

Opiate Detox made Easy

A Safe and Cost-Effective Approach to Opiate Detoxification

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Objectives

At the end of today's discussion you will have a better understanding of the following:

- Suboxone
- Identification of an appropriate patient for Suboxone
- An induction using Suboxone

Opioid Overdose Crisis

- Every day, more than 115 Americans die after overdosing on opioids.
- The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.

How did this Happen?

In the late 1990s, pharmaceuticals reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive. Opioid overdose rates began to increase.

In 2015, more than 33,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin, and illicitly manufactured fentanyl, a powerful synthetic opioid.¹ That same year, an estimated 2 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers, and 591,000 suffered from a heroin use disorder (not mutually exclusive).

What is being done to address this public health epidemic?

- In response to the opioid crisis, the U.S. Department of Health and Human Services (HHS) is focusing its efforts on five major priorities:
 - Improving access to treatment and recovery services
 - Promoting use of overdose-reversing drugs
 - Strengthening our understanding of the epidemic through better public health surveillance
 - Providing support for cutting-edge research on pain and addiction
 - Advancing better practices for pain management
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- Accessed March 26, 2018 HHS.gov :Secretary Price Announces HHS Strategy for Fighting Opioid Crisis
 - Thomas E. Price, M.D. National Rx Drug Abuse and Heroin Summit, April 19, 2017, Atlanta, Georgia

↑ Treatment access = ↑ Savings for Society and Families

- Treatment saves society money in costs of :
 - Emergency admissions from overdose
 - Prevention and Treatment for Blood Born Viruses
 - Reduces drug related crime
 - Multiple inpatient detox AND Most Importantly

