



OPIOID USE DISORDER

FIRST STEPS

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REMINDER OF ECHO PURPOSE

- Supportive and collaborative learning network with community clinicians and University of Utah specialists
- Use technology to leverage resources
- Case-based learning
- Share Best Practice
- Bilateral feedback

SO.....FIRST A CASE

- Case to discuss

SUMMARY OF POINTS LEARNED FROM CASE

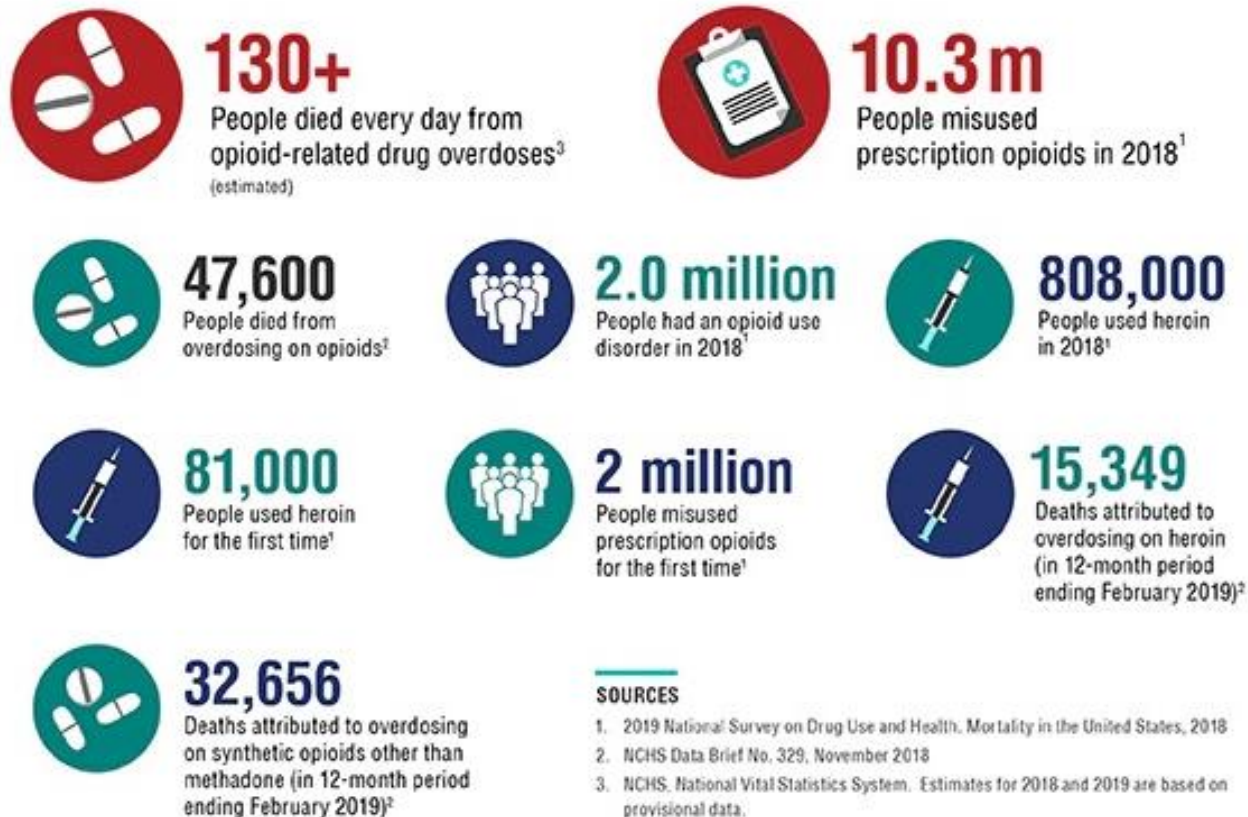
- Job #1 is to be there for the patient... where they “are”
 - What you want may not be what they want
 - If you scare them away...you cannot help
- Screen your patients to identify both celebrating success and to identify opportunities where you can provide further support
- Ask appropriate questions
- Be patient
- What else?

