Medication-Assisted Treatment for Opioid Use Disorder

Primer for non-medical staff working in RAAM clinics

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Provincial Counsellor Call

April 12, 2019

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WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

ROLE OF THE COUNSELLOR IN MANAGING OUD

Role of the counsellor

- Counsellors play key role in management of opioid use disorders in RAAM settings:
  - Counsellors spend more time with patients than physicians
  - Patients are more likely to confide in counsellors than in medical staff
  - Counsellors are more likely to provide discharge advice and be involved in discharge planning and referrals

Beyond clinical knowledge

- Importance of counsellors in early recovery
  - Counsellor attitude has been demonstrated to influence **future participation** in treatment
  - Showing **compassion** is essential, as patients often seek help after substance use has gotten them into crisis (e.g., children taken by CAS, DUI, job loss, etc.)
  - These individuals may be at increased risk for self-harm
  - A counsellor's **compassion**, **knowledge**, and **brief counselling skills** offer patients immediate support and the hope that things will improve if they continue working on their recovery

Goals for OUD patients

1. Explain to client what OUD diagnosis means.
2. Provide advice on avoiding opioid-related harms.
3. Address client's concerns.
4. Establish next steps.

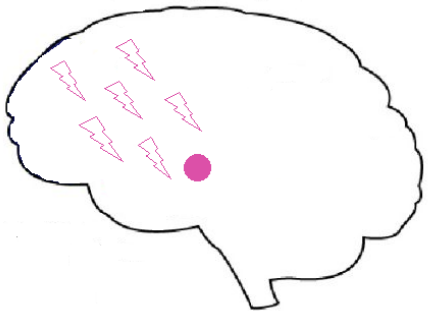
DELIVERING AN OUD DIAGNOSIS

What is OUD?

- People with OUD often have four traits:
  1. They cannot control their opioid use.
  2. They continue to use opioids even though it is harmful.
  3. They spend a lot of time obtaining opioids, using opioids, and recovering from opioid use.
  4. They have powerful urges or cravings to use opioids.

The addicted brain

- Humans have a reward centre in the brain and when an essential activity for survival is performed (e.g., eating), dopamine is released
  - Dopamine makes us feel good, so we are motivated to repeat the activity



- Drinking and using drugs causes an **even more powerful** release of dopamine
- This is what reinforces people's substance use, even when rationally they know it is harmful to them

What a diagnosis means

- Explain the following to your client:
  - An OUD diagnosis means that you have **lost control** over your opioid use
  - OUD happens to certain people because of **biological**, **social**, and **psychological reasons**
  - This **does not** make you weak, stupid, or a bad person
  - People with OUD **can and do** get better

Concurrent disorders

- People with OUD often suffer from other mental health issues, which may have contributed to their opioid use
- Common concurrent disorders include:
  - PTSD
  - Anxiety
  - Depression
- These issues must be addressed through counselling, in addition to working on OUD

AVOIDING OPIOID-RELATED HARMS

Tolerance and withdrawal

- When opioids are taken frequently for an extended period of time, the brain reacts and changes
  - User develops **tolerance**
  - In the event of sudden abstinence, they will experience **withdrawal**
- **Tolerance:** The requirement for an increasing amount of the substance to experience the same effects as before
- **Withdrawal:** The physical and psychological distress experienced when the regular opioid dose is missed (e.g., agitation, insomnia, craving, muscle aches, diarrhea)

What causes withdrawal?

