



UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

SHARED MEDICAL DECISION MAKING IN OUD TREATMENT

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SPEAKER DISCLOSURES

- ✓ Any conflicts of interest-none

OBJECTIVES

1. Describe utility of shared decision making in clinical medicine
2. Identify common challenges to starting MOUD
3. Discuss strategies to assist patients and providers to address these challenges

Case

- 42yo M with OUD, confirmed diagnosis of severe Social Anxiety Disorder, and possible GAD.
 - Taking to 2mg of Clonazepam BID x 4 years from illicit benzos, confirmed by wife and PCP. PCP confirms the patient has tried multiple antidepressants over the years the patient has been working with him.
 - He presents for OUD treatment and is now on Buprenorphine-Nal 24mg. He asks if you would prescribe him Clonazepam.
- **What would you do?**
 - A. Take on prescribing of Clonazepam
 - B. Start a Clonazepam taper
 - C. Send him to detox
 - D. Retry an SSRI/SNRI
 - E. Refer to therapy for anxiety

WHAT IS SHARED DECISION MAKING IN CLINICAL PRACTICE?

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- An approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options to achieve informed preferences.

Effects of SDM

- Improves (when pt perceived)
 - Patient satisfaction, reduces decisional conflict
- Uncertain
 - Impact on downstream patient outcomes not established

Marshall T, Kinnard EN, Hancock M, et al. Patient engagement, treatment preferences and shared decision-making in the treatment of opioid use disorder in adults: a scoping review protocol. *BMJ Open*. 2018;8(10):e022267. Published 2018 Oct 17.

doi:10.1136/bmjopen-2018-022267

Shay LA, Lafata JE. Where is the evidence? A systematic review of shared decision making and patient outcomes. *Med Decis Making*. 2015;35(1):114-131. doi:10.1177/0272989X14551638

SDM AND OUD TREATMENT

- 14 studies
- Targets for SDM
 - Methadone dose
 - Home vs office Bup induction
 - Counseling
 - Inpatient or outpatient w/d program