THINGS I HEAR FROM GOOD CLINICIANS

“IT IS NOT A PROBLEM IN MY PRACTICE”

- Maybe...or possibly you are not looking or patients don't feel comfortable sharing

THE OPIOID EPIDEMIC BY THE NUMBERS



<https://www.hhs.gov/opioids/about-the-epidemic/index.html>

HHS.GOV/OPIOIDS

“NOT IN MY PRACTICE...I CAN TELL WHO IS AN ADDICT”

- Without using a standardized tool, maybe not as well as you think
- Typical patient encounters identifies less than structured screening (Wilson2004)
 - 14% with serious problems
 - 0% with dependence
- Face-to-face structured screening identifies less than anonymous screening (Gryczynski2019)
 - 33% with previous year use
 - 23% with substance use disorder

Wilson CR, Sherritt L, Gates E, Knight JR. Are clinical impressions of adolescent substance use accurate? *Pediatrics*. 2004 Nov;114(5):e536-40. DOI: 10.1542/peds.2004-0098

Disclosure of Adolescent Substance Use in Primary Care: Comparison of Routine Clinical Screening and Anonymous Research Interviews
Jan Gryczynski, et al, *Journal of adolescent health* *Journal of Adolescent Health* 000 (2018) 1–3

“IS CALLING THEM ADDICTS...OK?”

- Is that welcoming and does it demonstrate support?
- The Use of “People-First Language”
 - Highlight that an individual’s condition is only one aspect of who they are
 - **Not** – “alcoholics,” “addicts,” and even the more generic “users”
 - **Try** - “person with a cocaine use disorder,” “adolescent with an addiction,” or “individuals engaged in risky use of substances,”

Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response.
Broyles LM1, Binswanger IA, Jenkins JA, Finnell DS, Faseru B, Cavaiola A, Pugatch M, Gordon AJ.
Subst Abus. 2014;35(3):217-21. DOI: 10.1080/08897077.2014.930372

“IS CALLING THEM ADDICTS...OK?”

- The Use of Language That Reflects the Medical Nature of Substance Use Disorders and Treatment
 - Not referring to individuals’ moral failings or lifestyle choices
 - Try acknowledging the myriad of physiological, genetic, psychological and sociocultural factors that contribute to SUD

Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response.
Broyles LM1, Binswanger IA, Jenkins JA, Finnell DS, Faseru B, Cavaiola A, Pugatch M, Gordon AJ.
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“IS CALLING THEM ADDICTS...OK?”

- The Use of Language That Promotes Recovery
 - Recognizes the person’s agency, choice, and preferences in the recovery process, even when differs from the professional’s recommendations
 - **DON’T** - adjectives such as “noncompliant,” “unmotivated,” or “resistant” can subtly reinforce paternalistic models of health care.
 - **DO** - “not in agreement with the treatment plan,” “opted not to,” “has not begun,” and “experiencing ambivalence about change”

Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response.
Broyles LM1, Binswanger IA, Jenkins JA, Finnell DS, Faseru B, Cavaiola A, Pugatch M, Gordon AJ.
Subst Abus. 2014;35(3):217-21. DOI: 10.1080/08897077.2014.930372

“SOME ARE EASY TO ID...ADDICTED BABIES”

- Babies cannot be “addicted”
- If babies cannot be addicted...what is addiction?

CHARACTERISTICS OF ADDICTION – DSM5

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use substance
5. Repeatedly unable to carry out major obligations at work, school, or home due to substance use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by substance use
7. Stopping or reducing important social, occupational, or recreational activities due to substance use
8. Recurrent use of the substance in physically hazardous situations
9. Consistent use of the substance despite acknowledgment of persistent or recurrent physical or psychological difficulties from using substances
10. Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. In older adults: use of less but achieving the same effect (Does not apply for diminished effect when used appropriately under medical supervision).
11. Withdrawal: development of a characteristic syndrome due to cessation of or reduction in heavy and prolonged use, or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision).

Scoring of SUD:

Mild = 2-3 criteria

Moderate = 4-5

Severe = 6-7

CHARACTERISTICS OF ADDICTION – BASICS

- Loss of consistent control over use
- Continued use in the face of adverse consequences
- Compulsivity
- Craving
- Distortions in thinking (denial, minimization, rationalization)

- **Look for these features when taking a substance use history**

- **So...babies cannot be addicted, they can be dependent**

“AREN’T THERE JUST ADDICTIVE PEOPLE”

