Harm Reduction Strategies for Patients with Opioid Use Disorder

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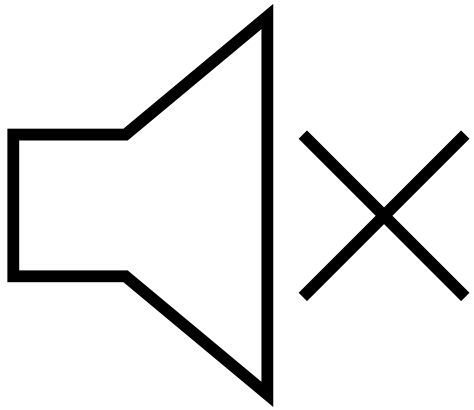
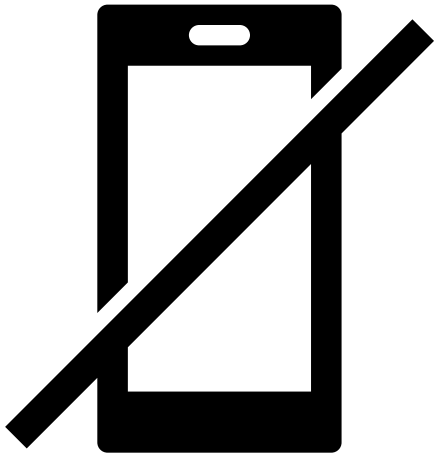
Learning Objectives

1. Appreciate the scope of the opioid abuse crisis
2. Understand the basic concepts of harm reduction
3. Become familiar with the principles of opioid replacement therapy

