



UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

THE UNSTABLE BUPRENORPHINE- NALOXONE PATIENT

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SPEAKER DISCLOSURES

- ✓ Any conflicts of interest-none

OBJECTIVES

1. To identify common complicating scenarios of an unstable Buprenorphine-Naloxone patient
2. Review evidence based responses to these clinical scenarios
3. Develop confidence in managing patients on Buprenorphine-Naloxone

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- Number of Participants with waiver: 21
- Reasons for not using Suboxone for Opioid Use disorders
 1. Lack of access for additional supportive treatment (9)
 2. Never trained in residency (8)
 3. Other (7)
 4. Clinic not supportive (6)
 5. Patients are hard to deal with (6)

HOW MANY BUPRENORPHINE-NALOXONE PATIENTS DO YOU MANAGE?

- 0
- 1-10
- 11-20
- 21-30
- >30

WHAT IS YOUR MOST COMMON “COMPLICATION” OF TREATING PATIENTS WITH BUPRENORPHINE-NALOXONE FOR OPIOID USE DISORDERS?

- On-going illicit use of opioids
- Other illicit drug use
- Co-occurring psych disorders
- Chronic pain
- Social chaos
- No-shows/early refills
- Diversion
- Others?

WHAT IS YOUR MOST CHALLENGING “COMPLICATION” OF TREATING PATIENTS WITH BUPRENORPHINE-NALOXONE FOR OPIOID USE DISORDERS?

- On-going illicit use of opioids
- Other illicit drug use
- Co-occurring psych disorders
- Chronic pain
- Social chaos
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- Others?

CASE 1

- 45yo M with Bipolar II on Bup-Nal 16mg qday x 4 months. Doing much better. Recent urine drug screen is showing high Buprenorphine and low Norbuprenorphine.
- Meds: Lamictal 200mg qday
- PMH: Bipolar II

WHAT IS YOUR RESPONSE?

- Everything looks ok
- I am guardedly optimistic about his progress
- I am guardedly pessimistic about his progress
- I am very concerned

CASE 1-WHAT IS GOING ON?

- 45yo M with Bipolar II on Bup-Nal 16mg qday x 4 months. Doing much better. Recent urine drug screen is showing high Buprenorphine and no Norbuprenorphine.

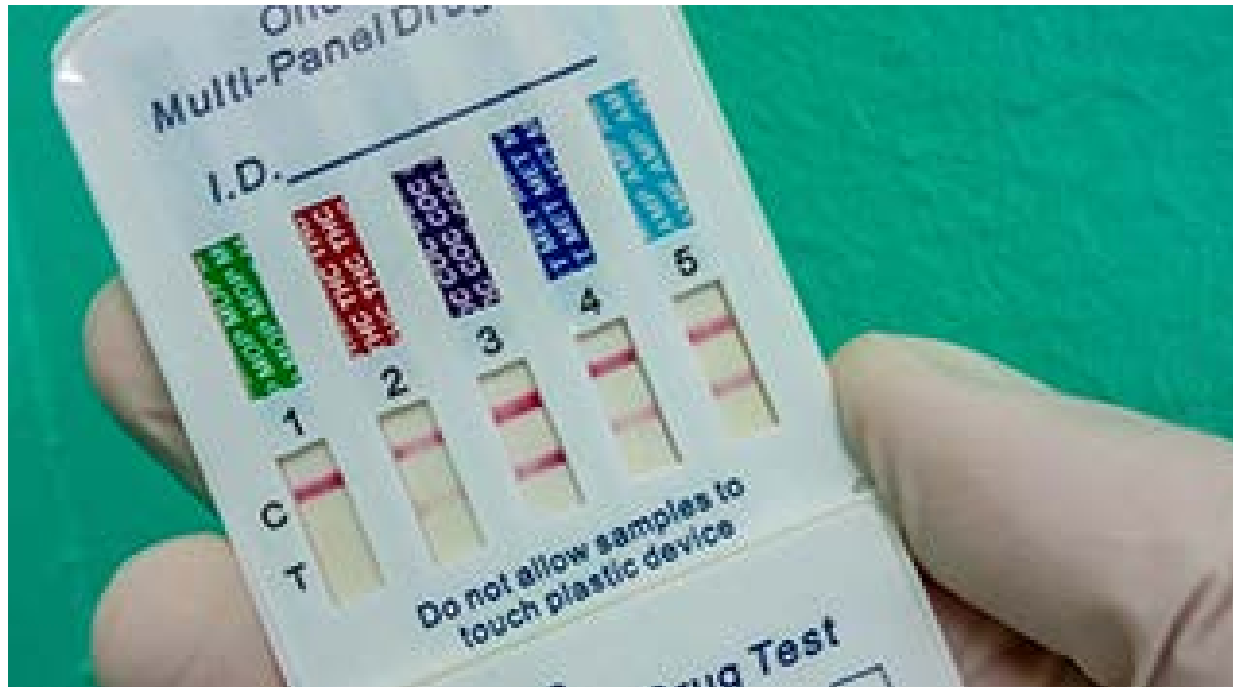
DO YOU USE A QUANTITATIVE URINE DRUG SCREEN REGULARLY?