- **Genetic**
 - 40 to 60% of the vulnerability for addiction is genetic
- **Multifactorial**
 - Drug self-administration
 - Alcohol intoxication responses
 - Alcohol withdrawal responses
 - Frontal theta oscillations
 - Interference with drug metabolism
 - And many others
- **Earlier first use of drugs/ alcohol increases risk**
 - Environmental factors
 - Low socioeconomic class
 - Poor parental support
 - Within-peer group deviancy
 - Drug availability
 - Stress (including abuse and trauma)
 - Social isolation in adolescence
- **Co-occurring psychiatric disorders**
 - 30%(+) of people with psychiatric disorders have substance use disorders
 - More risk for suicidal symptoms and completed suicide
 - Increased risk for psychosis
 - Drug use/SUDs can lead to psychiatric disorders
 - Psychiatric disorders can lead to drug use/SUDs

“BY THE TIME I SEE THEM THEY ARE TOO GONE”

- At any stage of Substance Use Disorder you can help
- Understand the progression of substance use disorder
- Screen everyone so you can recognize people at a lower severity that you feel comfortable

“WHAT IS THE PROGRESSION OF SUD?”

- Experimentation
 - Euphoria / positive reinforcement (no negative consequences)
- Neuroadaptation
 - Tolerance, increased use
- Increased use
 - Withdrawal / negative reinforcement
- Loss of control - with negative consequences
 - Imbalance in the brain reward/conditioning circuits vs. executive functioning

READINESS FOR CHANGE

- Precontemplation stage
 - Not currently considering change
- Contemplation
 - Undertakes a serious evaluation of considerations for or against change
- Preparation
 - Planning and commitment are secured
- Action
 - Specific behavioral change
- Maintenance
 - Works to maintain and sustain long-term change

DiClemente, C.C. and Prochaska, J.O. (1998) Toward a comprehensive, Transtheoretical model of change: Stages of change and addictive behaviors. In: Miller, W. R. and Heather, N., eds. Treating Addictive Behaviors. 2nd edition. New York: Plenum.

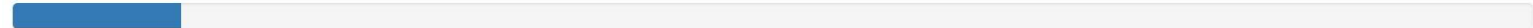
“IF EARLIER IS BETTER, HOW CAN I SCREEN?”

- Use a standardized tool in a supportive workflow
- There are many tools

SCREENING – NIDA QUICKSCREEN

+ NIDA Drug Screening Tool NIDA-Modified ASSIST (NM ASSIST)

Clinician's Screening Tool for Drug Use in General Medical Settings*



In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)				
<input checked="" type="radio"/> Never	<input type="radio"/> Once or Twice	<input type="radio"/> Monthly	<input type="radio"/> Weekly	<input type="radio"/> Daily or Almost Daily
Tobacco Products				
<input checked="" type="radio"/> Never	<input type="radio"/> Once or Twice	<input type="radio"/> Monthly	<input type="radio"/> Weekly	<input type="radio"/> Daily or Almost Daily
Prescription Drugs for Non-Medical Reasons				
<input checked="" type="radio"/> Never	<input type="radio"/> Once or Twice	<input type="radio"/> Monthly	<input type="radio"/> Weekly	<input type="radio"/> Daily or Almost Daily
Illegal Drugs				
<input checked="" type="radio"/> Never	<input type="radio"/> Once or Twice	<input type="radio"/> Monthly	<input type="radio"/> Weekly	<input type="radio"/> Daily or Almost Daily
<input type="button" value="PREVIOUS"/>		<input type="button" value="NEXT"/>		

What about legal Adult Use of cannabis?



*Note: This website collects no personally identifiable information and does not store your responses to any of the following questions.



National Institutes of Health – Turning Discovery into Health®

<https://www.drugabuse.gov/nmassist/>

SCREENING - NIDA

- Quick Screen
 - If NEVER responded to ALL questions
 - Give supportive feedback to reinforce abstinence
 - Screen is complete
 - Tobacco
 - Identifies at-risk use
 - Move to measures to support quitting
 - Binge Drinking
 - Identifies at-risk use
 - Follow measure as discussed in previous lecture
 - Illegal drugs/Prescription drugs for non-medical reasons
 - Proceed to NIDA-Modified ASSIST for further information