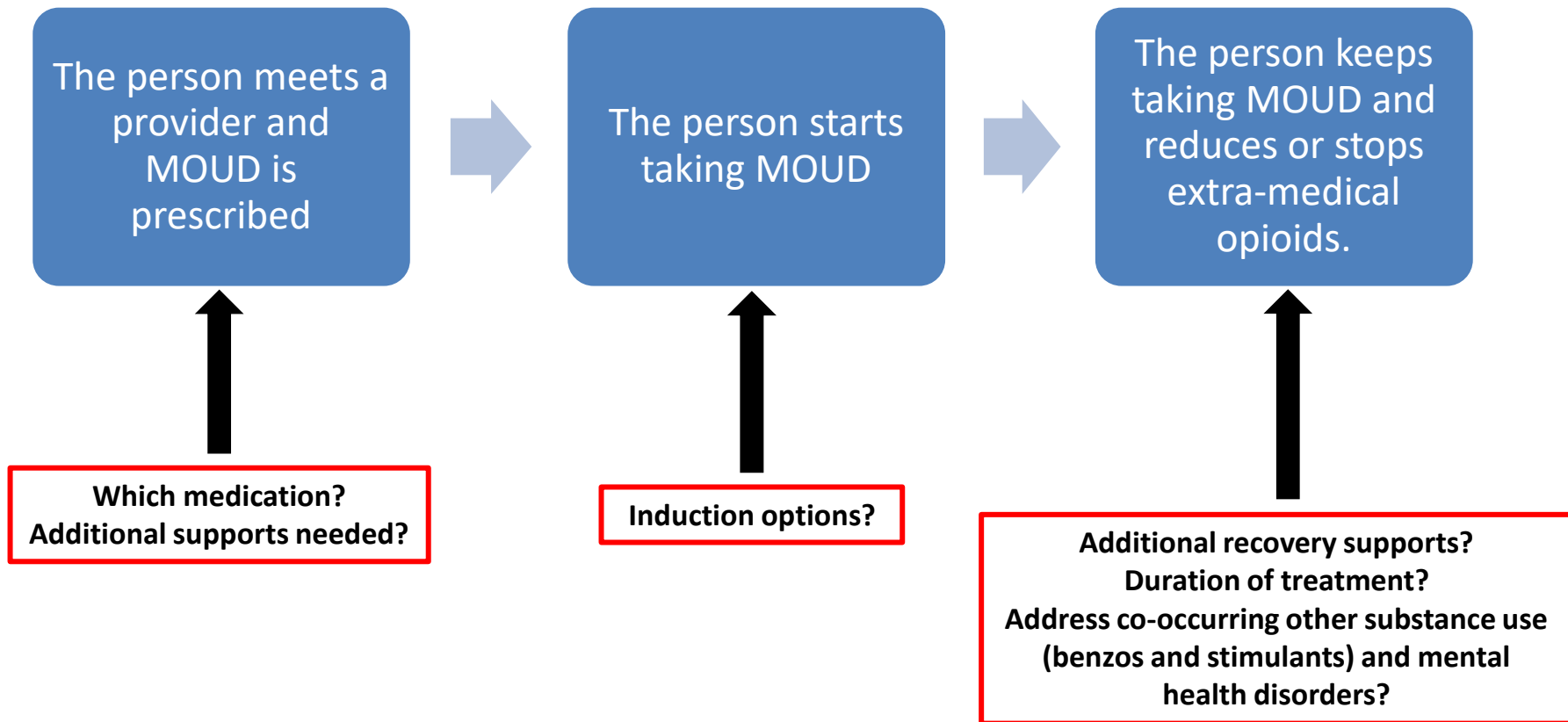
RESULTS OF 14 SDM FOR OUD

- SDM is feasible and acceptable
- Patient guided methadone dosing remained reasonable, perceived adequate
- Home or office inductions had similar outcomes
- Patient satisfaction increased

- Limitations
 - Quality of SDM unclear (no validated tool used)
 - Health outcomes not well tracked

WHAT ARE SOME SHARD DECISION POINTS IN OUD TREATMENT?

MOUD *Decisions Points*



WHICH MEDICATION

- How do you talk about this?
- How are people choosing which medication to try?
- Do you use a decision aid when talking about the different options?

LEARN ABOUT TREATMENT

for you, your family member or friend, or your community

ABOUT US

GET STARTED



Treatment Options

This section provides information about the treatments for opioid use disorder and stimulant use disorder. Learn more about these options and what might work for you.



For Professionals

This section features resources, tools, and information for professionals who work with people who have opioid or stimulant use disorder.



For Family/Friends

This page provides information and tools to help you better understand opioid or stimulant use disorder and how you can support someone you care about.



Decisions in Recovery: Treatment for Opioid Use Disorder

Handbook



<https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4993.pdf>

CASE: BUPRENORPHINE INDUCTION

- 59 year old woman using opioids for 6 years, heroin & fentanyl
- Had been on buprenorphine previously, about 3 months
 - Difficulty getting started with previous method of waiting for w/d
 - Difficulty staying on buprenorphine
 - Continued extra-medical opioid use
- Read about “Bernese Method” online and wants to try it

HOW TO START BUPRENORPHINE

- How do you talk about this?
 - What options for induction are you presenting?
 - Are there any expectations you are setting?
- How are people choosing what option to try?
- Do you use a decision aid when talking about the different options?

What is a realistic expectation for a successful Buprenorphine induction?