Community agreements



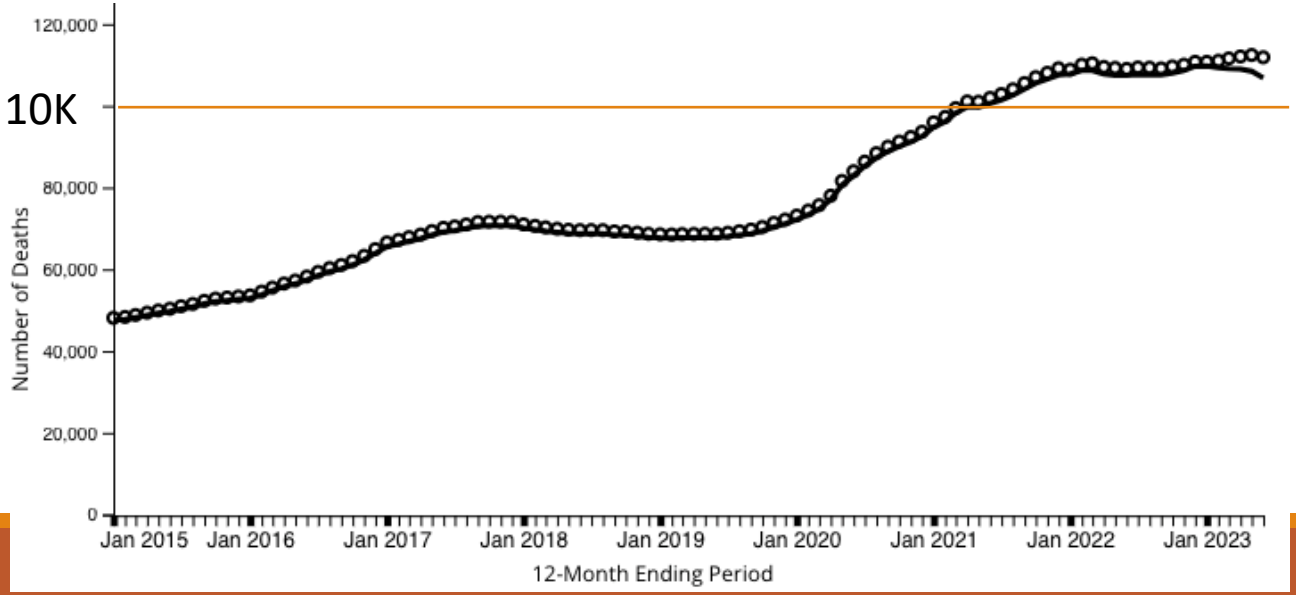


Conflict of Interest

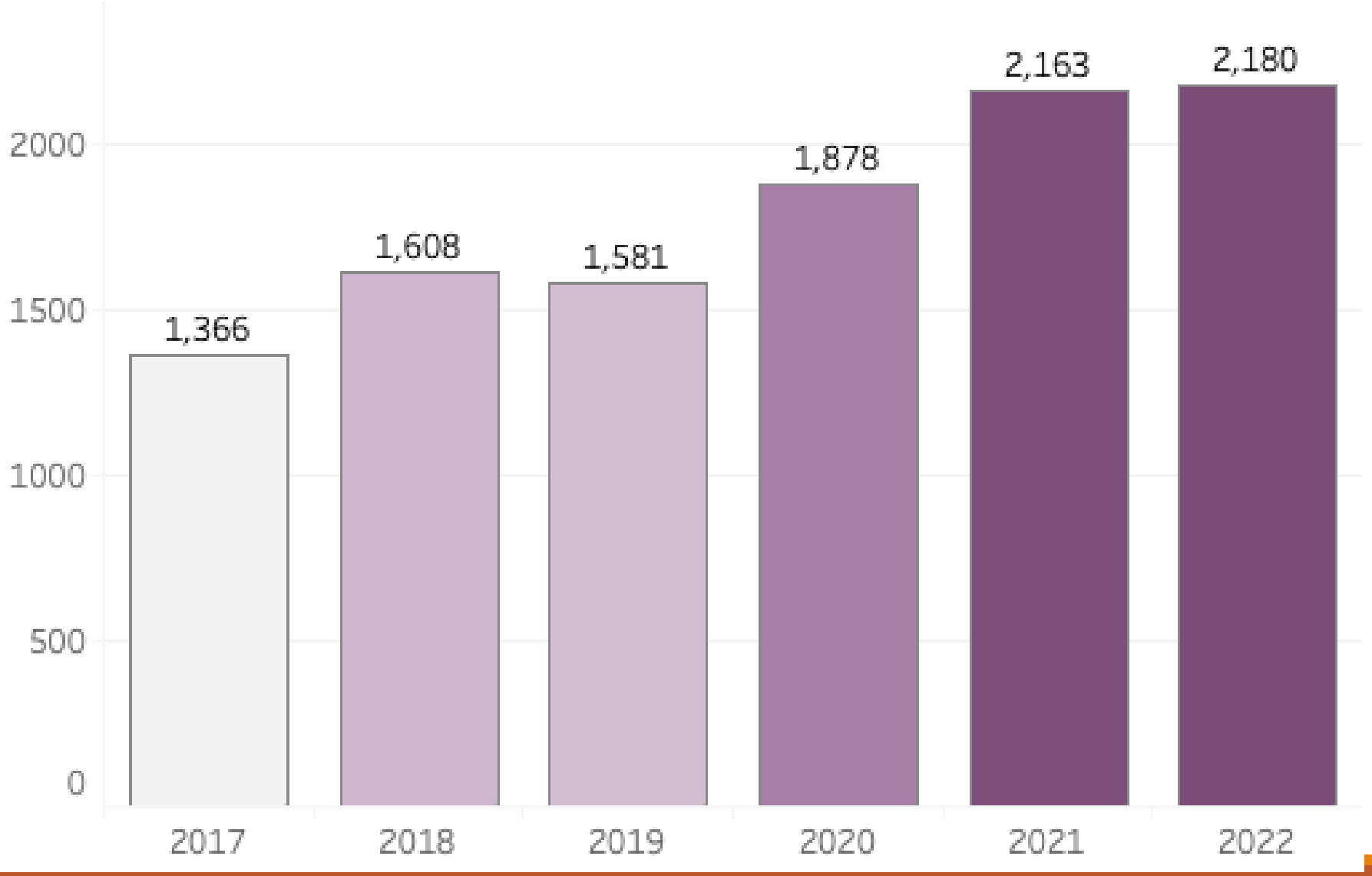
None

Epidemiology