<https://www.drugabuse.gov/nmassist/>

SCREENING – NIDA ASSIST - DETAILS

Ask the following questions for each drug mentioned in Question 1:	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Q2. <i>In the past 3 months</i>, how often have you used (insert name of drug)?	0	2	3	4	6
If the answer to Question 2 is “never”, skip to Question 6. Otherwise, continue with Questions 3					
Q3. <i>In the past 3 months</i>, how often have you had a strong desire or urge to use (insert name of drug)?	0	3	4	5	6
Q4. <i>In the past 3 months</i>, how often has your use of (insert name of drug) led to health, social, legal or financial problems?	0	4	5	6	7
Q5. <i>In the past 3 months</i>, how often have you failed to do what was normally expected of you because of your use of (insert name of drug)?	0	5	6	7	8
Ask Questions 6 & 7 for all substances <i>ever used</i> (i.e., those mentioned in Question 1) :	NO	YES, but not in the last 3 months	YES, in the past three months		
Q6. Has a friend or relative or anyone else ever expressed concern about your use of (insert name of drug)?	0	3	6		
Q7. Have you ever tried and failed to control, cut down, or stop using (insert name of drug)?	0	3	6		
Instructions: Ask Question 8 if patient mentions ANY drug that might be injected, including those that might be listed in the ‘Other’ category (e.g., steroids). <u>Circle appropriate response.</u>					
Q8. Have you ever used any drug (including steroids) by injection? • Indicate you are referring to non-medical use only.	No, never	Yes, but not in the last 3 months	Yes, in the past 3 months		

<https://www.drugabuse.gov/nmassist/>

SCREENING – NIDA ASSIST - SCORING

- For each substance described as used in the previous 3 months
- Scores may be very different for different substances
- Use clinical judgement if poly-substance use with lower scores
- Scoring
 - Lower Risk (0-3)
 - Moderate Risk (4-26)
 - High Risk (>26)

<https://www.drugabuse.gov/nmassist/>

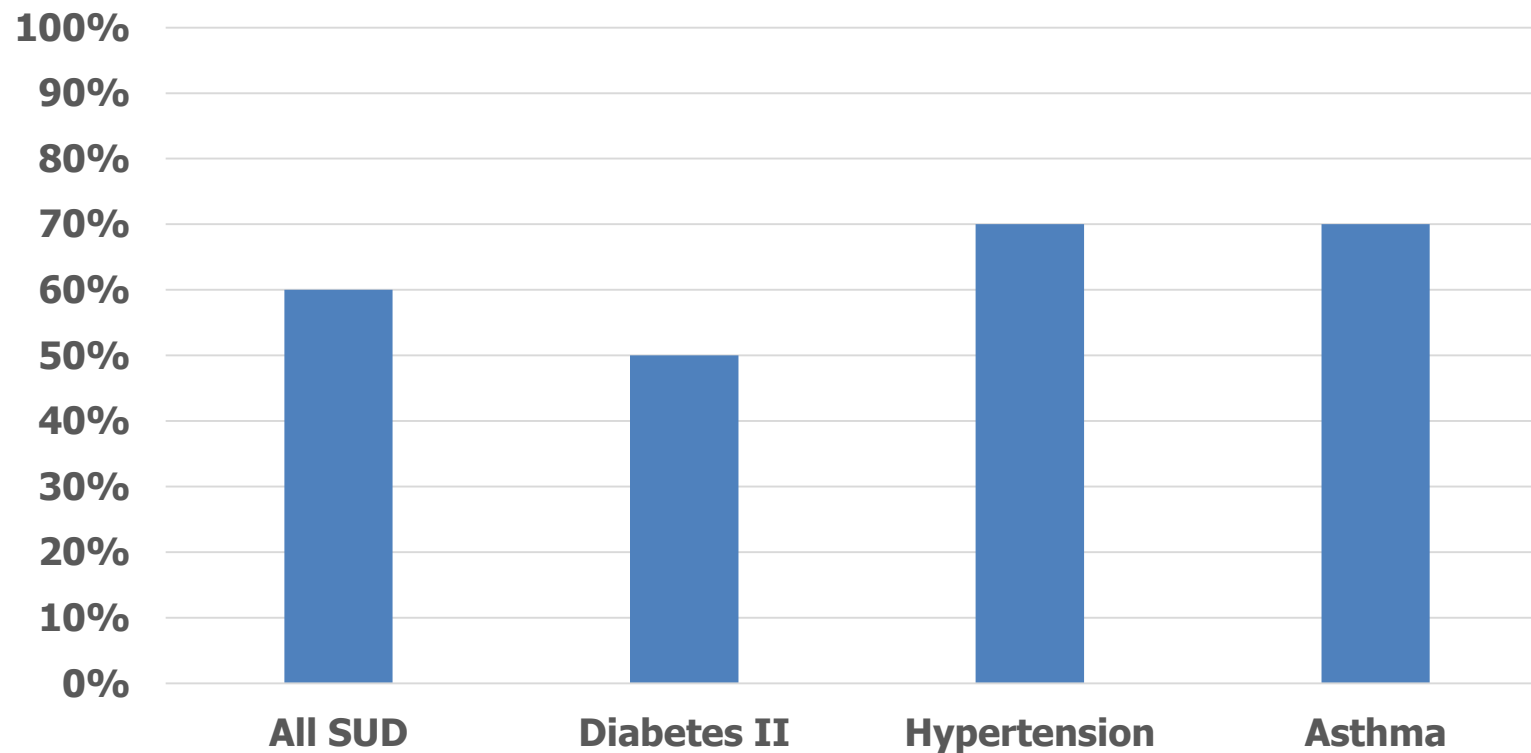
“SO I HAVE A SEVERITY SCORE...NOW WHAT”

