Improving Prescribing of Medications for Opioid Use Disorder

Approaches to Managing Challenging Cases for Seasoned Prescribers

Addiction Treatment Starts Here: Primary Care

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Objectives

- Review challenging MOUD cases, including benzodiazepine use, complex chronic pain, and co-occurring substance use disorder
- Identify approaches to manage patients who are tenuously stable on buprenorphine

Medications for Opiate Use Disorder basics

- Straight forward?
- What did you sign up for?

Maybe not so basic after all…

- How many patients do we have that are really that simple?
- How many of your patients absolutely never make you wonder if you're doing the right thing?
- How many of your patients make you think, "Yeah, we covered all of this in school or my training program, or in the 8 or 24 hour x-waiver"?

And what about ***those*** patients?

- The ones that, when you see them on your grid, your heart drops.
- The ones that make you wonder why you're doing this?
- The ones whose behavior never seems to change, no matter what you do.


END

Patient 1

- Mr. B is in his early thirties. Came to Southern California to “get clean”.
- History of depression, anxiety, PTSD.
- 2-3 psychiatric hospitalizations for suicidal ideations.
- 2 years ago attempted to overdose
- Sexual abuse as a child. Brother died from overdose. Multiple family members with substance use disorders.

Patient 1 (continued)

- Just left a private rehab recently.
- Feels judged by his family for using buprenorphine. Previously "hard core" in NA – judges himself for using buprenorphine. Doesn't want to take more than a tiny dose.
- Using meth. "Honestly, I microdose. I don't even like the stuff. I hardly use any. I have ADD really bad and I struggle badly." Feels that meth helps him get things done, focus, but side effects are too much, doesn't eat and sleep. "I need a fucking job. I need Adderall so I don't use meth".
- Terrified of rejection. Anything that providers say that doesn't coincide with his views is a possible betrayal.

Patient 1 (continued)

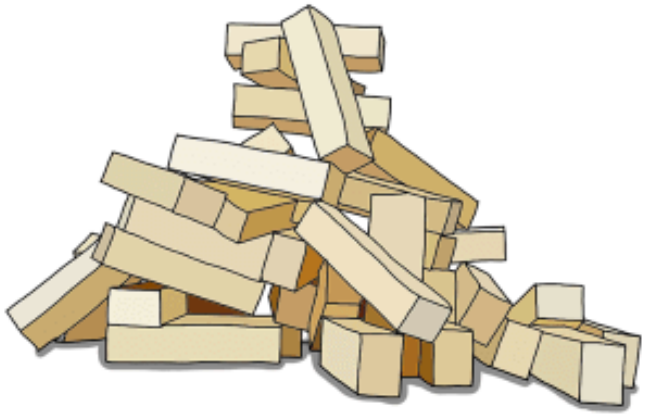
- Tries to see different providers, makes bargains to get to goals. Went to inpatient, but left after a week. Wants to get back to a "nice" rehab, but only has Medi-Cal. Has seen therapists, counselors on intermittent basis. One of our most experienced counselors left his first meeting with him with a shell-shocked look on his face.
- Multiple trials of SSRI's. Prazosin. SNRI's, gabapentin, mood stabilizers.
- Misses appointments. Doesn't have working phone usually.
- Living on the street now, after long stint couch surfing.

Suggestions?

Talking points

- Methamphetamine
- Contingency management
- Levels of care
- Psychiatry and behavioral health
- Methadone clinic
- Continue treatment?
- LAHSA

RECOGNIZE MOMENT OF FRUSTRATION



BE MINDFUL TO CAPTURE THE PRECISE MOMENT WHEN YOU START FEELING FRUSTRATED.

Patient 2

- Mr. H is a 20 year-old man, coming to clinic for past year and a half.
- Was going to meetings, using buprenorphine from mother about 7 months before started with our program.
- History of depression.
- Dad on meth, heroin, is homeless. Mom in recovery – doing well on bup/nal. Sister (intentionally?) died from OD.

Patient 2 (continued)

- Lost ID over year ago, perpetually working on steps to get that done, finish school, get job.
- Was going to DMH for depression, was on SSRI.
- Doesn't engage in individual therapy/counselling.
- Had a good run of making it to appointments, had a part time job. Was on a small dose of bup, negative for opiates, but always positive for meth.

Patient 2 (continued)

- Decided that he wanted to stop buprenorphine.
- Stopped coming to groups.
- Intermittent follow-up with colleague
- Colleague frustrated with him – Negative urines.
- Wants to kick him out of the program. Three strikes and you're out.

Patient 2 (continued)

- Colleague felt he was diverting his meds. Wanted to get a serum toxicology screen.
- Lots of "I". "I don't think he's taking his meds." "I told him to get his labs." "I don't want to lose my license." "I told him to go to meetings." "I told him to work with the therapist".

Suggestions

Talking points

- Leave "I" out of the conversation.
- What happens when patients are out of treatment?
- Ambivalence towards MAT
- Teens, young adults
- UDS – not a stick
- Provider concerns about license

Harm Reduction

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.

Harm Reduction

- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

Harm Reduction

- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.


XANAX
KING CROWN
JEWELERS

Patient 3

- Mr. O is a man in his late 20's, who presented for opiate and benzodiazepine use.
- Started marijuana and EtOH early teens, benzos and oxy age 18. Methadone for 3 years previously. A couple years on buprenorphine. OD 3-4 times. Multiple witnessed ODs.
- Anxiety, ADD, PTSD, depression bipolar. Was on Vyvanse, Zyprexa, Lexapro, Prozac, Adderall, Abilify, Lamictal, Effexor. PHQ upper teens.
- Multiple mental stabilization stays at hospital in setting of substance use and domestic conflict. At least two 14 day hospitalizations for dual diagnosis.

Patient 3 (continued)

- Girlfriend died from OD 2 years ago – he found her (he believes she intentionally OD'ed due to paranoia that he was cheating on her). She was living with his family at the time, and this was so stressful for his family that they relocated to CA. . . Started heavier use of benzo's, heroin.
- Best friend, and others died from overdoses.
- Dad drinking, cocaine in AA.

Patient 3 (continued)

- Using about 1g heroin daily, 10-20 mg Xanax daily.
- Absolutely refuses to go to inpatient, or IOP.
- Not interested in methadone.
- Has an incredibly supportive mother

Suggestions?

Talking points

- Inpatient vs outpatient?
- Benzodiazepines + buprenorphine
- Meet patients where they are at
- Harm reduction (again, always)

I am not a glass half-full kind of person. Nor am I inclined to say that as long as someone plays the game, that they are a winner. However, with our patients with substance use disorders, I feel there is some need to change parameters for determining success. Recognize that this is a long process, and that patients engaging in treatment is a victory in and of itself.

Questions?