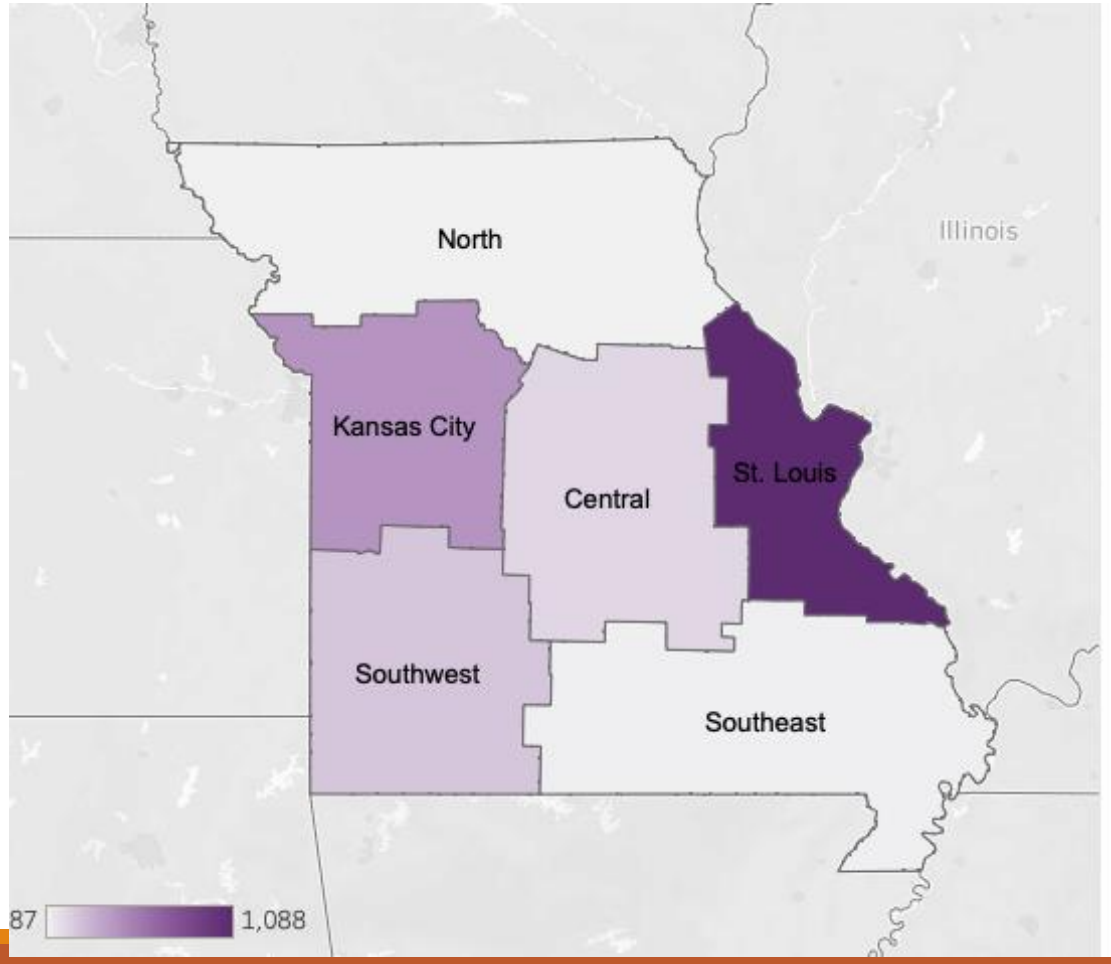
- In the United States:
  - 5.6 million people (aged 12 or older) in 2021
  - Predicted number of deaths (July 2022-June 2023): 111,877