- Scoring
 - Lower Risk (0-3)
 - Provide feedback on results
 - Reinforce Abstinence
 - Offer Continued Support
 - Moderate Risk (4-26)
 - Provide Feedback on results
 - Advise, Assess, and Assist (Provide services/care)
 - Consider referral based on clinical judgement
 - Offer continued support
 - High Risk (>26)
 - Provide Feedback on results
 - Advise, Assess, and Assist (Provide services/care)
 - Arrange Referral
 - Offer continued support

<https://www.drugabuse.gov/nmassist/>

“WHAT DOES IT MATTER, THEY JUST USE”

- Like other chronic diseases there are periods when people will return to use
- Other chronic diseases have frequent periods where patient's condition is not well controlled



McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation. *JAMA*. 2000;284(13):1689–1695. doi:10.1001/jama.284.13.1689

“THERE IS NO MEDICAL TREATMENT FOR OUD”

- There are a FDA approved researched medications
 - Methadone – Full agonist
 - Buprenorphine – Partial agonist
 - Naltrexone – Full antagonist

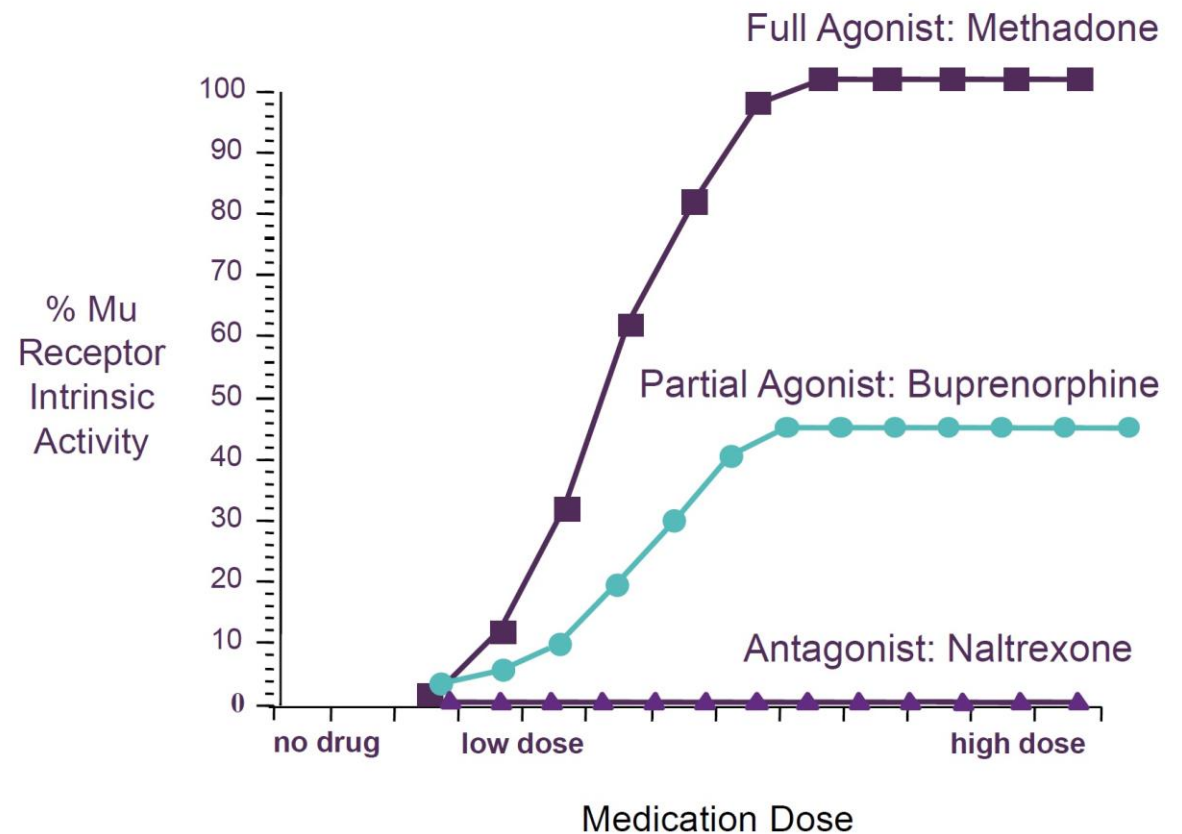
 - Full agonist, Partial agonist, Full antagonist...what is the difference?

