications</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypersensitivity</td>
<td>Vulnerability to overdose</td>
</tr>
<tr>
<td>Patient currently physically dependent on opioids – <em>will develop severe precipitated opioid withdrawal</em></td>
<td>Injection site reactions associated with injectable naltrexone</td>
</tr>
<tr>
<td>Patient receiving opioid analgesics</td>
<td>Risk of hepatotoxicity</td>
</tr>
<tr>
<td>Patients in acute opioid withdrawal</td>
<td>Monitor for development of depression and suicidality</td>
</tr>
<tr>
<td></td>
<td>Thrombocytopenia or coagulation disorder – injection bleeding risk</td>
</tr>
</tbody>
</table>

ASAM National Practice Guideline, June 1, 2015.
XR-Naltrexone Compared to Buprenorphine

- Tanum, et al, 2017: Open label RCT
  - 159 patients randomized / 105 completed study
  - Inpatient detox setting
  - 12 weeks follow up
  - Primary Outcomes: retention in treatment, group proportion of opioid-negative UDTs, days of use of heroin or other opioids
  - XR-NRT non-inferior to buprenorphine (relatively low dose) for treatment retention and decreasing opioid use at 12 weeks
    - Lower use of heroin or other opioids in XR-NRT group
- Secondary outcomes: XR-NRT superior to buprenorphine on reduction in heroin craving, reduction of insomnia, satisfaction with treatment, life satisfaction, and reduction of pain. No difference in anxiety or depression

Tanum L et al. JAMA Psych, 2017
X:BOT Trial (XR-Naltrexone Compared to Buprenorphine)

- Lee, et al, 2018: Comparative Effectiveness RCT
  - 570 patients randomized / 474 completed
  - 8 INpatient detoxification/residential treatment programs around the US
    - Sites utilizing non-opioid detox had better success with XR-NRT induction
  - 24 weeks of follow up
  - Primary outcome: “time to relapse”
    - 7 consecutive use days
    - 4 consecutive use weeks
    - Beginning no earlier than 21 days post-randomization

Lee, et al. X:BOT. Lancet, 2018
### X:BOT Trial (XR-Naltrexone Compared to Buprenorphine)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>XR-NXT (n=283)</th>
<th>BUP-NX (n=287)</th>
<th>Treatment Effect*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients Inducted to study medication (ITT)</td>
<td>204 (72%)</td>
<td>270 (94%)</td>
<td>OR 0.61, 0.09-0.28 P&lt;0.0001</td>
</tr>
<tr>
<td>Weeks Relapse-free survival (ITT)</td>
<td>8.4 (3-23.4)</td>
<td>14.4 (5.1-23.4)</td>
<td>HR 1.36, 1.10-1.68 P=0.0040</td>
</tr>
<tr>
<td>24-week relapse rates (ITT)</td>
<td>65%</td>
<td>57%</td>
<td>OR=1.44, 1.02-2.01 P=0.04</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>XR-NRT (n=204)</th>
<th>BUP-NX (n=270)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks Relapse-free survival Per-protocol</td>
<td>20.4 (5.4-23.4)</td>
</tr>
<tr>
<td>24-week relapse rates per-protocol</td>
<td>52%</td>
</tr>
</tbody>
</table>

- Patients were less likely to be inducted on XR-NTX, less likely to relapse if they received buprenorphine.
- Once started on medication, a statistically significant difference was not observed btw medications.
Models of Care Treating Patients with OUD

- Office-based buprenorphine therapy
- Buprenorphine HIV evaluation and support collaborative model
- One-stop shop model
- Integrated prenatal care and MAT
- Hub and spoke model
- Medicaid health home model
- Project ECHO
- Collaborative opioid prescribing model
- Nurse care manager model
- ED initiation of buprenorphine
- Inpatient initiation of MAT
- Southern Oregon model

What is Medication Management?

- Treatment of opioid withdrawal
- Medication initiation
- Evaluation for safety and effectiveness
- Confirmation of adherence
  - Urine drug testing, pill counts, patient report
- Evaluating treatment plan based on patient need and adherence
- Referral for or treatment of mental illness, if needed

Also involves
- Psychosocial needs assessment
- Supportive counseling
- Case management
- Links to existing family supports
- Referral to community services

ASAM National Practice Guideline, 2015
Role of Counseling

• Purpose:\(^1\)
  ▪ Modify behaviors that maintain or reinforce drug use
  ▪ Develop coping strategies
  ▪ Encourage medication adherence
  ▪ Treat or identify concomitant mental illness that can complicate SUD or trigger relapse