- Yes
- No

WHAT TOOLS DO YOU HAVE TO USE ON UNSTABLE BUPRENORPHINE PATIENTS?

WHAT TOOLS DO YOU HAVE TO USE ON UNSTABLE BUPRENORPHINE PATIENTS?

- Dose adjustment
- Number of days Buprenorphine is dispensed
- Frequency of visits
- Increase in urine drug screens
- Change psychosocial intervention
- Pill counts
- Regular use of the PMP
- Treatment change
 - Higher level of care
 - Medication change
- Administrative taper



ON-GOING OPIOID USE

RED FLAGS



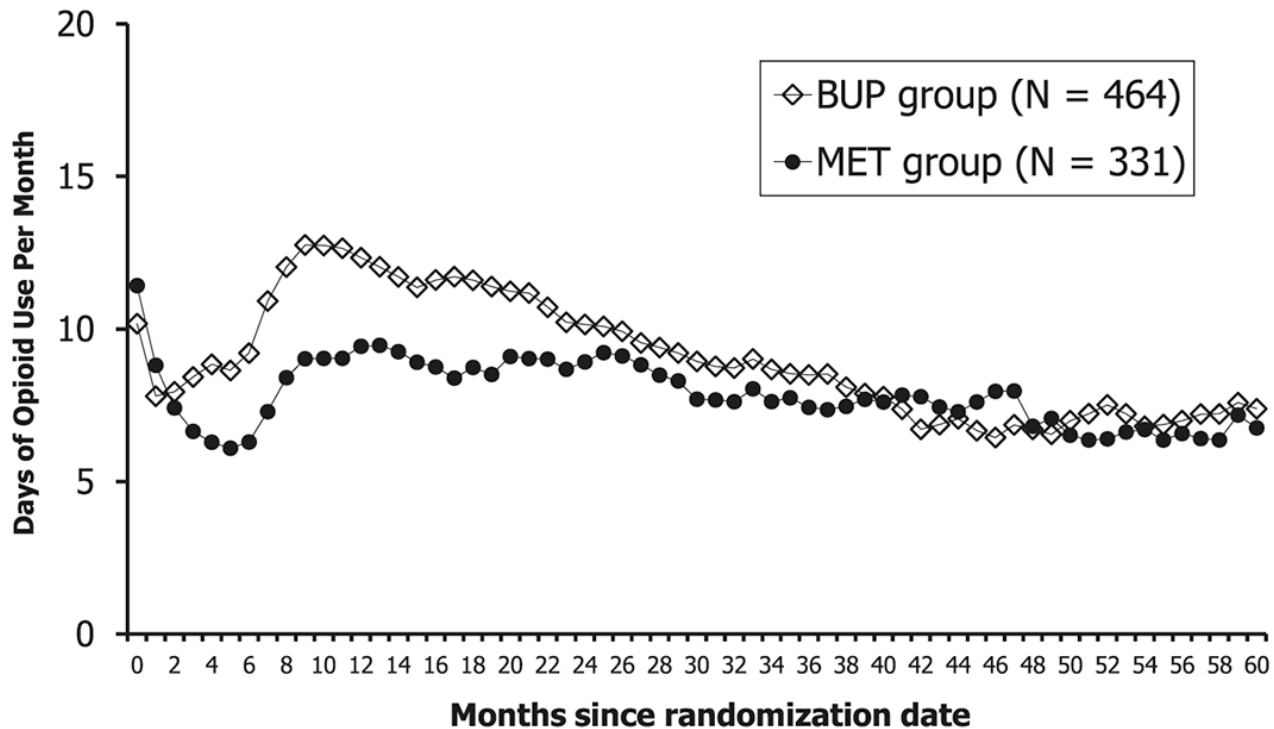
- Missing/cancelling appointments
- Patient tells you they have used
- + urine drug screens
 - Type of opioid use?
 - Cocaine use?
 - Benzodiazepines?

Relapse is common

Recovery is an ongoing process

LONG-TERM OUTCOMES AFTER RANDOMIZATION TO BUPRENORPHINE/NALOXONE VERSUS METHADONE IN A MULTI-SITE TRIAL

Days of Opioid Use by the Two Randomized Groups (N = 795)



CASE 1

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- Meds: Lamictal 200mg qday
- PMH: Bipolar II

WHAT NEXT STEP WOULD YOU TAKE?