<https://www.drugabuse.gov/nmassist/>

TREATMENT OPTIONS

- Affinity
 - Strength of receptor binding
- Activation
 - Effect on the receptor
- Dissociation
 - Disengagement from receptor

Opioid (μ) Receptor Activity for Medications treating Opioid Use Disorder



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

BUPRENORPHINE

- Available in multiple delivery systems
 - Mono product (Buprenorphine only)
 - Sublingual Tablets/Films (Buprenorphine/Naloxone)
 - Implant (Buprenorphine)
 - Depot Injections (Buprenorphine)

BUPRENORPHINE/NALOXONE

- First FDA approval in 2002 for OUD treatment
- Partial opioid agonist
- Transmucosal film or tablet
- 24mg Buprenorphine/day usually the highest effective dose
- Ceiling Effect with lower opioid overdose risk in adults
- Office based prescribing by MDs, DOs, PAs, or NPs with DEA waiver or “X license”

BUPRENORPHINE IMPLANT

- FDA approved in 2016
- Treatment of OUD in patients who have been clinically stabilized on transmucosal buprenorphine 8 mg/day or less.
- 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 DEPOT INJECTION

- 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 hours after injection
- Steady state achieved in 4 to 6 months
- After discontinuation, patients may have detectable plasma levels for 12 months or longer

