ECHO IDAHO: OPIOID ADDICTION AND TREATMENT

Stigma and MAT: 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 & Misconceptions

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.
6. If it’s an opioid blocker, it must be better.
“Those Patients”
“Those Patients” → \(\text{STIGMA}\)

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.

<table>
<thead>
<tr>
<th>Terms Not to Use</th>
<th>Terms to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>addict, abuser, user, junkie, druggie</td>
<td>person with a substance use disorder</td>
</tr>
<tr>
<td>alcoholic, drunk</td>
<td>person with an alcohol use disorder</td>
</tr>
<tr>
<td>oxy-addict, meth-head</td>
<td>person with an opioid use disorder</td>
</tr>
<tr>
<td>ex-addict, former alcoholic</td>
<td>person in recovery</td>
</tr>
<tr>
<td>clean/dirty (drug test)</td>
<td>negative/positive result(s)</td>
</tr>
<tr>
<td>addictions, addictive disorders</td>
<td>addiction, substance use disorder</td>
</tr>
</tbody>
</table>
Inductions too difficult

try HOME inductions

Inductions too difficult →

**STARTING BUPRENORPHINE** ("Bupe" or "Suboxone")

Congratulations on starting treatment!

**WHAT TO START WITH?**
- Buprenorphine (Bupe) pills or films (8 mg)
- (※There are many different brand names and generic forms of Bupe. Some are shown below.)
- 6 Ibuprofen pills (200 mg) – for body pain, take 1-2 pills every 4 hours as needed
- 6 Clonidine pills (0.1 mg) – for anxiety, take 1 pill every 8 hours as needed
- 6 Imodium pills (200 mg) – for diarrhea, take 1 pill after each episode of diarrhea. Max 6 pills per day

**WHEN AM I READY TO START BUPE?**
- Wait until you have at least 5 symptoms to start Bupe. If you don’t have 5 symptoms, wait a bit longer and review the symptoms again. It is very important that you wait until you feel at least 5 symptoms before starting Bupe! To be sure that you are ready to start, it’s best to have at least 1 of the 5 symptoms in the gray shaded area.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Do I have this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel like yawning</td>
<td>No</td>
</tr>
<tr>
<td>My nose is running</td>
<td>Yes</td>
</tr>
<tr>
<td>I have goose bumps</td>
<td>Yes</td>
</tr>
<tr>
<td>My muscles ache</td>
<td>Yes</td>
</tr>
<tr>
<td>My bones &amp; muscles ache</td>
<td>Yes</td>
</tr>
<tr>
<td>I have hot flashes</td>
<td>Yes</td>
</tr>
<tr>
<td>I’m sweating</td>
<td>Yes</td>
</tr>
<tr>
<td>I feel unable to sit still</td>
<td>Yes</td>
</tr>
<tr>
<td>I am shaking</td>
<td>Yes</td>
</tr>
<tr>
<td>I feel nauseous</td>
<td>Yes</td>
</tr>
<tr>
<td>I feel like vomiting</td>
<td>Yes</td>
</tr>
<tr>
<td>I have cramps in my stomach</td>
<td>Yes</td>
</tr>
<tr>
<td>I feel like using</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**THINGS NOT TO DO WITH BUPE**
- DON’T use Bupe when you are high—it will make you doze off!
- DON’T use Bupe with alcohol—this combination is not safe.
- DON’T use Bupe with benzos (like Xanax ("sticks")), Klonopin, Valium, Ativan) unless prescribed by a doctor who knows you are taking Bupe.
- DON’T use Bupe if you are taking pain killers until you talk to your doctor.
- DON’T use Bupe if you are taking more than 60 mg of methadone.
- DON’T swallow Bupe – it gets into your body by melting under your tongue.
- DON’T lose your Bupe – it can’t be refilled early.

**HOW TO TAKE BUPE**
- Before taking Bupe, drink some water.
- Put Bupe under your tongue.
- Don’t eat or drink anything until the Bupe has dissolved completely.

**PLAN**
- Use your list heroin / methadone / pain pill: __________
- When you have at least 5 symptoms from the list, then you are ready to start.
- Start with ________ pill or film under your tongue.
- Wait ________ minutes
- If you still feel the same or just a little better, then take another ________ pill or film
- Wait 2 hours – if you still feel sick or uncomfortable, take another ________ pill or film.

**PROBLEMS? QUESTIONS?**
- Call ____________ if you still feel sick after taking a total of ________ pills or film (____ mg).

**NEXT STEPS**
- Appointment with ________
- Appointment with Dr. ________

**WHAT I TOOK**

<table>
<thead>
<tr>
<th>Time</th>
<th>Amount of pills or films</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>am / pm</td>
</tr>
<tr>
<td>Day 2</td>
<td>am / pm</td>
</tr>
<tr>
<td>Day 3</td>
<td>am / pm</td>
</tr>
</tbody>
</table>

Unpublished protocol, Cunningham et al, Montefiore Medical Center, Bronx, NY 2018
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
• Patient-centered approach
• Should not tie life-saving medication to counseling requirements

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.
Polysubstance use a failure?

• Continued polysubstance use often related to underdosing of bupe

• Bupe treats OUD, but not other SUD – patients can be successful in 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.

*Cunningham et al. Am J Addict 2013.*
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 medicines can help reduce the withdrawal symptoms that can occur when opioid addiction medications are stopped.
Lowest possible dose, shortest possible time?

• Buprenorphine is always going to be safer
• 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.”

If it’s an opioid blocker, it must be better?

• Data limited & study quality poor
  – Most RCTs compared to placebo
  – RCTs against buprenorphine flawed

• Observational studies suggest increased risk of death from overdose

• Mortality benefit from methadone and buprenorphine, not from ER naltrexone

• Should only be used in unique situations

An opioid blocker better? →

FDA issues warning letter for not including the most serious risks in advertisement for medication-assisted treatment drug

think twice before prescribing ER naltrexone for OUD

**do prescribe naloxone**
Common Myths & Misconceptions

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. 
   
6. Think twice before choosing opioid antagonist over opioid agonist therapy →
Key Points

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.
6. Focus on access to opioid agonist therapy (bupe or methadone) for OUD.
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.

Annals.org

For author affiliations, see end of text.
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