• Some evidence shows that psychosocial treatment improves adherence and retention in treatment\(^2-3\), but findings are mixed\(^4-7\)

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1. ASAM National Practice Guideline, 2015
6. Tetrault JM et al, K Subst Abuse Treat 2012
7. Weiss RD et al, Arch Gen Psych 2011
Effective Counseling Modalities

• Relationship building
• Cognitive behavioral therapies
• Contingency management
• Relapse prevention
• Motivational interviewing

Case

- Jane is a 23 year old female with chronic low back pain from a motor vehicle accident at age 16 who presents to your office asking for help to stop using IV heroin.
- She has been using opioids daily for about 4 years. She started using illicit prescription opioids, then switched to IV heroin daily about 2 years ago when she could no longer afford illicit opioid pills.
- She has attempted non-medication-based addiction treatment in the past and quickly relapsed.
- She also drinks approximately 14 alcoholic drinks per week, but has never had alcohol withdrawal symptoms when she stops drinking. She feels that she could easily stop drinking alcohol. She denies other drug use.
- She denies other mental health or medical issues, but has had two opioid overdoses in the past year.
- She lives with her parents who are supportive of her. She is on probation for possession of opioids.
- She reports opioid withdrawal symptoms including anxiety, restlessness, nausea, stomach cramping, and diarrhea. Her vital signs and physical exam are normal except for gooseflesh, dilated pupils, and bilateral upper extremity track marks.
Case Questions

• Is medication indicated for this patient?
  ▪ Yes

• What additional work up or evaluation is needed to decide upon medication for this patient?
  ▪ Urine drug screen and pregnancy test
  ▪ DSM-5 evaluation
  ▪ General medical evaluation

• How will you address the concomitant alcohol use?
  ▪ May need to consider medically supervised withdrawal
  ▪ Structure care to monitor this closely
# Pros and Cons of Each Medication

<table>
<thead>
<tr>
<th>Medication</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| Buprenorphine    | • Quick stabilization of withdrawal  
                  • May also treat concomitant pain                     | • Possible overdose risk with concomitant alcohol use       |
| Methadone        | • Quick stabilization of withdrawal  
                  • May be more effective to treat concomitant pain        | • Possible overdose risk with concomitant alcohol use       |
| XR-Naltrexone    | • Will treat concomitant alcohol use disorder  
                  • No risk of withdrawal if patient is incarcerated     | • More severe withdrawal  
                  • Delay in initiation of treatment                     |

*Ultimate choice of medication should be based on patient choice, but access to treatment program, insurance coverage, and medication access will also likely guide decision.*
More Information on Medication Treatments

https://store.samhsa.gov/

Medications for Opioid Use Disorder

Part 1: Introduction to Medications for Opioid Use Disorder Treatment
For healthcare and addiction professionals, policymakers, patients, and families

Part 2: Addressing Opioid Use Disorder in General Medical Settings
For healthcare professionals

Part 3: Pharmacotherapy for Opioid Use Disorder
For healthcare professionals

Part 4: Partnering Addiction Treatment Counselors With Clients and Healthcare Professionals
For healthcare and addiction professionals

Part 5: Resources Related to Medications for Opioid Use Disorder
For healthcare and addiction professionals, policymakers, patients, and families

References


Late-Breaking Research Oral Session at CPDD 79th Annual Scientific Meeting 2017. http://cpdd.org/meetings/2017-meeting-information/


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- Walsh, SL, Comer, SD, et al. (2017) Effect of Buprenorphine Weekly Depot (CAM2038) and Hydromorphone Blockade in Individuals With Opioid Use Disorder: A Randomized Clinical Trial. JAMA Psychiatry;74(9):894-902
PCSS Mentor Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medication-assisted treatment.

- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.

- No cost.

For more information visit: pcssNOW.org/clinical-coaching
Have a clinical question?

Ask a Colleague

A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now
PCSS-MAT is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with the: Addiction Technology Transfer Center (ATTC); American Academy of Family Physicians (AAFP); American Academy of Neurology (AAN); American Academy of Pain Medicine (AAPM); American Academy of Pediatrics (AAP); American College of Emergency Physicians (ACEP); 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 Psychiatric Nurses Association (APNA); American Society of Addiction Medicine (ASAM); American Society for Pain Management Nursing (ASPMN); Association for Medical Education and Research in Substance Abuse (AMERSA); International Nurses Society on Addictions (IntNSA); National Association of Community Health Centers (NACHC); National Association of Drug Court Professionals (NADCP), and the Southeast Consortium for Substance Abuse Training (SECSAT).

For more information: www.pcssNOW.org

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