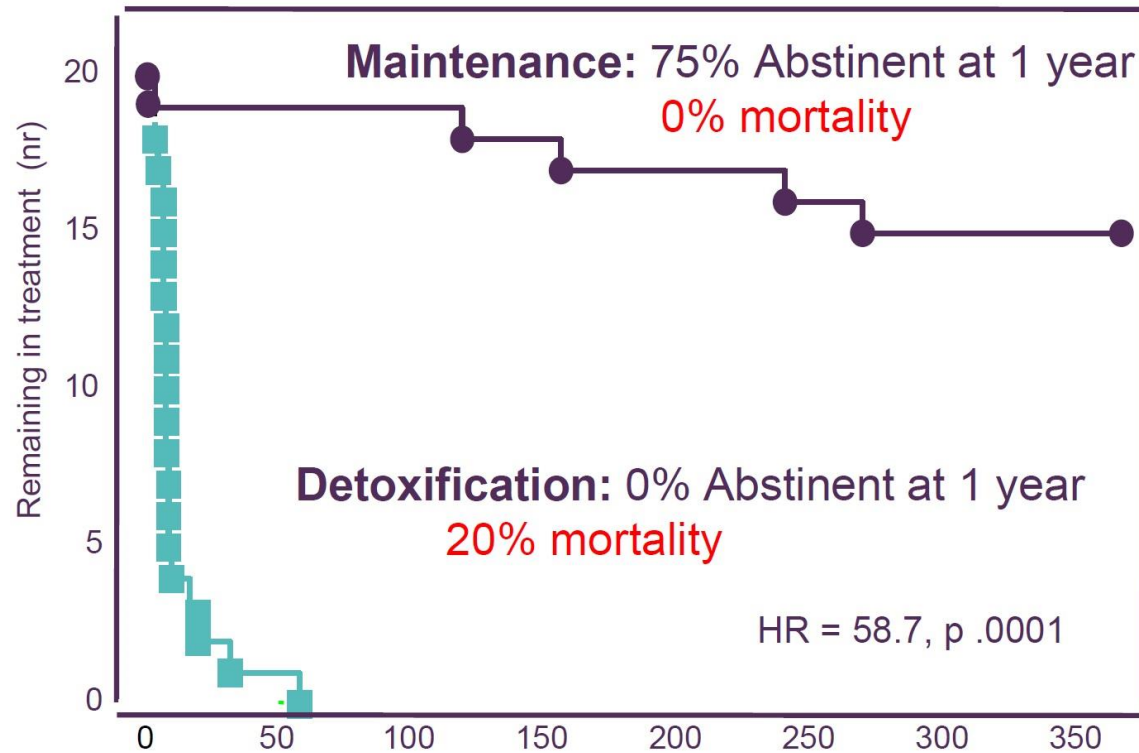
NALTREXONE

- Available in multiple delivery systems
 - Oral
 - Extended-Release Intramuscular Injection

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

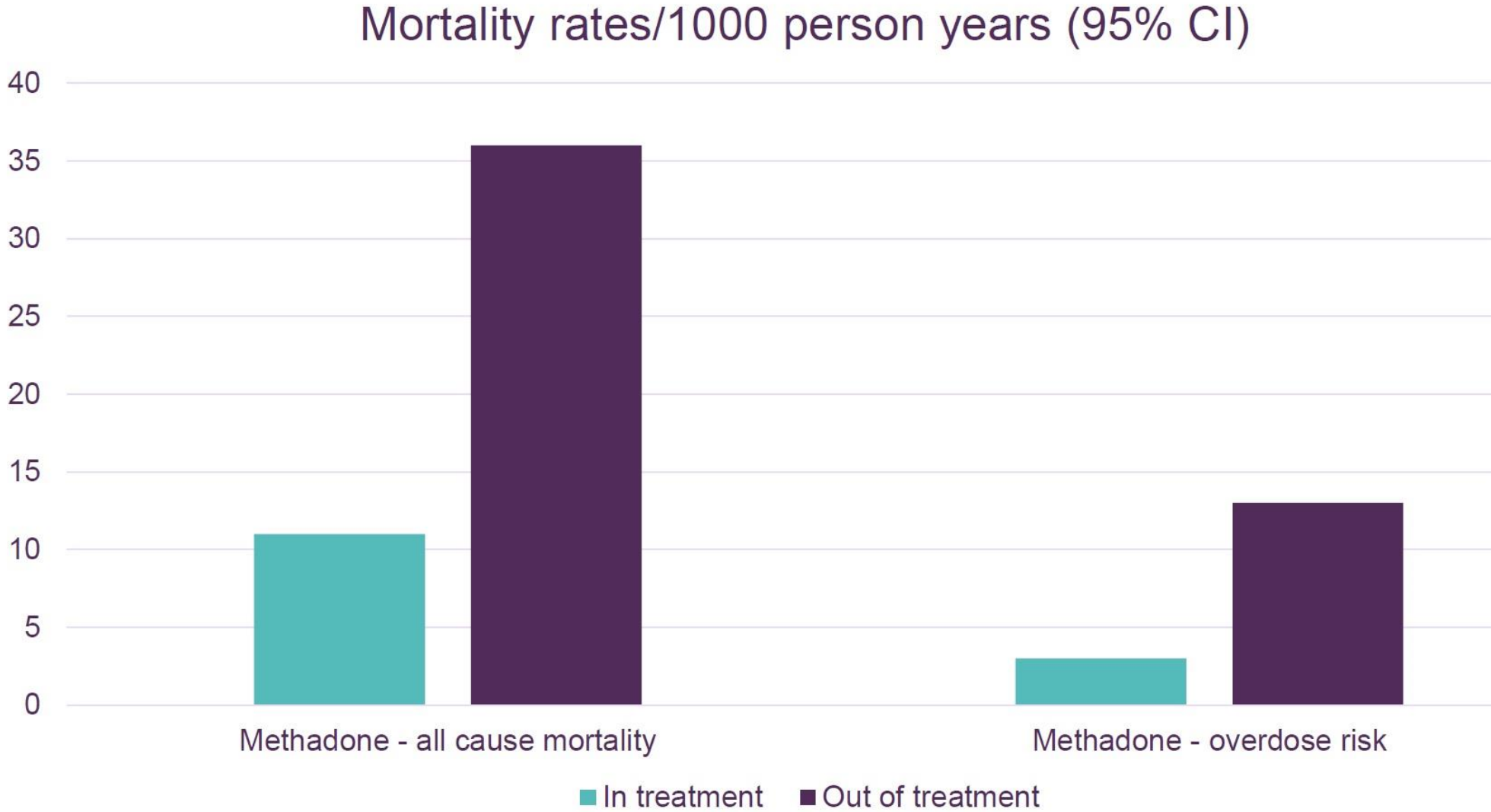
“CANT I JUST REFER FOR ACUTE DETOXX?”