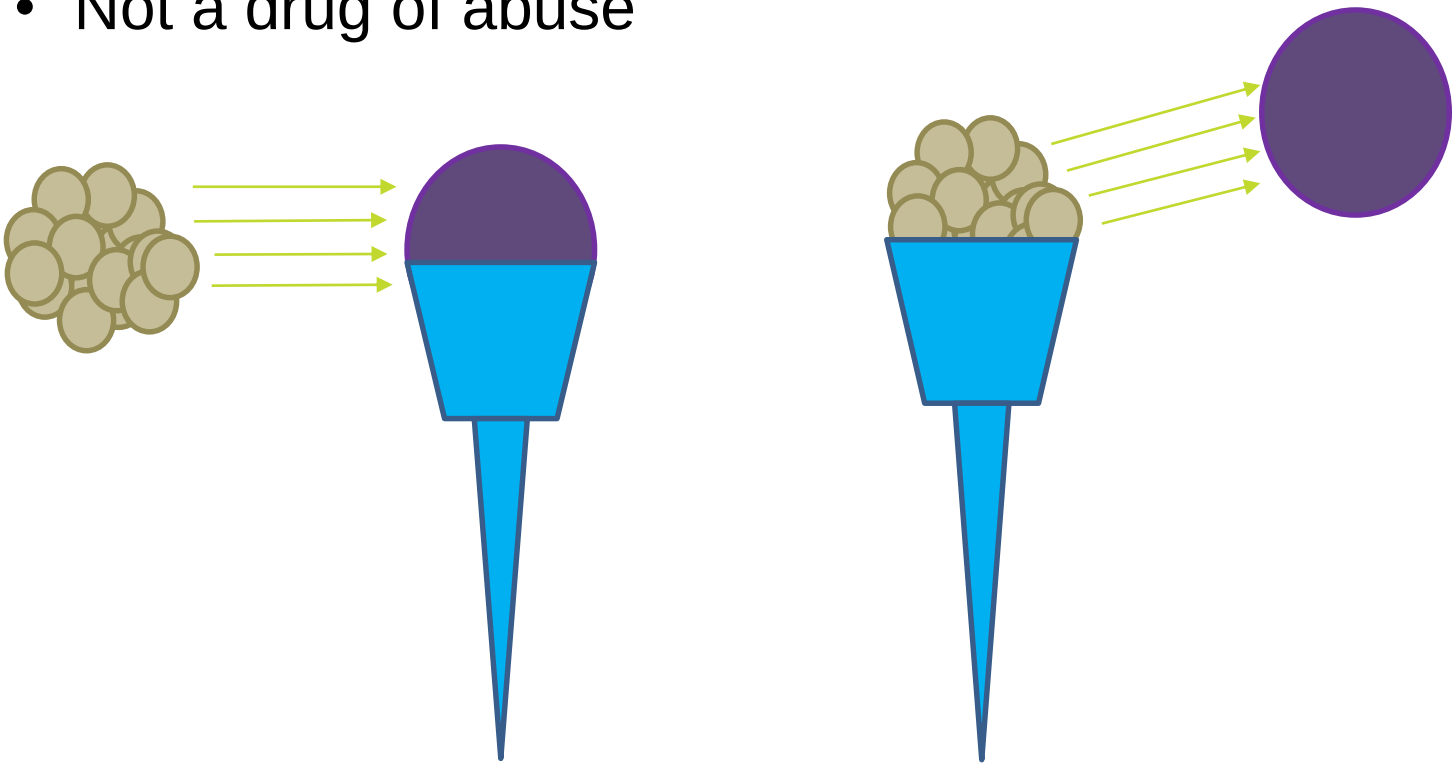
- Opioids activate **opioid receptors** in the brain, causing the user to feel less pain and less stress
- As the opioids leave the system, the empty receptor causes pain and discomfort due to the change in the nervous system

Harm reduction

- Opioid tolerance goes down quickly (takes only a few days)
- If a client is going to use opioids after a period of abstinence, advise them to use **harm reduction methods**:
  - Use much less than before
  - Don’t use intravenously
  - Don’t use benzodiazepines, alcohol, or other sedating drugs while using opioids
  - Never use opioids alone
  - Call 911 if a friend has taken opioids and is nodding off
  - Never let someone who is nodding off fall asleep
  - Carry naloxone

Naloxone

- Naloxone is a medication that temporarily reverses the effect of an opioid overdose
  - It pushes the opioids off of the opioid receptors
  - Gives the user an extra 20–30 minutes to get to a hospital
  - Not a drug of abuse



Give take-home naloxone

- Give a take-home naloxone kit to anyone at risk of an opioid overdose:
  - Not on OAT, on OAT but started in the past two weeks, or on OAT but continuing to use substances
  - On high dose opioids for chronic pain
  - Treated for overdose (or reports a past overdose)
  - Injects, crushes, smokes or snorts potent opioids (fentanyl, morphine, hydromorphone, oxycodone)
  - Recently discharged from an abstinence-based treatment program, WMS, hospital, or prison
  - Uses opioids with benzos and/or alcohol
  - Uses any street drugs (risk of fentanyl contamination)

TREATMENT

Patient concern: Treatment

- **“Do I really need treatment? Shouldn’t I be able to stop using on my own?”**
  - Successful recovery from OUD **requires** treatment
  - Like other illnesses such as diabetes and depression, OUD is caused by biological, psychological, and social factors, and just like these other illnesses, it is very hard for people to manage on their own
  - However, **effective treatment is available**

Opioid agonist therapy (OAT)

- OUD is often treated with **methadone** or **buprenorphine**, opioid medications that start to reduce cravings within days
  - Buprenorphine can also manage withdrawal symptoms
  - Buprenorphine must be initiated while patient is in withdrawal, or else it triggers severe withdrawal
- OAT meds are dispensed daily under the observation of a pharmacist
- After several weeks, the patient is given take-home doses if they have stopped illicit drug use, as demonstrated by regular urine drug screens
- This ‘contingency management approach’ is effective at reducing drug use and ensures patient safety