- A. 10%
- B. 33%
- C. 50%
- D. 67%
- E. 90%

Retrospective Population-based study out of BC, Canada 2008-2018

- Number of individuals: 45,608
- Number of MOUD treatment episodes from that group: 220,474
- Successful Inductions: < 60% for all meds
 - **59%** for methadone
 - **56.7%** for buprenorphine

36% of the induction attempts for Buprenorphine came on treatment attempt 6+

Treatment Retention

Medication	Median Episode Duration
Methadone	40 (9-183)
Buprenorphine	27 (7-84)

LOW DOSE EVIDENCE BASE

Emerging

- Rigorous evaluation of this technique is lacking
 - Many successful case series are from hospital settings
 - *Beware of sampling bias*
 - Range of dosing protocols being tried
 - Not sure who will benefit the most
- WA State community experience → Mixed

LOW DOSE START BEST PRACTICES

- Communicate expectations with the patient
 - Discomfort of withdrawal symptoms
 - Availability of support
 - “This may take a few attempts.”
- If it doesn't work the first time, don't lose hope
 - Continue to engage the patient
 - If the patient continues to respond to engagement there is a chance
- What else?

POTENTIAL DECISION POINTS TO DISCUSS WITH PATIENTS

- Inpatient vs Outpatient
- Induction dosing
 - What has or has not worked in the past and why?
 - Low dose?
 - Regular dose?
- Use of support medications?
- How soon to follow-up?
- Where to do it?
- How to connect if not going well?
- Others?

ADDITIONAL DECISION POINTS

- **Additional recovery supports?**
- **Duration of treatment?**
- **Address co-occurring other substance use (benzos and stimulants) and mental health disorders?**

BENZOS DETOX VS MAINTENANCE

- 2003, Israeli Methadone Clinic, N=66
 - All had documented benzo use disorder
- Clonazepam detox vs Clonazepam maintenance
 - Patient's choose which option
 - All started on 6mg total daily dose and then tapered off or down to maintenance dose (4-8 wks for maintenance dose)
 - Clonazepam given under daily supervision
 - Occasional misuse ok
- Failure
 - 2 daily benzo misuses above permitted dose
 - If continue to misuse → change modality of stop

DETOX VS MAINTENANCE

- 2003, Israeli Methadone Clinic, N=66
- Clonazepam detox vs Clonazepam maintenance

Mean maintenance dose: 2.64mg total daily dose

Co-occurring psych disorder: 64% (38%-mood, 32%-anxiety, 70% had personality disorder-antisocial most common)

Table 1. Success and failure rates of clonazepam detoxification (CDTX) and maintenance (CMT) at 2, 4, 6, 8, 10 and 12 months

