ECHO Idaho: Opioid Addiction and Treatment

What's MAT got to do with it? Common Myths and Misconceptions
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Learning Objectives

• Review common myths and misconceptions
• Discuss best practices for office-based treatment of opioid use disorder with buprenorphine/naloxone
Common Myths & Misperceptions

1. I don’t want “those patients” in my waiting room.
2. Induction is too time consuming & difficult.
3. I don’t have behavioral health in my clinic, so I can’t start prescribing bupe.
4. Continued polysubstance use is a sign of treatment failure.
5. The goal should be the lowest possible dose, for the shortest possible time.
“Those Patients”
“Those Patients” → STIGMA

Stigma decreases access to care
Meth-head  User  Dirty
Crack-head  Addict  Clean
Abuser    Junkie
Druggie
Alcoholic  Abuse
“Those Patients” → \( \text{STIGMA} \)

Changing the Language of Addiction

Terms that stigmatize addiction can affect the perspective and behavior of patients, clients, scientists, and clinicians. Clinicians especially need to be aware of person-first language and avoid more stigmatizing terms.

**Terms Not to Use**
- addict, abuser, user, junkie, druggie
- alcoholic, drunk
- oxy-addict, meth-head
- ex-addict, former alcoholic
- clean/dirty (drug test)
- addictions, addictive disorders

**Terms to Use**
- person with a substance use disorder
- person with an alcohol use disorder
- person with an opioid use disorder
- person in recovery
- negative/positive result(s)
- addiction, substance use disorder

**ECHO IDAHO**
Inductions too difficult

try HOME inductions
Inductions too difficult →

Unpublished protocol, Cunningham et al, Montefiore Medical Center, Bronx, NY 2018
Inductions too difficult →

Figure 1. Treatment retention following home buprenorphine induction (N=103).
Don’t have behavioral health

• DATA Waiver requires the *ability* to refer
• Not all patients need behavioral health
• Many patients do well with medications alone
Don’t have behavioral health →

• Treatment plan needs to be tailored to the individual – and patients find behavioral support in many ways, as they do for other chronic diseases

Don’t have behavioral health →

**Figure 2.** Self-Reported Frequency of Illicit Opioid Use in Opioid-Dependent Patients Receiving Buprenorphine–Naloxone in Primary Care.

SMM1 denotes standard medical management and once-weekly medication dispensing, SMM3 standard medical management and thrice-weekly medication dispensing, and EMM3 enhanced medical management and thrice-weekly medication dispensing.

*Fiellin et al. NEJM 2006.*
Polysubstance use a failure?

• Continued polysubstance use often related to underdosing of buprenorphine
• Buprenorphine treats OUD, but not other SUD – patients can be successful in their treatment of OUD while continuing to use other substances
• ASAM National Practice Guideline recommends AGAINST suspending MAT because of polysubstance use

Polysubstance use a failure?

**FIGURE 1.** Buprenorphine treatment retention by baseline cocaine use.

**FIGURE 2.** Self-reported opioid use among participants who initiated buprenorphine treatment by baseline cocaine use.

Polysubstance use a failure? 

FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks.

This provides updated information to the FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines, requires its strongest warning issued on August 31, 2016.

Safety Announcement

[9-20-2017] Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these...
Lowest possible dose, shortest possible time?

• Buprenorphine is always going to be safer
• Goal dose where withdrawals and cravings controlled – for most patients around 16mg/day (FDA approved to 24mg/day)

Fiellin et al. JAMA Intern Med 2014; Martin et al. Annals 2018;
Lowest dose, shortest time? →

- Most patients will need long-term (life-long?) buprenorphine
- High failure rates with early discontinuation
- Increase in mortality off buprenorphine
- Most cessation related to discharge
- SAMHSA Tip 63: “The best results occur when a patient receives medication for as long as it provides a benefit.”

Common Myths & Misperceptions

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Best Practices

1. Embrace opioid use disorder like any other chronic disease and take it on in primary care!
2. Let patients do their own inductions in the comfort of their own home, on their own time.
3. Behavioral supports should be patient-centered and depend on their desires & needs.
4. Patients often struggle with multiple chronic diseases; they may not be ready to tackle all of them simultaneously.
5. Less is not more, both in terms of dose and duration! For many this will be a lifelong treatment.
Recommended Reading

**SPECIAL ARTICLE**

**Annals of Internal Medicine**

**The Next Stage of Buprenorphine Care for Opioid Use Disorder**

Stephen A. Martin, MD, EdM; Lisa M. Chiodo, PhD; Jordon D. Bosse, MS, RN; and Amanda Wilson, MD

Buprenorphine has been used internationally for the treatment of opioid use disorder (OUD) since the 1990s and has been available in the United States for more than a decade. Initial practice recommendations were intentionally conservative, were based on expert opinion, and were influenced by methadone regulations. Since 2003, the American crisis of OUD has dramatically worsened, and much related empirical research has been undertaken. The findings in several important areas conflict with initial clinical practice that is still prevalent. This article reviews research findings in the following 7 areas: location of buprenorphine induction, combining buprenorphine with a benzodiazepine, relapse during buprenorphine treatment, requirements for counseling, uses of drug testing, use of other substances during buprenorphine treatment, and duration of buprenorphine treatment. For each area, evidence for needed updates and modifications in practice is provided. These modifications will facilitate more successful, evidence-based treatment and care for patients with OUD.


For author affiliations, see end of text.
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Buprenorphine received approval from the U.S. Food and Drug Administration (FDA) in 2002 for

“The consensus panel recommends that physicians administer initial induction doses as observed treatment”
Acknowledgment

• Chinazo Cunningham MD MS, Associate Chief of Division of General Internal Medicine, Professor of Medicine, Albert Einstein College of Medicine/Montefiore Medical Center
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