- Determine why they are still using?
- Do more frequent urine drug screens
- Administrative taper
- Refer to methadone clinic
- Other

NEXT STEPS



- Evaluation → Why are they still using?
 - Iatrogenic?
 - “I want to be able to stop this med in a few months”
 - Cravings?
- Check the following:
 - Adherence to med (utox)
 - Dose of Buprenorphine
 - Pill count
 - Therapy, Mutual Help Group
 - Other?

DOSE AND STABILITY

- > 16mg
 - Less illicit use
 - Increased retention in treatment → less illicit opioid use
- Consider 16mg-24mg qday in patient's with
 - Long standing IV heroin use
 - Chronic pain

ONGOING TREATMENT AND STABILITY

- Maintenance treatment should be continued
 - Most patients will relapse within the first month
 - These populations have been found to be at particular high risk
 - Younger adults
 - Prescriptions opioid users
- Keep treating



POLY-PHARMACY/OTHER DRUGS

POLYDRUG USE (IN GENERAL)

- Associated with greater psychopathology
- Increased levels of risky behaviors
- Poor treatment engagement
- Worse outcomes

- Common in Opioid Use Disorder patients
 - Up to 70% lifetime
 - Cocaine (6-68%), Alcohol (25-49%), Cannabis (8-41%)

- Notable in opioid treatment: cocaine
 - Higher opioid use at baseline
 - Higher relapse rates

CASE 2

- 30yo F on Bup-Nal 12mg-4mg, who comes 2 times a month and has not missed any appointments, going to NA regularly, but urine drug screen is positive for amphetamines and benzos, but no opioids. Recently her drug screens are becoming consistently more positive. She admits to use and says she will stop.

WHAT WOULD YOU DO NEXT?

- Continue Buprenorphine-Naloxone treatment and further evaluate
- Administrative taper and further evaluate
- Refer to Methadone clinic
- Drop her dose and increase frequency of visits

NEXT STEPS



- Evaluation → Why are they using it?
 - Psychiatric issue?
 - Another substance use disorder?
 - Opioid disorder not adequately treated?
- “I am treating her opioid use disorder and she is doing well with that.”

REDUCING POLY-SUBSTANCE USE

- Continue treating with Buprenorphine
 - Dose change?
 - Pill counts
- Increase frequency of visits, utox's
- Screen for mental illness and treat
- If continued use consider higher level of care
- Consider prescribing of all controlled substances

- Would you stop treatment because of the risk of OD on benzodiazepines and Buprenorphine?



A WORD ON CANNABIS AND BUPRENORPHINE

CANNABIS AND OPIOID MAT

- Common: 39-66%
- Impact on treatment outcomes → Mixed
 - Associated with non-medical opioid/heroin use
 - No impact, form of self-regulating
- Cannabis is addictive
- Case reports of cannabis + Bup vasospasm?



CLINIC GAMES, HEADACHES, AND SIGHS

HOW IMPORTANT STRICT SHOULD YOU BE IN YOUR TREATMENT REQUIREMENTS?

- Very strict-it is the only way patients can be helped
- Very strict-it is the only way I can keep my practice manageable
- Moderately strict
- Not strict

STRICT TREATMENT REQUIREMENTS?

- Patient compliance is often poor in addiction treatment centers
- Patient compliance in other chronic diseases not any better
- Patients can feel undermined → resentment
- One-size fits all problem

NEXT STEPS



- Evaluate → Why are they doing this?
 - Untreated psychiatric issue
 - Opioid disorder not adequately treated?
 - Are there too many treatment restrictions
- Continue treating
- Address issue
- Review clinic policy/treatment agreement
 - Stick with prescribing limits

