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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

# THE UNSTABLE BUPRENORPHINE-NALOXONE PATIENT


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## UNIVERSITY OF WASHINGTON


UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

# SPEAKER DISCLOSURES

- ✓ Any conflicts of interest-none

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# 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

# HOW MANY BUPRENORPHINE-NALOXONE PATIENTS DO YOU MANAGE?

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

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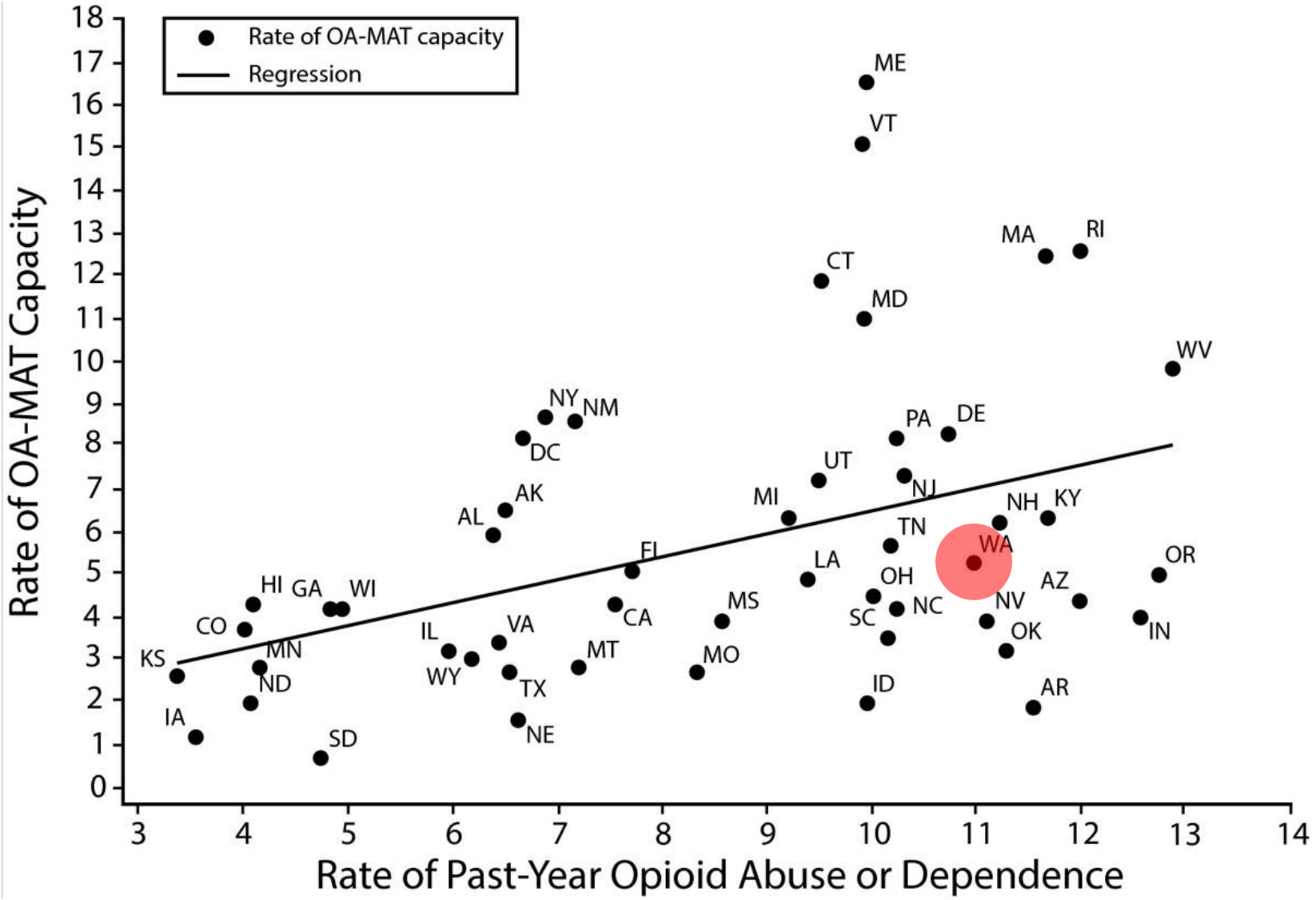


- 12th highest rate of past-year opioid abuse or dependence
- 22nd highest rate of OA-MAT capacity

Jones C, et al 2015

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# COMMON "COMPLICATIONS" OF TREATING PATIENTS WITH BUPRENORPHINE-NALOXONE FOR OPIOID USE DISORDERS?

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# COMMON "COMPLICATIONS" 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?