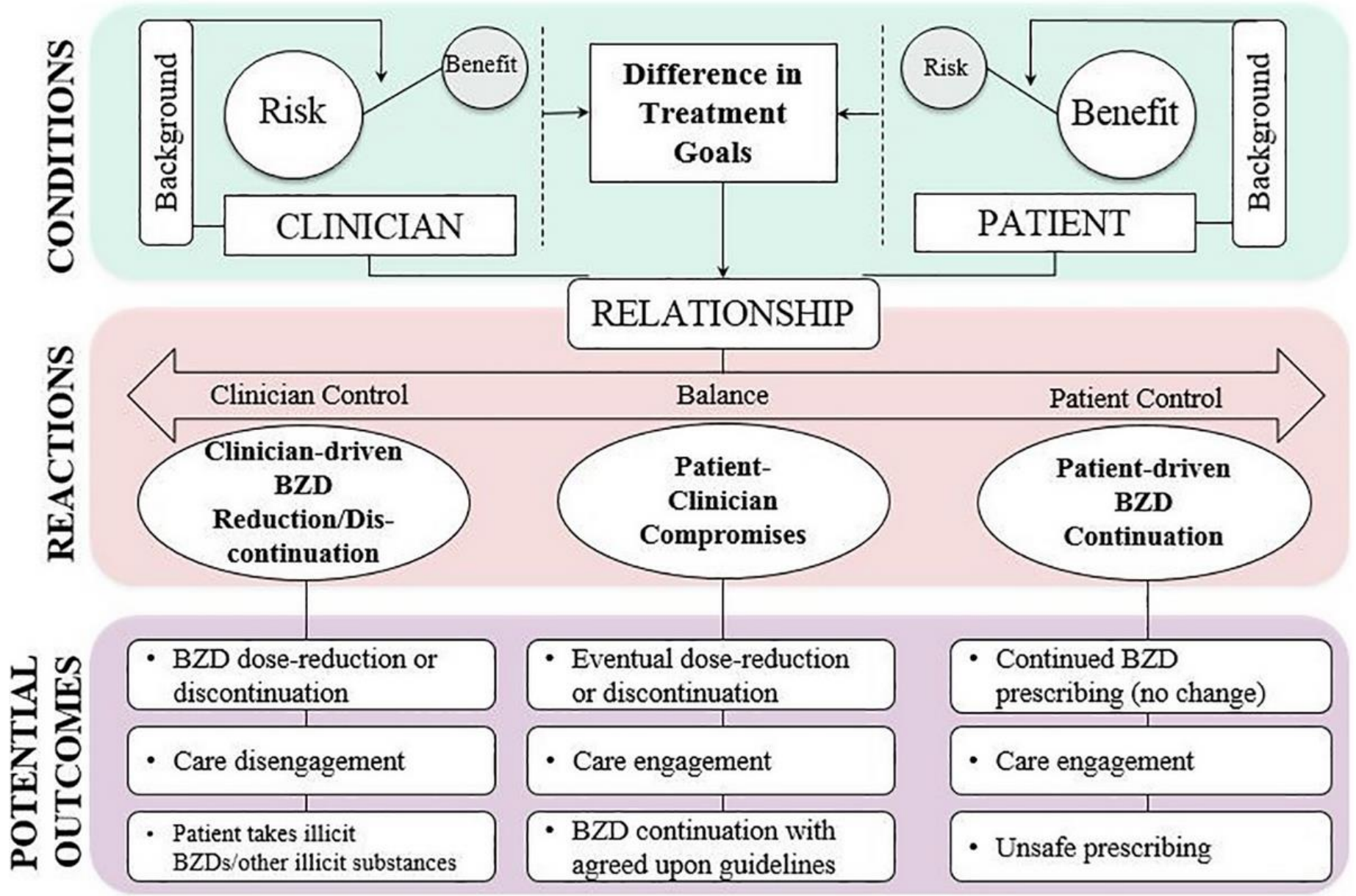
	2 months	4 months	6 months	8 months	10 months	12 months
CDTX	n = 33	n = 31	n = 30	n = 30	n = 29	n = 29
Success	9 (27.3%)	7 (22.6%)	5 (16.7%)	5 (16.7%)	4 (13.8%)	4 (13.8%)
Failure	24 (72.7%)	24 (77.4%)	25 (83.3%)	25 (83.3%)	25 (86.2%)	25 (86.2%)
CMT	n = 33	n = 33	n = 32	n = 29	n = 28	n = 26
Success	26 (78.8%)	25 (75.8%)	24 (75%)	20 (69%)	19 (65.5%)	17 (65.4%)
Failure	7 (22.2%)	8 (24.2%)	8 (25%)	9 (31%)	9 (34.5%)	9 (34.6%)

****CMT Success groups: had more mood and anxiety disorders****

****CDTX Success group: higher methadone doses****

“IT COULD BE DANGEROUS...”

- 26 semi-structured interviews with 26 MOUD patients and 10 MOUD providers.
 - N=9 Office based buprenorphine clinic; N=17 methadone clinic
 - Patients were using benzos at least 3 times a week
- Results
 - Patients focus on benefits (reduce anxiety) over risks (overuse, loss of control, sleep all day)
 - Patients can learn to use benzos safely (as people stabilize in MOUD they use benzos more safely and appropriately)
 - Clinicians prioritized risks of benzos over benefits → different tx goals/outcomes
 - **Compromise can balance differences**



SUMMARY

- There are many decision points in MOUD to consider.
- Individualized treatment is typically needed.
- Shared decision making can help with:
 - Individualizing care
 - Aligning treatment goals
 - Clarify expectations
 - Improve satisfaction
 - Improve outcomes (?)