- If you had a patient with severe asthma in the ED...would you treat them and send them home without maintenance medication?

Kakko, J, Svanborg, K, et al. (2003) 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomized, placebo controlled trial. *Lancet*, 361 (9358):662-8.

METHADONE



Sordo, et al. (2017) Mortality Risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ* 357:j1550

“I’M NO PSYCHIATRIST & CAN’T DO THERAPY”

- Combined psychosocial and agonist maintenance interventions for treatment of opioid dependence
 - No difference in outcomes
 - But studies had multiple issues including that the duration of the studies
 - Just do what you would do for any other chronic relapsing condition

Amato L et al. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. Cochrane Database of Systematic Reviews 2011 Issue 10. Art. No.: CD004147. DOI: 10.1002/14651858.CD004147.pub4.

WHAT CAN YOU DO TODAY?

- Minimize shame maximize openness/awareness in your setting
 - Words and actions
- Put in place standardized methods of universal screening
- Become aware of resources in and outside of your practice setting
- Identify patients that you are comfortable caring for and begin...and refer the ones you currently are not comfortable
- Within patients current wishes thoughtfully and supportably match to appropriate care
- Return to use is NOT a failure or a reason to discharge the patient from your care
- Harm Reduction
- Nothing changes until you change something...Send me an email today with what you plan on doing before Ground Hogs Day (February 2, 2020) and I will follow-up with you

SUBMIT A CASE

[Health Care Home](#) / [Project ECHO](#) /

BEHAVIORAL HEALTH

SUBMIT A CASE >

ON THIS PAGE

- [Offering Resources & Support in the Field of Behavioral Health](#)
- [Past Behavioral Health Sessions](#)
- [Clinical Team](#)
- [Behavioral Health Schedule](#)
- [Mental Health Forms & Checklists](#)

OFFERING RESOURCES & SUPPORT IN THE FIELD OF BEHAVIORAL HEALTH

Led by a robust team of psychiatric specialists from University Neuropsychiatric Institute, this program gives you the opportunity to present cases and learn best practices on the diagnosis and treatment of mental health disorders. Topics will cover commonly seen cases in primary care, including pharmacological and non-pharmacological treatments.

This program is currently on summer break through October 3, 2019. To register for the upcoming academic year (2019-2020), please visit: <https://www.surveymonkey.com/r/BHECHOay1920>.

Contact Us

Sarah Day
Program Coordinator
Phone: 801-587-2436
sarah.day@hsc.utah.edu

SESSION TIME
Weekly Thursdays
12:00-1:00 PM MST

SUBMIT A CASE

PROJECT ECHO

Resize font: [Returning?](#)

Behavioral Health ECHO case presentation form

Please fill out the following information as completely as possible. Some information is about you (contact information) and the rest is regarding the patient case you wish to present. After submitting your case, you will have the option to print/save a copy of your submission. Please email any questions to Christina Choate at christina.choate@hsc.utah.edu.

DO NOT INCLUDE ANY PATIENT PHI IN THIS FORM!

Page 1 of 1

Your first name: <small>* must provide value</small>	<input type="text"/>
Your last name: <small>* must provide value</small>	<input type="text"/>
Your professional credentials: <small>* must provide value</small>	<input type="checkbox"/> MD, DO <input type="checkbox"/> PhD <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Clinical Pharmacist <input type="checkbox"/> Student
Name of your hospital / clinic / school: <small>* must provide value</small>	<input type="text"/> <small>i.e. where do you work?</small>
Your email address: <small>* must provide value</small>	<input type="text"/>
Your phone number: <small>* must provide value</small>	<input type="text"/>
Date of case presentation: <small>* must provide value</small>	<input type="text"/> Today Y-M-D <small>Year-Month-Day</small>