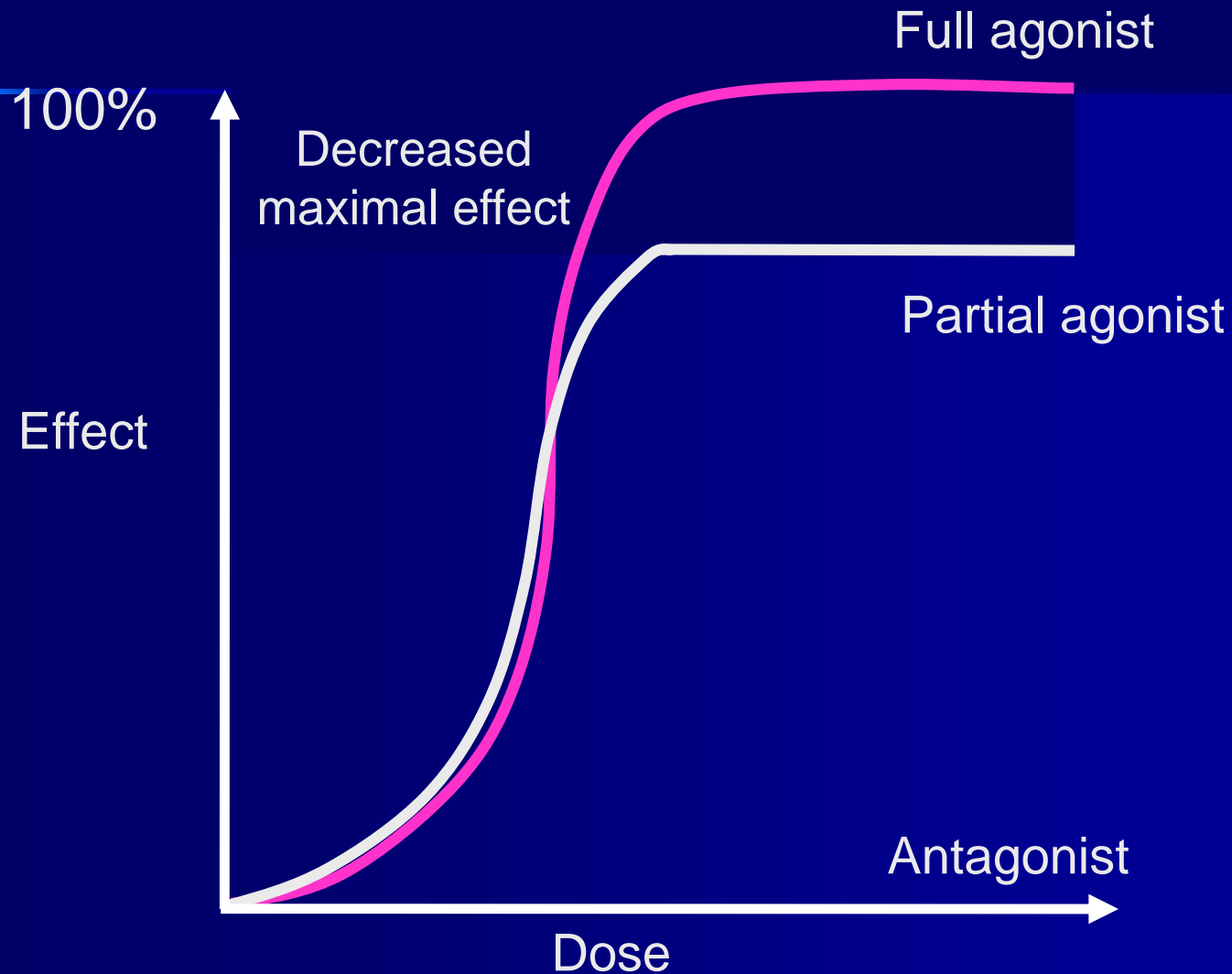
HUMAN LIVES

Treatment for Opiate Dependence

Pharmacological treatment

- Methadone (Dolophine[®], Methadose[®]), buprenorphine (Suboxone[®], Subutex[®], Probuphine[®], Sublocade[™]), and naltrexone (Vivitrol[®]) are used to treat opioid addiction. Acting on the same targets in the brain as heroin and morphine, methadone and buprenorphine suppress withdrawal symptoms and relieve cravings. Naltrexone blocks the effects of opioids at their receptor sites in the brain and should be used only in patients who have already been detoxed. All of these medications help patients reduce drug seeking and related criminal behavior and help them become more open to behavioral treatments.
- A NIDA study found that once treatment is initiated, both a buprenorphine/naloxone combination and an extended release naltrexone formulation are similarly effective in treating opioid addiction. Because full detoxification is necessary for treatment with naloxone, initiating treatment among active users was difficult, but once detoxification was complete, both medications had similar effectiveness. (New to me)
- <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>
Accessed March 12, 2018

Understanding opioid effects



Psychosocial Treatment

- 12 step programs
- Cognitive Behavioral Therapy,
- Motivational Enhancement Therapy, etc
- Cognitive-Behavioral Therapy (Alcohol, Marijuana, Cocaine, Methamphetamine, Nicotine)
- Contingency Management Interventions/Motivational Incentives (Alcohol, Stimulants, Opioids, Marijuana, Nicotine)
- Community Reinforcement Approach Plus Vouchers (Alcohol, Cocaine, Opioids)
- Motivational Enhancement Therapy (Alcohol, Marijuana, Nicotine)
- The Matrix Model (Stimulants)
- 12-Step Facilitation Therapy (Alcohol, Stimulants, Opiates)
- Family Behavior Therapy
- Behavioral Therapies Primarily for Adolescents

- <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies> Accessed March 20, 2018

Treatment modalities based on severity of addiction (from least severe to most severe)

- Outpatient Treatment
- Intensive Outpatient Treatment
- Inpatient Treatment
- Residential Treatment (up to two years)

Treatment Goals

- Ease withdrawal symptoms
- Minimize/eliminate craving for opioids
- Block euphoric effect of exogenous opioids
- Improve all functional spheres of
(Look at Addiction Severity Index, McLellan)

Buprenorphine aka Subutex and Suboxone

Buprenorphine is a long-acting partial mu opiate agonist that acts on the receptor targets of heroin and morphine, but does not produce the same intense "high" or dangerous side effects, thus allowing it to be treatment for addiction to opiate analgesics. Subutex is buprenorphine alone.

Suboxone 8/2 (Buprenorphine and naloxone) limits diversion by causing severe withdrawal symptoms in those who inject it to get "high," but no adverse effects when taken orally (naloxone is minimally absorbed when taken orally). Suboxone is preferred by government agencies.

What is buprenorphine?