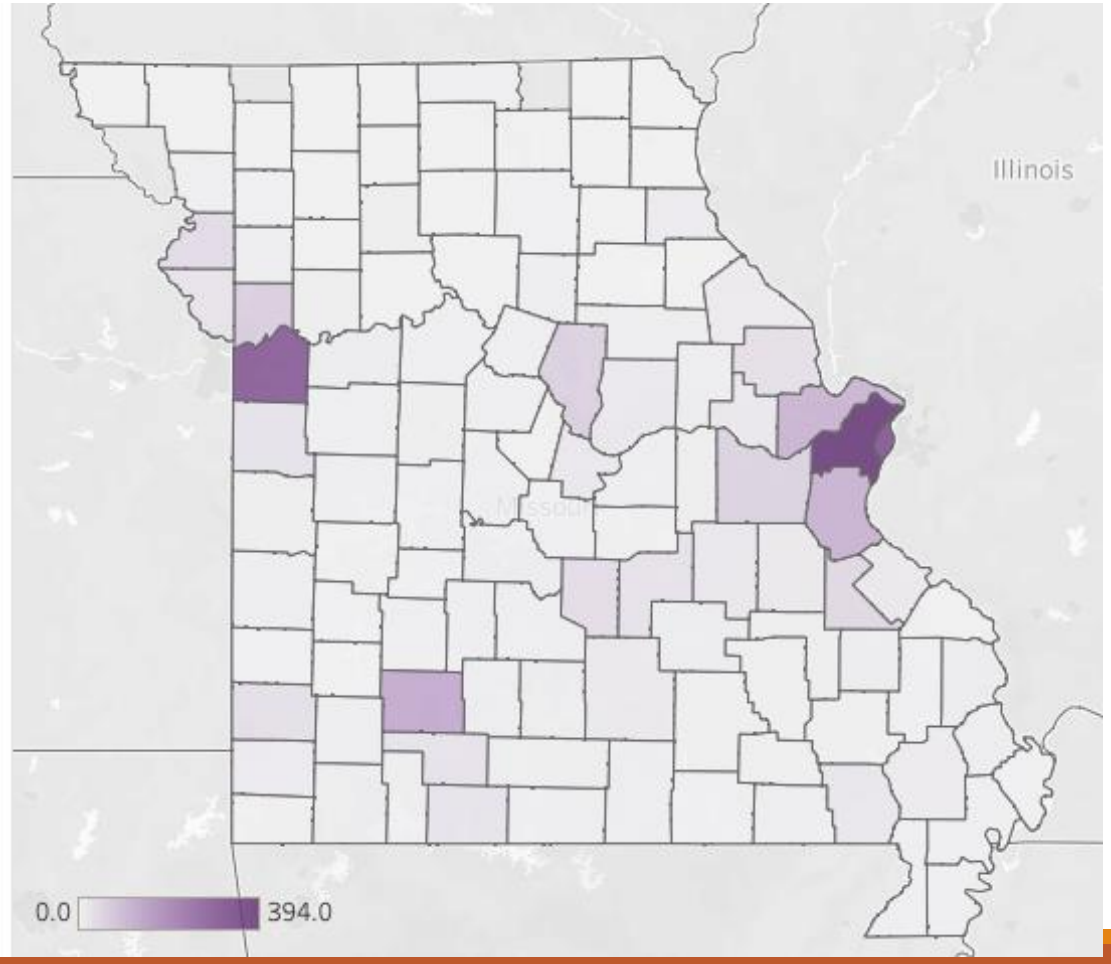


Missouri Resident **All Drug** Overdose Deaths

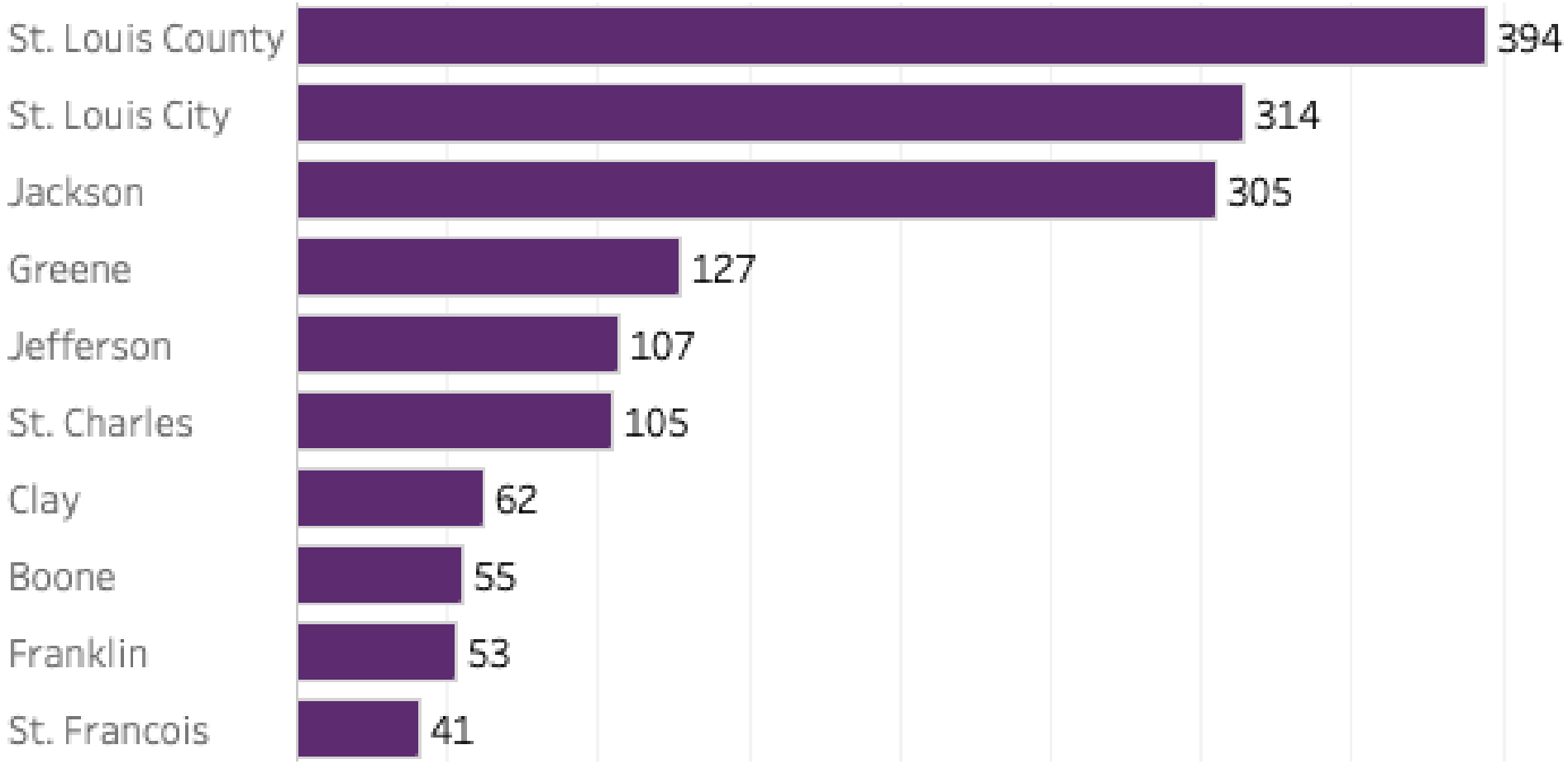


Drug Overdose Mortality Counts





Top 10 Counties with the overdose mortality



Should we treat OUD?

- We already see many of these patients in our practice.
- We have prescribed opioids for acute and chronic pain.
- According to a JAMA Psychiatry study by Cicero (2014),

  75% of those who began their opioid misuse in the 2000s reported that their first regular opioid was a prescription drug[1]

[1] Cicero, 2014
[2] Canfield, 2010
[3] Bawor, 2015

…So, why should we treat OUD?