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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)

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

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# 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 pychosocial intervention
- Pill counts
- Regular use of the PMP
- Treatment change
  - Higher level of care
  - Medication change
- Administrative taper

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# 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

Anglin et al, 1997; Simpson et al, 1007; Hubbard et al, 1997; Mithcell et al, 2011

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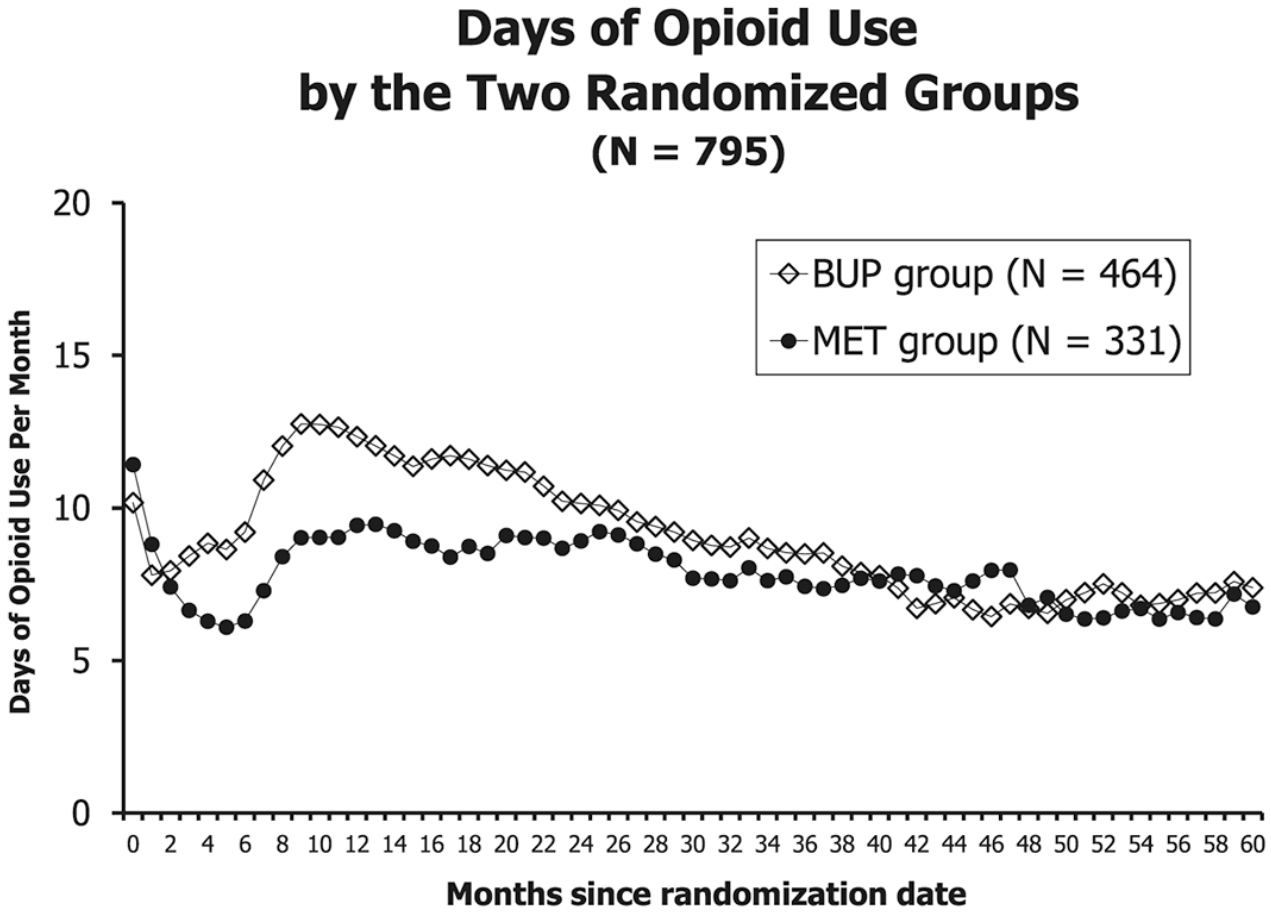
## LONG-TERM OUTCOMES AFTER RANDOMIZATION TO BUPRENORPHINE/NALOXONE VERSUS METHADONE IN A MULTI-SITE TRIAL




**Addiction**
Volume 111, Issue 4, pages 695-705, 13 JAN 2016 DOI: 10.1111/add.13238
http://onlinelibrary.wiley.com/doi/10.1111/add.13238/full#add13238-fig-0001

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# 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

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# 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

Comer S, et al, 2001; Fareed A, et al, 2012, Hser Y, et al, 2014

# 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

Bentzley BS et al, 2015

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# POLY-PHARMACY/OTHER DRUGS

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# 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

Booth BM et al, 2006; Sumnall HR et al, 2004; Patterson TL et al, 2005; John D et al, 2001; Bovasso G et al, 2001; Williamson A et al, 2015, Hser YI et al, 2016; Savant et al, 2013

# NEXT STEPS

- Evaluation→Why are they using it?
  - Psychiatric issue?
  - Another substance use disorder?
  - Opioid disorder not adequately treated?

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# REDUCING POLY-SUBSTANCE USE

- Continue treating with Buprenorphine
  - Increase dose?
- 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

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# A WORD ON CANNABIS AND BUPRENORPHINE

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# 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?