- Partial μ -opioid agonist
- High receptor affinity and receptor occupancy:
 - 95% occupancy at 16 mg
(Greenwald et al, 2003)
 - Blocks the effect of the use of opioids
- Lower intrinsic activity than full agonists:
 - Favorable safety profile due to “ceiling” effect
 - Lower street value
 - Lower abuse potential (Walsh and Eissenberg, 2003)
 - Dose range generally within 12–24 mg
(aim for 16 mg)

Pharmacological Benefits

- Slow receptor dissociation:
- Longer duration of action
- Milder withdrawal
- Lower physical dependence liability than full agonists such as Methadone
- Limited development of tolerance
- Ceiling effect on respiratory depression
 - Increased safety against overdose

Naabt (gives nice explanation regarding agonist, partial agonist, antagonist)

So what does an opioid-dependent individual look like?

- Majority 20-39 years of age...
 - But can be any age
- Many unemployed...
 - But can be employed
- Many uneducated...
 - But many highly educated...
- Unexpected potential patients include
 - Post-operative patients
 - Chronic pain patients
 - A loved one?

Not just heroin...

- Hydromorphone (Dilaudid)
- Oxycodone (OxyContin, Percodan, Percocet, Tylox)
- Methadone (Dolophine)
- Hydrocodone (Lortab, Vicodin)
- Morphine (MS Contin, Oramorph)
- Fentanyl (Sublimaze))
- Codeine
- Opium

Getting started

- **Engage** the patient in the treatment process
- **Ascertain** valid information in order to identify most suitable treatment plan
- **Diagnose** dependence
- **Determine** suitability and obtain patient consent for OBT with buprenorphine
- **Create** the treatment plan

Is your patient appropriate for Suboxone?

Assess the following:

- Drug use history
 - Past and present drug use
 - Quantity, frequency, duration
 - All drug classes
 - Assessment of dependence – DSM 5
 - Treatment history
 - Motivation(s), patient goals, #Previous attempts, treatment agents

Complete Psychiatric history and mental status examination

- Psychosocial circumstances:
 - Family history, homeless?, education
 - Financial resources
- Medical H and P
 - Clinical lab tests (especially LFT and HCV, HIV, HCG) as well as standard primary care labs

Looking for signs of opiate use

- The following signs indicate possible opioid use:
 - Track or puncture marks
 - Infections (abscesses, cellulitis)
 - Constricted pupils (opioid intoxication)
 - Dilated pupils (opioid withdrawal / or possible stimulant intoxication)
 - Confusion or disorientation

Signs and symptoms of Withdrawal

- Sweating
- Yawning
- Anxiety
- Increased BP and respiratory rate
- Cravings
- Lacrimation -tearful
- Piloerection-geesebumps
- Rhinitis-runny nose
- Gastrointestinal symptoms
 - Abdominal cramps, Diarrhea

Not all patients are suitable

- Contraindication for buprenorphine treatment:
 - Hypersensitivity to buprenorphine or naloxone
- Age < 16 years
- Unstable dual diagnosis/psychiatric co-morbidity
- Unstable poly-drug use (especially benzodiazepines, cocaine and alcohol)
- HIV/HCV with acute hepatic dysfunction
- No support services = poor prognosis