Treating OUD SAVES LIVES!

Why Opioid Replacement Therapy?

- Harm Reduction! - The use of the opioid agonists methadone and buprenorphine reduces:[1,2]

Overdose	Illicit drug use	Transmission of infectious diseases

- Those receiving medications as part of their treatment are 75% less likely to die due to their substance use disorder than those not receiving medication[2]

[1]NIDA 2018
[2]ASAM 2013
[3]NIDA,2019

Treating OUD Reduces Crime!

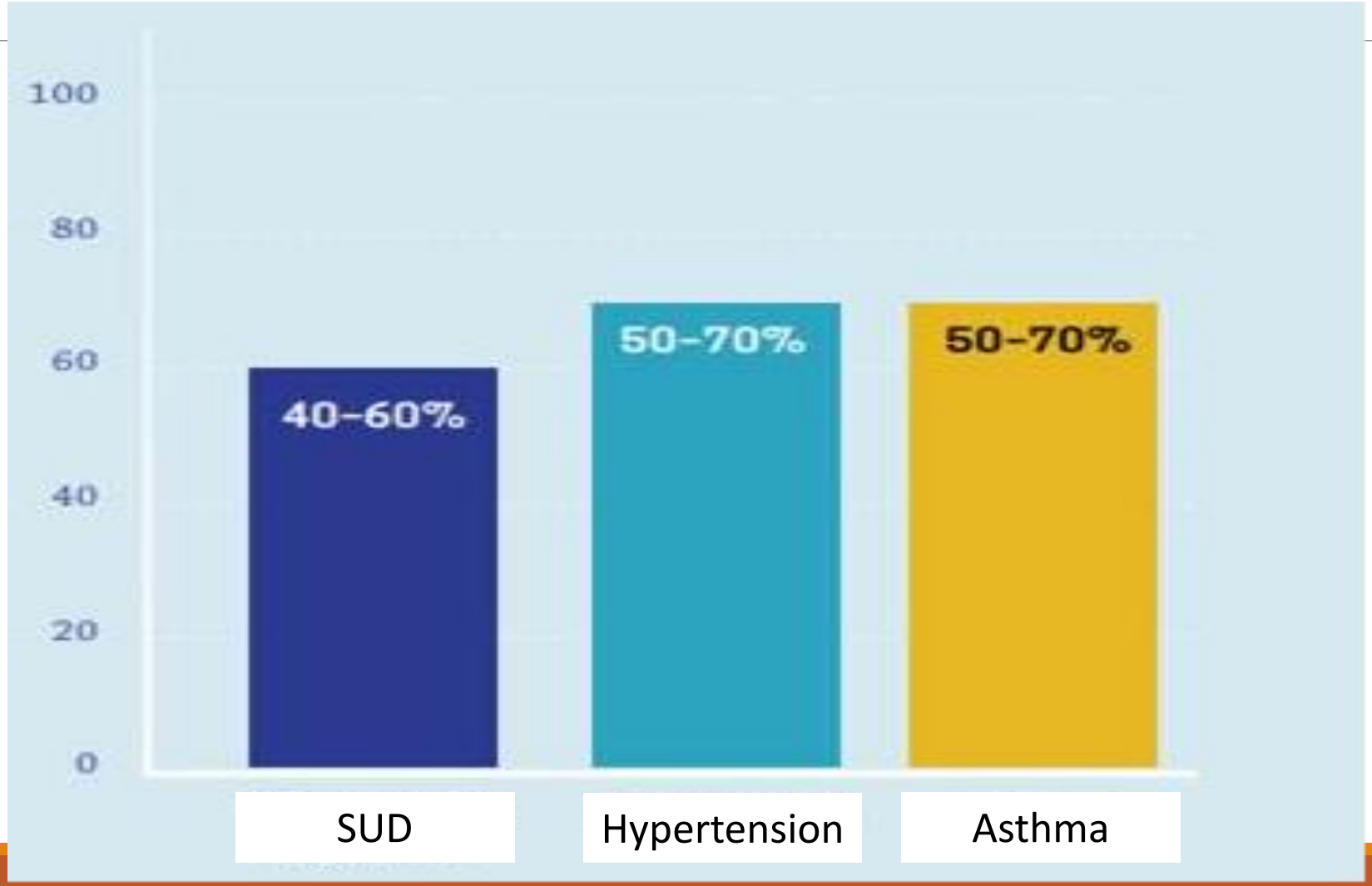
Every $1 invested in substance use treatment returns a yield of $4-7 in reducing drug-related crimes, criminal justice, and theft