CASE 3

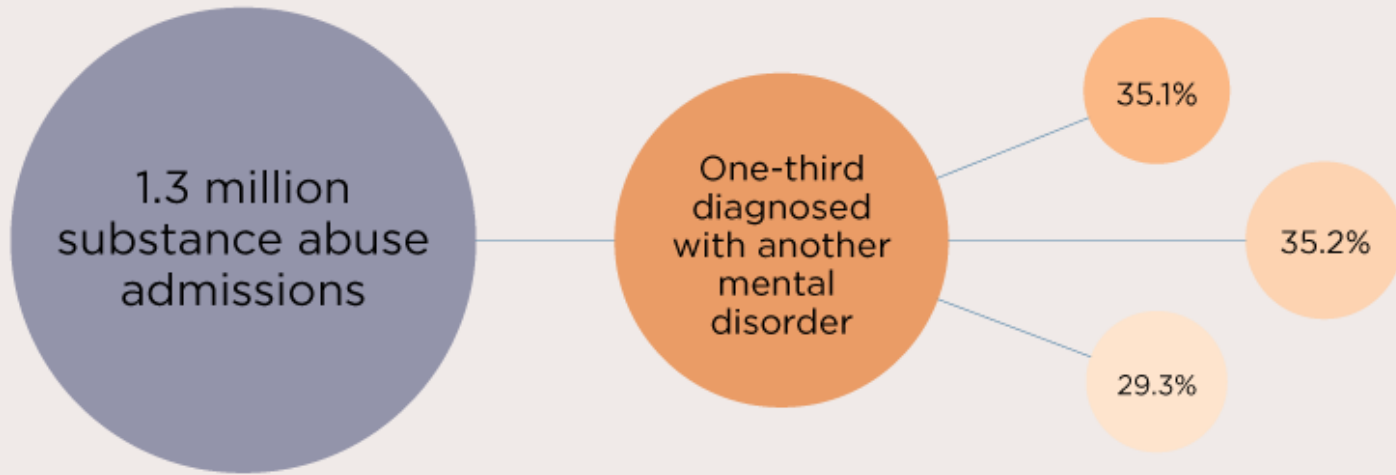
- 33yo M on Bup-Nal 8mg-2, he comes sporadically, working full time, relapsed 2 times in past 6 months. Was initially depressed and unemployed, but mood is much better. Has had 2 jobs over past year in sales. Gets in trouble around getting his paperwork done, will put it off and avoid it. He fights throughout your visits.

WHAT WOULD YOU DO NEXT?

- Increase his dose because he is likely relapsing
- Get a utox more regularly
- Screen for a psychiatric disorder
- Refer to methadone clinic
- Discontinue treatment

Co-Occurring Disorders in Drug Treatment Centers

- Abusing one drug
- Abusing two drugs
- Abusing three or more drugs



Source: SAMHSA 2012 TEDS Report

MentalHelp.net

CO-OCCURRING PSYCH DISORDERS

CO-OCCURRING PSYCH DISORDERS

- These are common
 - Lifetime rate of 47%
 - Current rates from 39-70%
 - Depression, Anxiety, Personality disorders
- Will impact treatment success

NEXT STEPS



- Screen for psychiatric disorders
 - Depression: PHQ9
 - Anxiety: GAD7
 - PTSD: PC-PTSD
 - ADHD: ASRS
- Treat them
 - Continue to treat opioid use disorder (will help mood)
 - Psychopharm (wait a week?)
 - Therapy
 - Enroll in collaborative care



CHRONIC PAIN

BUPRENORPHINE & PAIN PATIENTS

- Concerning behavior
 - Runs out early
 - Increasing use
 - Needing prns
 - PMP irregularities
 - Intoxicated presentation
 - Expresses worry about addiction
 - Strong preference for med
 - Concern about future availability
 - Opioids are the only option
- Difficult to engage around addiction issues
- Consider split dosing
- May help with patients on high dose opioids
- Not a panacea, but...

ENCOURAGING ENGAGEMENT

- Focus on patient's goals
 - Housing
 - Personal life
 - Work
- Use as a form of measurement based care

MINIMIZING INSTABILITY

- Know your comfort level
 - i.e. Poly drug use is going to be harder to treat
 - Expect relapses
- See weekly at the beginning
- Titrate faster
- Understand patient goals
- Involve social support early-family, partner

SUMMARY

- Hang in there with patients-expect a relapse
- Patients do better at higher doses
- Treat co-occurring psychiatric disorders
- Don't discontinue treatment
- Work with patient's on life goals
- Shared decision making
- Not a good fit? → help with transfer to new treatment center
- Get ongoing support → UW PACC!



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Psychiatry and Addictions Case Conference

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Psychiatry and Addictions Case Conference (UW PACC)

Thursday, September 29, 12:00 PM - 1:30 PM PST

Alcohol Use Disorders and Harm Reduction

Speaker: [Susan E. Collins, PhD](#)

Panelists: [Mark Duncan, MD](#), [Richard Ries, MD](#)

[Session Agenda](#)

[Save to My Outlook Calendar](#)

UW PACC is sponsored by the UW Integrated Care Program (ICTP), funded and supported by the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout the State of Washington.

[Schedule of Upcoming Presentations](#)



Strength of Model: Clinical Support

FEEDBACK

- “Our office has been unanimously impressed by the applicable and information-rich lectures. The guidance provided by your group will be invaluable in our area.”
- “For instance, through the PACC program I have already had a chance to meet my counterparts in Port Angeles and Port Townsend, which means I already have some opportunities to arrange continuity of care for some of my rapidly migrating working class clients.”

CASE

27yo M presented looking for treatment of a prescription opioid use disorder.

PMH:

Anxiety

ADHD

Meds:

Adderall

Substance Use History:

Cannabis: x years, daily

Benzodiazepines: Xanax 5/7 days