Methadone vs. buprenorphine

	Methadone	Buprenorphine
Classification	Full opioid – affects opioid receptors until all are fully activated	Partial opioid – opioid receptors not activated to the same extent as with methadone
Method	Taken once daily mixed in juice	Usually taken once daily under the tongue
Side effects	More side effects More likely to cause overdose	Fewer side effects Less likely to cause overdose
Withdrawal and cravings	More effective at relieving withdrawal and cravings	Somewhat less effective at relieving withdrawal and cravings

Patient concern: Medication use

- **“Isn’t medication cheating? Aren’t I just substituting one addiction for another?”**
  - Methadone and buprenorphine are very different from other opioids
  - When taken in the right dose, **neither one causes euphoria or intoxication**
  - Withdrawal relief will last for a **full 24 hours** when taken in the right dose
  - People will not have to spend time and money trying to acquire these medications

Patient concern: Is it for life?

- **"How long do I need to stay on this medication for?"**
  - How long a patient stays on OAT is up to them
  - Relapse is **much less likely** if medications are tapered **gradually** once life becomes more stable
  - Abstinence from non-prescribed opioids for at least six months might be a sign of being ready to start tapering
  - The longer the patient has been addicted to opioids, the longer they should stay on methadone or buprenorphine

Patient concern: Chronic pain

- **"I have chronic pain. If I switch from my regular opioid to methadone or buprenorphine, won't my pain get worse?"**
  - No; in fact, OUD often makes pain worse for two reasons:
  1. People with OUD typically experience **withdrawal** every day as the opioid wears off, which magnifies perception of pain.
  2. People with OUD are often **depressed and anxious** because their addiction is making their life very difficult, which also magnifies people's sense of pain
  - By treating the OUD, the patient will experience a decrease in chronic pain as well as an improvement in daily functioning

Coping with cravings (1)

- People in early recovery are likely to experience **cravings**
- **Keep busy:** Scheduling and keeping a routine can be a helpful way to avoid using:
  - Attend self-help groups like NA or SOS, which provide structure, social support, and accountability through sponsors
  - Exercise, take daily walks
  - Keep regular sleeping and eating routines
  - Spend as much time as possible with supportive family and friends who do not use drugs
  - Keep appointments with addiction counsellors and doctors

Coping with cravings (2)

- **Keep focused:** Staying sober requires paying close attention to how you're feeling, and keeping sobriety as the main priority:
  - Take your medication
  - Avoid HALT states: Hungry, Angry, Lonely, Tired
  - When you have a craving, call a support first
  - Don't focus on other issues – they can be dealt with later as long as you remain sober
  - Know your triggers and do your best to avoid them (e.g., certain people or places, or emotions like stress)
  - Don't give up – sub-acute withdrawal can last for several weeks or months, and the anxiety, insomnia, fatigue, and cravings that you may be experiencing are all temporary

Key messages for patients

- **"You have been diagnosed with an OUD."**
  - This means that you have been unable to stop using opioids, even though it has become harmful to you
- **"Treatment exists and is incredibly effective."**
  - Explain options for medication-assisted treatment
  - Explain options for psychosocial treatment
- **"There are things you can do to help cope with cravings."**
- **"Once you start treatment, other aspects of your life will improve tremendously."**
  - E.g., mood, pain, relationships, daily functioning, finances

CASE SCENARIO

Karen

Karen is a 30-year-old woman who was brought by her friends to the ED after an accidental overdose after injecting fentanyl. Her overdose symptoms have resolved and she was started on buprenorphine. She is following up with you at the RAAM the next day.

Question

- What would you prioritize for your first session with Karen?

Advice for Karen (1)

- Emphasize that Karen **must take her buprenorphine daily** as prescribed to relieve withdrawal symptoms/ cravings
- Encourage Karen to **connect with her primary care doctor** if she has one
- Karen should carry the **take-home naloxone kit** with her at all times, and know how to administer the medication
- Explain that being on buprenorphine does not necessarily protect her from an overdose, especially on fentanyl
- If she must use:
  - Use the smallest amount possible to relieve withdrawal
  - Do not mix opioids with benzos or alcohol, and never use alone

Advice for Karen (2)

- Let Karen know that **treatment is incredibly effective**, and that if she stays on her treatment plan, her mood and function will **improve dramatically**
- While starting her new treatment routine, Karen must do her best to **avoid people and places associated with her drug use**