Wasserman et al, 1998; Balhara et al, 2014; Roux et al, 2011

# CLINIC GAMES, HEADACHES, AND SIGHS

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# 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

Bentzley BS et al, 2015; Coviello et al, 2006; McLellan et al, 2000

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# 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

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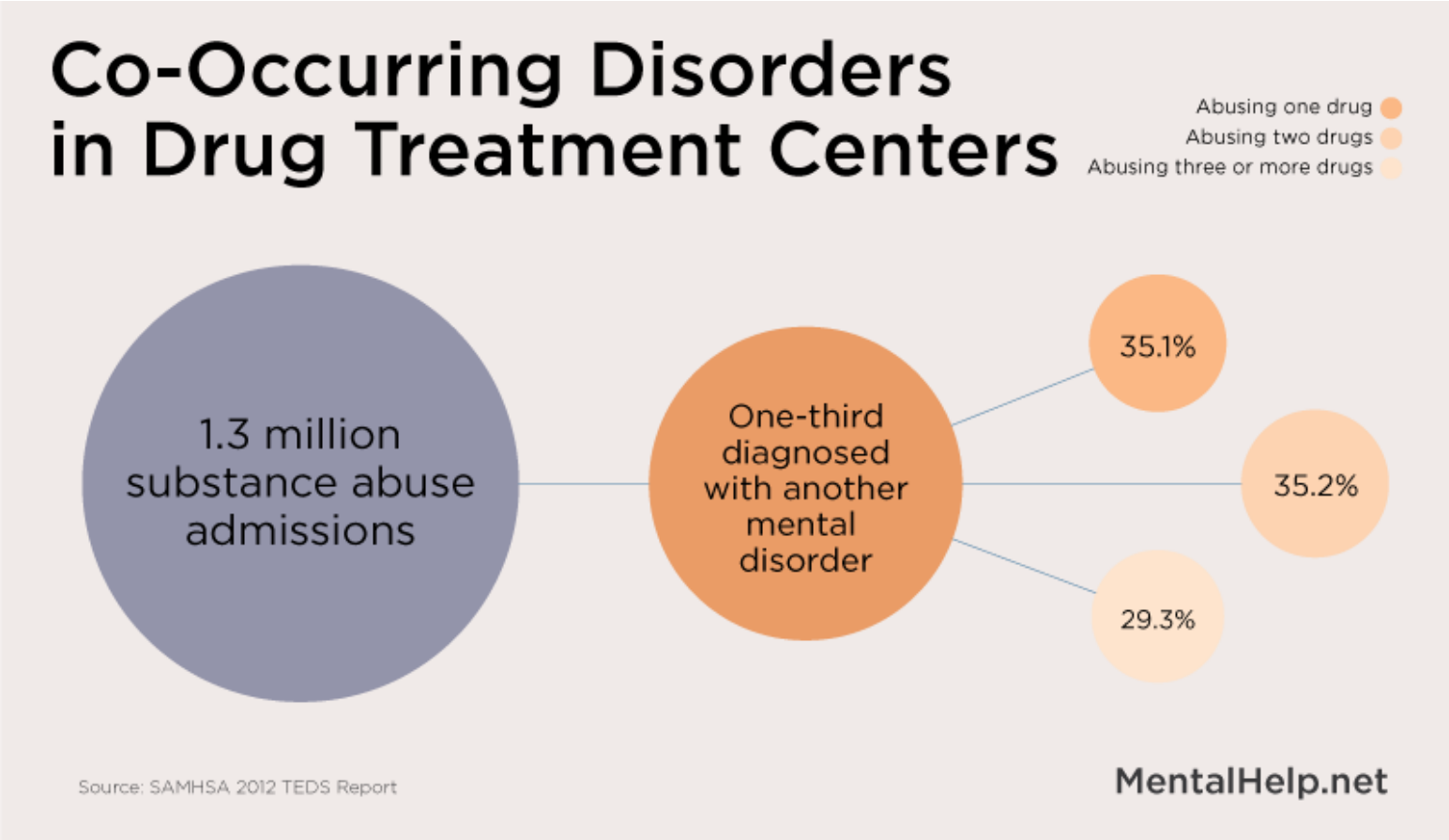


# CO-OCCURRING PSYCH DISORDERS

# CO-OCCURRING PSYCH DISORDERS

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

- Will impact treatment success

Savant et al, 2013; Brooner et al, 1997; Rounsaville et al, 1982

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# NEXT STEPS

- Screen for psychiatric disorders
  - Depression: PHQ9
  - Anxiety: GAD7
  - PTSD: PC-PTSD

- Treat them
  - Continue to treat opioid use disorder (will help mood)
  - Psychopharm (wait a week?)
  - Therapy
  - Enroll in collaborative care

Savant et al, 2013; Prins et al, 2003

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# CHRONIC PAIN

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# 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...

Daitch D, et al 2014

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# ENCOURAGING ENGAGEMENT

- Focus on patient's goals
  - Housing
  - Personal life
  - Work

- Use as a form of measurement based care

Ling et al, 2012; Mitchell et al, 2011

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# 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

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# 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

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# 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

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