1 ASAM 2017
2 NIDA 2019

Treatment of OUD

- Medication Assisted Treatment (MAT) vs **Medications for OUD (MOUD)**
- Medication: help stabilize the brain (reduce w/d and cravings)
- Patients can
  - Learn healthy coping and life skills
  - Acquire jobs
  - Take care of their family
  - Engage in medical and recovery care

SUD is a Chronic Disease!



NIDA. Drugs, Brains, and Behavior: The Science of Addiction. National Institute on Drug Abuse website. July 20, 2018.

Opioid Use Disorder is a Chronic Disease

- Everyone is susceptible to develop OUD
- Yes, there are predisposing risk factors
- But it can happen to anyone

Treating OUD reduces disease spread.

HIV incidence ↓

Hepatitis C incidence ↓

Endocarditis incidence ↓

1 Gowing 2012
2 Peles, Schreiber, Rados, Adelson 2011
3 Barocas, Morgan, Wang, McLoone, Wurvel, Stein 2020

Stigma and Bias: Barriers to treating SUDS?

Four factors leading to MOUD stigma[1]

- Framing of SUDs as a ‘willful choice,’ not a disease
- Separation of SUDs treatment from primary care
- Stigmatizing language associated with SUDs
- Justice system’s lack of recognition for MOUD as an option for medical treatment for individuals with SUD

[1]Wakeman S, Rich J 2017

What is “Harm Reduction”?

Harm Reduction

SAMHSA defines harm reduction as
"a **practical and transformative** approach that incorporates community-driven public health strategies – including prevention, risk reduction, and health promotion – to **empower** PWUD and their families with the choice to live **healthy, self-directed, and purpose-filled lives**. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in **these strategies and the practices that flow from them**."

Supporting Principles

SAMHSA Harm Reduction Framework

What can we do to practice harm reduction?

Practical Actions/Tips

- Motivational Interviewing
- Narcan
- Syringe exchange program
- Discussion – Plan A/B/C
- Overdose Detection App

Website

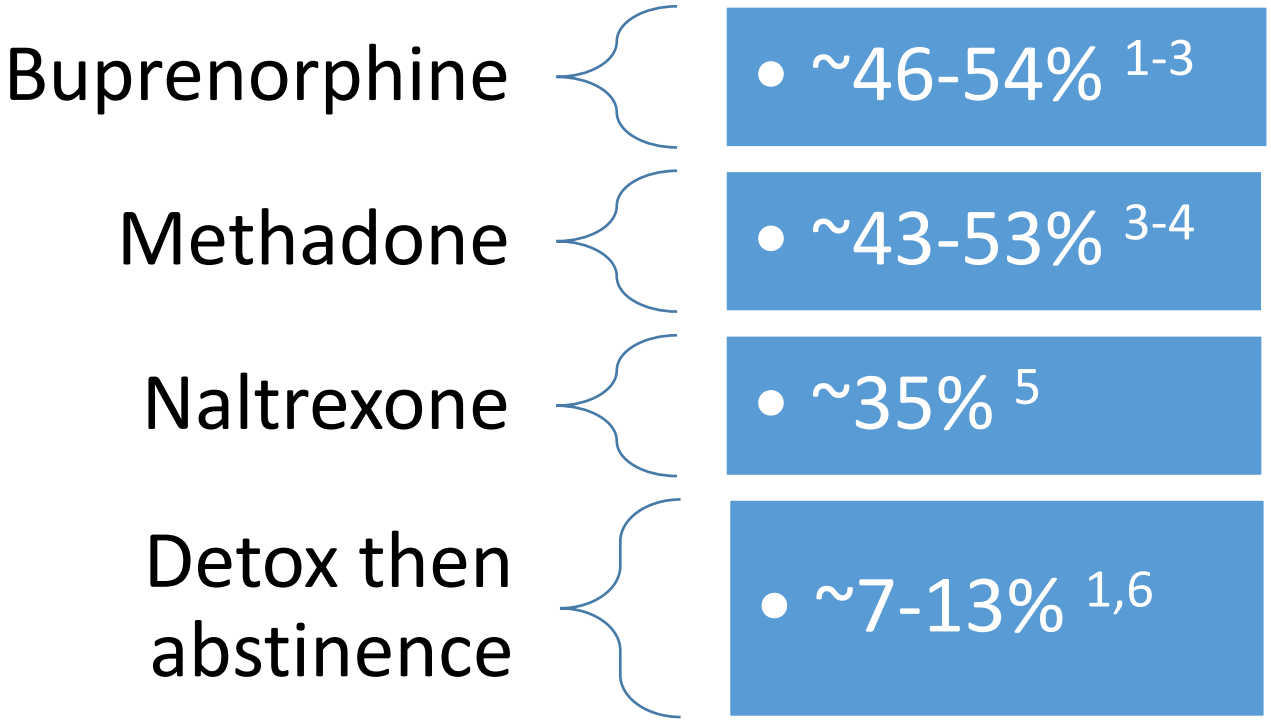

Resources for Safer Injection and Substance Use
Safer Injection
Alternatives to Injection
Heart Infections (Infective Endocarditis)
Other Health Complications From Injection
Overdose Prevention
Treatment Resources and Harm Reduction Resources
Medication for Opioid Use Disorder
For Clinicians

OUD Treatment Options

- Simple detoxification and no other treatment
- Counseling and/or peer support with/without MAT
- Partial Agonist (Buprenorphine) at the mu-receptor – OBOT/OTP
- Agonist (Methadone) at the mu-receptor - OTP
- Antagonists (Naltrexone) at the mu-receptor
- Referral to short or long term residential treatment

Federations of State Medical Boards 2013

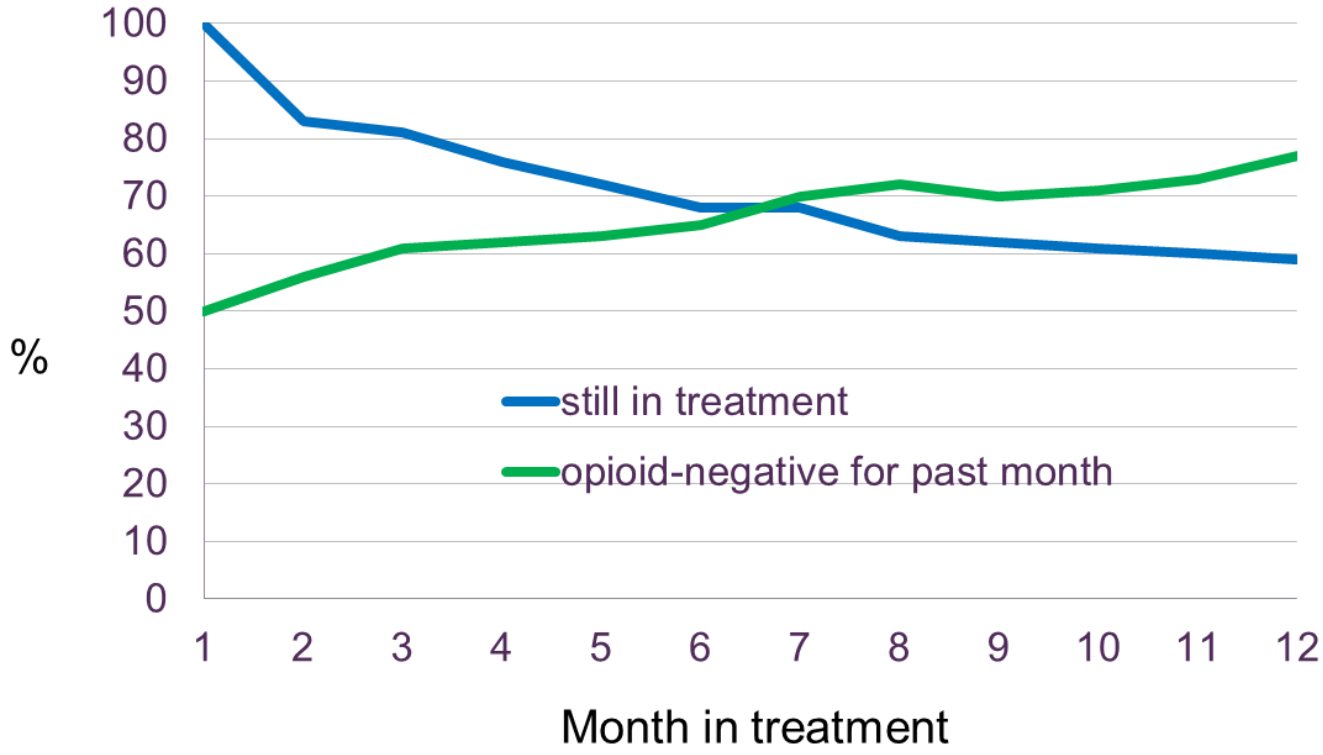
OUD Treatment Approaches & Rates of Adherence



[1]Weiss R, Rao V 2017
[2]Mintzer Il, Eisenberg M, Terra M, et al. 2007
[3]Potter J, Marino E, Hillhouse M, et al. 2013
[4]Strain E, Stitzer M, L ebson I 1993
[5]Lee J, Nunes E, Novo P, et al. 2018
[6]Tuten M, DeFulio A, Jones H, et al. 2012

Treatment Retention and Decreased Illicit Opioid Use on MAT

Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids



Kakko et al, 2003
Soeffing et al., 2009

Good News - Just In!

You no longer need a DEA “X Waiver” to prescribe Buprenorphine for OUD

Consolidated Appropriations Act of Congress Dec 29 2022

Buprenorphine (w/ or w/o Naloxone)

1) If used correctly, takes care of withdrawal and cravings, but patient does not get high
2) Few Drug-Drug interactions
3) Average 16mg/day, Rarely up to 24mg/day (**hard stop** at 32mg/day)
4) It is safe – overdose extremely unlikely (more with EtOH & Benzos)
5) Combo product with naloxone is abuse deterrent (less IVDA)
6) Studies show an antidepressant effect (raises serotonin levels)
7) Patients do not build up a tolerance

Buprenorphine also…

5. **Is less impairing**
   - Safer in the elderly
6. **Does not affect the QT interval**
7. **Safe in renal insufficiency or renal failure**
8. **Easier to wean than other opioids**

Buprenorphine Induction

- There is little science on how to do this
- Most studies show all techniques are effective
- Many patients have done this without our help

Buprenorphine Induction Goals

1. **Avoid precipitating withdrawal symptoms**
   - You want patient to begin withdrawal *prior* to induction

2. **Titrate to dose of buprenorphine at which the patient has:**
   - No opioid withdrawal symptoms
   - No or minimal cravings
   - Minimal or no side effects
   - Discontinued or markedly reduced use of other opioids

Buprenorphine Induction: Administration

- With patient in withdrawal, give 4mg (usually) under tongue
- Wait 1-2 hours and repeat if withdrawal sxs continue
- Usually, maximum 16 mg on day 1
- Increase to 20-24 mg/d over the next two days **only if** withdrawal symptoms continue.
- See the patient in 2-7 days.

How Long Should Patient Be on Buprenorphine?

- **Evidence is variable**
  - Studies as long as 16 weeks show high relapse rates with medication withdrawal
  - Improved retention rates in treatment with extended buprenorphine maintenance
- **Continue maintenance as long as patient is benefitting from treatment**

  (decreased substance use, meeting employment, educational, relationships goals)

  - Note: Provider can have discussions regarding reduction in dose with improving stability or patient preference however: Caution patients about discontinuing medication too early in treatment

Kakko et al., 2003
Weiss et al., 2011

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Resources

AAFP's OUD Treatment Manual: https://www.aafp.org/news/health-of-the-public/20210209oudmanual.html

STFM Addiction Medicine Curriculum: *https://www.stfm.org/teachingresources/curriculum/nationaladdictioncurriculum/*

Curbsiders Addiction Medicine Podcast: https://thecurbsiders.com/addiction

ASAM National Practice Guideline for the Use of Medications in the Treatment of Addictions Involving Opioid Use https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-pocketguide.pdf?sfvrsn=35ee6fc2_0

SAMHSA's TIPS 42: https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004

Resources for Safer Injection and Substance Use: https://safersubstanceuse.org

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