Treatment planning

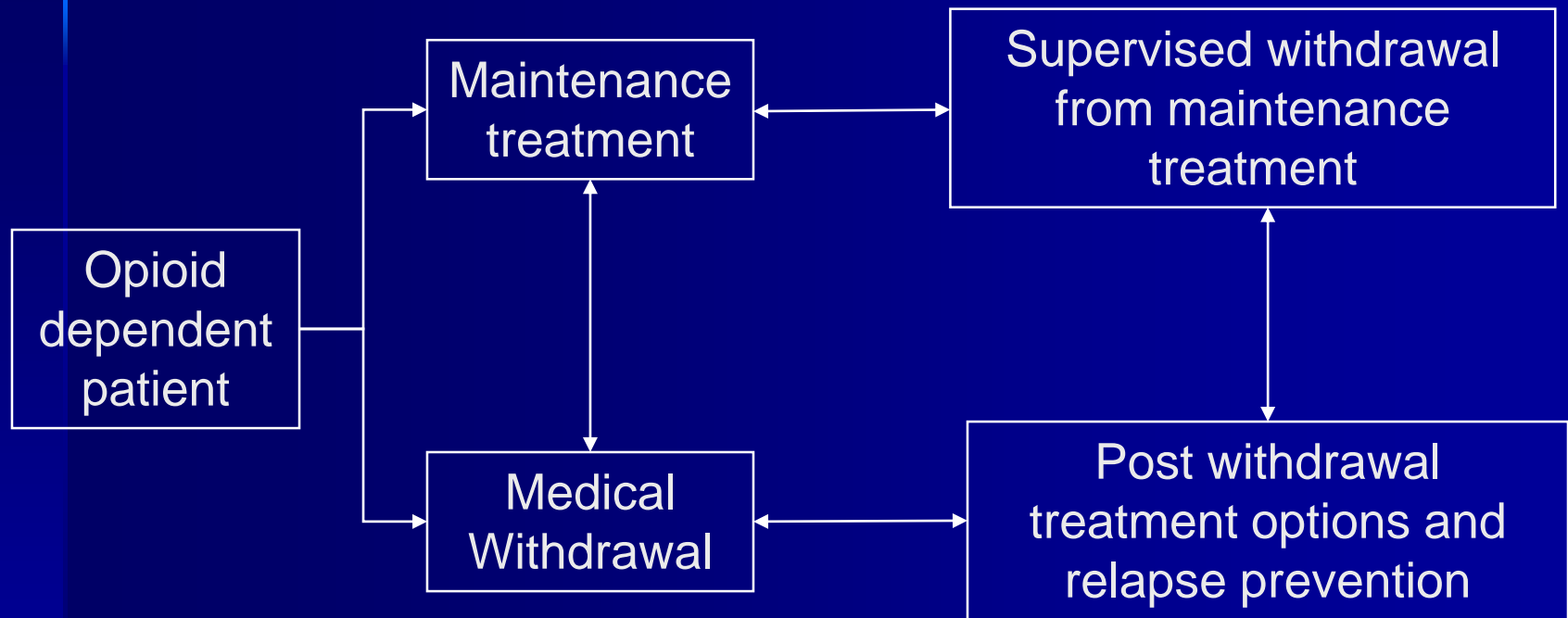
- ✓ Patient is dependent & suitable for Office Based Treatment with buprenorphine

Patient needs
identified from
assessment procedures



Available resources
including referral
availability

Into the treatment maze



Induction

- Day of Induction, Vital sign, the COWS, test urine for all major drugs including Methadone. Pt ideally is in mild to moderate withdrawal.
- Day 1: Two to three hours in your office
 - Initial dose 4 mg (sl)
 - Second dose of 2-4 mg after assessing initial response (if needed)
 - 4 mg take home dose (to use if needed)
- Day 2:
 - First day's dose plus 2–4 mg as indicated by patient's response
- Day 3:
 - Target 16 mg according to patient's response

After the first day

- Stabilization doesn't happen over night
 - Patient may be uncomfortable for several days (up to 2 weeks) after induction, however this is unusual.
- Frequent patient review is required over several weeks, months
- Patients typically want to be on and off. Detox is NOT Treatment.
- It takes about 90 days for the "brain to reset itself and shake off the immediate influence of a drug.

Example of outpatient medical withdrawal schedules

Day**	Buprenorphine dose (mg)	
	Equal Reduction*	50% Reduction*
1–4	16	16
5– 8	14	8
9–12	12	4
13–16	10	2
17–20	8	0
21–24	6	
25–28	4	
29–32	2	
33–36	0	

* Adapted from Amass et al, 1994b

** The number of days at each dose can be extended (eg, 7 days, etc.)
to extend the duration of the detoxification (Mudric et al, 1998)

Narrowing the treatment gap

- Suboxone available through office-based practice
- Lower requirement for supervision
- Expands treatment to meet need although it is still under utilized in doctor's offices and inpt units



There is no such thing as
recreational drug use.

— *Alan J. Leshner* —

AZ QUOTES

Former Director of National Institute on Drug Abuse

Truly inspirational leader and researcher

Consulted with my mother Shirley Coletti, President and Founder of
Operation Par, Inc. Comprehensive drug treatment program in
Florida. (see operationpar.org)

In conclusion, GO TO:

<https://pcssnow.org/clinical-coaching/coaches/?location=nevada>

to see yours truly serving as national mentor for those learning how to use Suboxone and other medications for addictions treatment. I can teach you!!

Further questions email me at Pamela.detrick@va.gov or go to

<https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine>