IOTOD improving outcomes in the treatment of opioid dependence

Refining abstinence-based pathways

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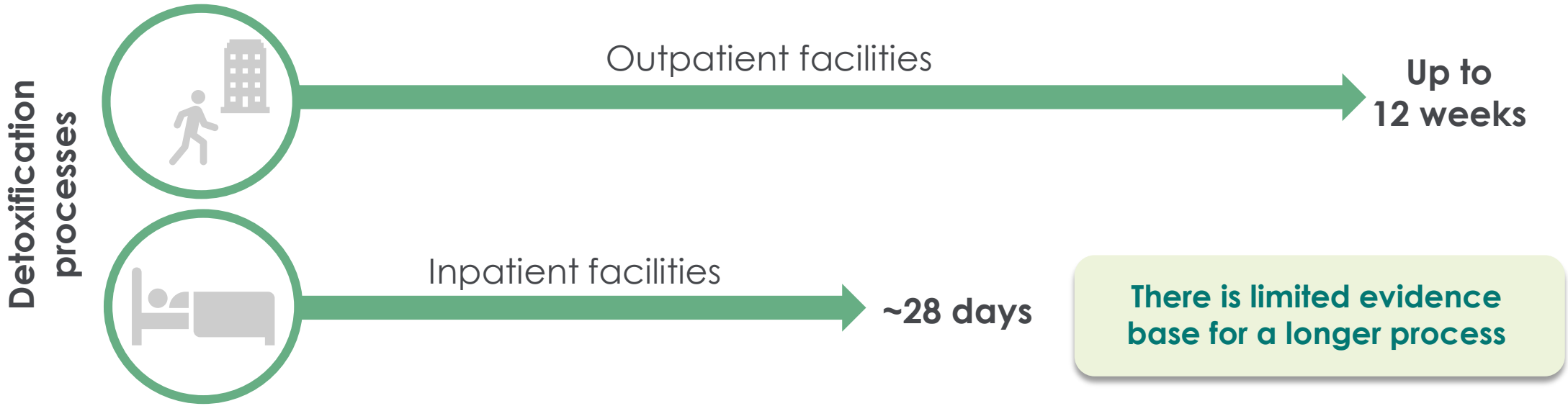
Learning objective

After this talk participants should be able to:

- **Describe abstinence-based pathways for stable opioid-dependent patients who are highly motivated to cease opioid use**

Introduction

- **'Detoxification'** – a medically supervised intervention to resolve withdrawal symptoms associated with chronic drug use
  - Sometimes a prerequisite for initiating long-term abstinence-based inpatient treatment



Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management [Accessed May 2019];
EMCDDA. Cost and financing of drug treatment services in Europe: an exploratory study. 2011. Available at: http://www.emcdda.europa.eu/system/files/publications/648/TDSI11001ENC_314423.pdf [Accessed May 2019].

Patient profile: assessing suitability for detoxification

The following factors can be used to guide both clinician and patient opinions on the patient's suitability for detoxification:

- Is the patient **fully committed to and informed about the process?**
- Is the patient fully **aware of the high risk of relapse and impact of the reduced opioid tolerance?**
- Is the patient **in a stable and supportive social situation** or able to go into one following detoxification?
- Are there **plans for continuing support and treatment** in place?

Psychosocial support, drug-free support and overdose training are vital during detoxification

Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management. [Accessed May 2019]

Forcing detoxification

- **There is limited evidence of coerced detoxification treatment having any significant positive impact on drug use or criminal reoffending in comparison to voluntary or untreated individuals.**
  - **For example**: In China, of PWUDs (people who use drugs) placed in a mandatory drug treatment centre, 46% used illicit drugs in less than a month or within 6 months of their release, and 10% relapsed in 7 to 12 months.

Therefore…

Clinicians **should not** coerce or encourage patients who are on stable doses of opioid substitution treatment to start a gradual reduction

Unbiased evidence and issues should be discussed to enable an informed decision surrounding detoxification by the patient

Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management [Accessed May 2019]; Werb et al. *Int J Drug Policy* 2016;28:1–9; Huang et al. *Int J Drug Policy* 2010;22(2):128–32.

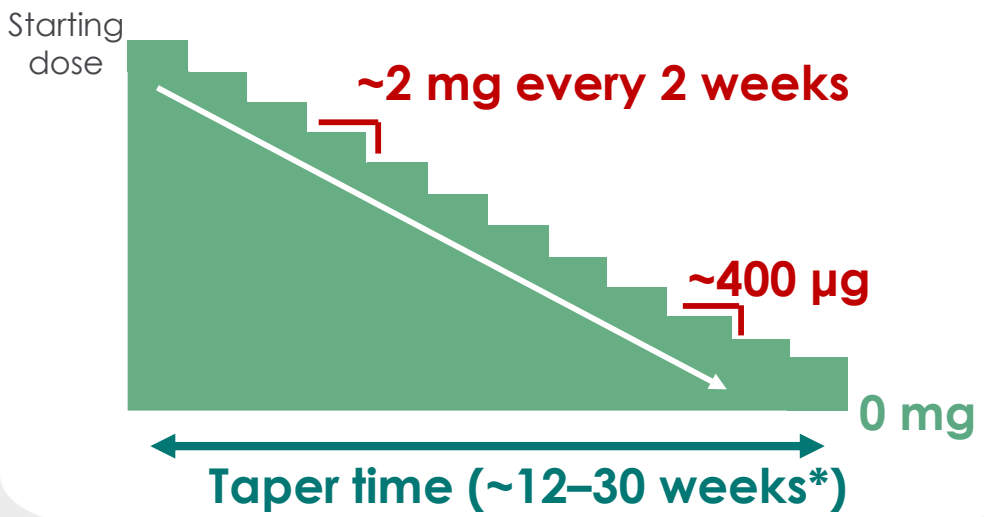
Dosing regimens for outpatient detoxification

Methadone

Synthetic **full** μ-opioid receptor agonist

Buprenorphine

Synthetic **partial** μ-opioid receptor agonist



*** Time is dependent on starting dose**

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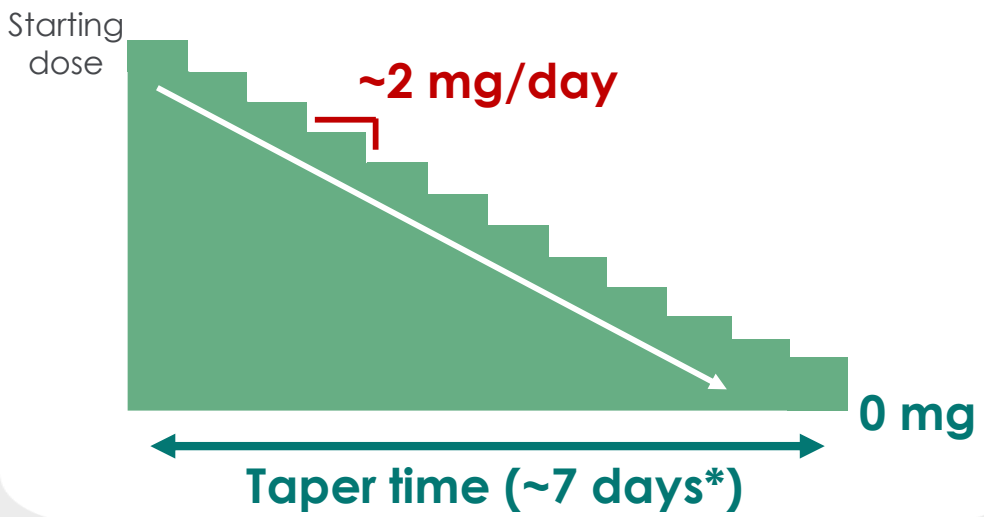

*** Time is dependent on starting dose**

Kleber. *Dialogues Clin Neurosci* 2007;9:455–70.; Speaker's Insight

Which regimen for detoxification?

Patients report that they are able to reduce buprenorphine doses more quickly than methadone doses

Neither opioid medicine appears more effective than the other in achieving good outcomes from detoxification

Detoxification should be carried out with the medicine on which the patient had stabilised

Ultra-rapid detoxification under general anaesthesia or heavy sedation must not be offered. This is because of the risk of serious adverse events, including death

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Symptomatic treatment of withdrawal

Lofexidine

- **Alpha-adrenergic agonist**
- Authorised for the **management of opioid withdrawal**
- **7–10 days** with doses starting at **800 µg daily** and rising to max of 2.4 mg in divided doses
  - Dose is reduced over subsequent days
- Considered for those who have decided: **not to use methadone or buprenorphine for detoxification**; **or to detoxify within a short time period; or have mild or uncertain dependence**
- **Side effects**:
  - Dry mouth and mild drowsiness
  - Clinically significant hypotension and/or bradycardia

Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management [Accessed May 2019];

Other symptomatic treatments

To reduce the physical effects of withdrawal symptoms:

Loperamide

Diarrhoea

Metoclopramide/ Prochlorperazine

Nausea

Vomiting

Stomach cramps

Diazepam

Anxiety

Sleeplessness

Agitation

NSAIDs / Paracetamol / topical rubefacients

Muscle pain

Headaches

Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management [Accessed May 2019];

Choosing the correct setting for detoxification

- Detoxification can take place at different intensity levels within a variety of settings

Community	Inpatient Units	Residential Units	Prisons
Examples: • Drug and recovery services • Recovery residences • Structured day programmes • Criminal justice treatment services • Peer recovery support services	**Criteria:** • Offered after repeated failure with community services • High level of medical/ nursing support • For comorbid health issues/ concurrent detoxification	**Criteria:** • Offered to those with less severe opioid dependence • Considered for those significant comorbid health issues / concurrent detoxification	**Caution:** • Stabilisation period and support may not be possible • Can increase risk of self-harm and death • Risk of post-release overdose

National Institute for Health and Care Excellence. CG52: Drug misuse in over 16s: opioid detoxification. 2007.
Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management [Accessed May 2019];

Naltrexone

- Synthetic **μ-opioid receptor antagonist**

Effective for **highly motivated** opioid-dependent people who **want to remain in an abstinence programme**

All potential adverse effects should be explained e.g. risk of overdose from attempting to overcome the blockade effect

Due to potential hepatotoxic effects, **liver function tests are required** before and during treatment

Should only be prescribed when an individual is opiate free e.g. minimum of 7–10 days after methadone dosing or a few days after buprenorphine dosing

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Naltrexone for relapse prevention

Dosing:

25 mg dose
Day 1

Total weekly dose 350 mg

- 50 mg daily:

Mon	Tue	Wed	Thur	Fri	Sat	Sun
50 mg	50 mg	50 mg	50 mg	50 mg	50 mg	50 mg

- **Or** larger doses on 3 days of the week, for example:

Mon	Tue	Wed	Thur	Fri	Sat	Sun
100 mg		100 mg		150 mg		

Formulations:

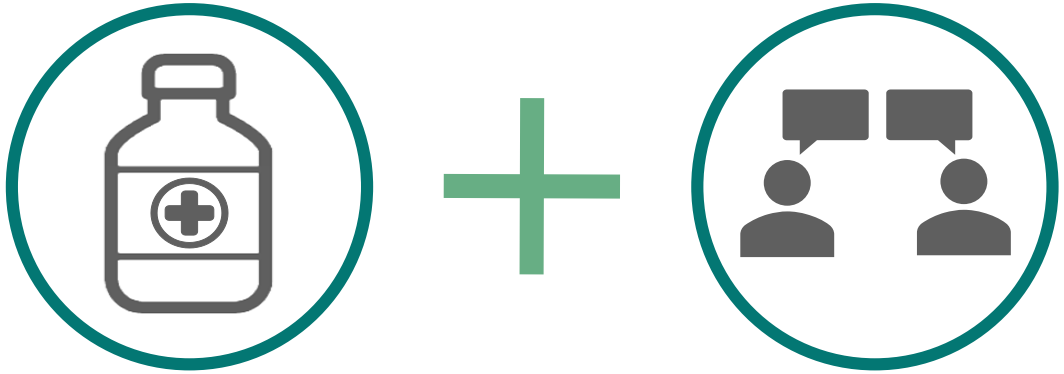
- Oral naltrexone is associated with poor patient adherence
- Implant and depot forms of naltrexone may improve adherence
- Currently, a depot formulation has been approved in the US but not in Europe

Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management [Accessed May 2019];

Psychosocial intervention

- Individuals entering detoxification can experience intense personal and medical difficulties
- **Withdrawal can cause or exacerbate current emotion, psychological or mental problems**

- **For opioid-related detoxification where medication is usually necessary, a full programme of psychosocial support should be implemented alongside the medication provided**



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Center for Substance Abuse Treatment (2015) Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 45. HHS Publication No. (SMA) 15-4131. Rockville, MD.

Psychosocial interventions

Provide **training on overdose** in case of relapse

Provide opportunities to **learn how to reduce the risk of relapse**

Provide **drug-free support** e.g. counselling, goal-setting and encouraging realistic expectations

Address the psychological, social and relationship problems that may have initiated or maintained drug use

Support retention in treatment long enough to complete detoxification

National Institute for Health and Care Excellence. CG52: Drug misuse in over 16s: opioid detoxification. 2007; Department of Health. UK guidelines on clinical management. Drug misuse and dependence. 2017; Amato et al. *Cochrane Database Syst Rev* 2011;7(9):CD005031.

Cochrane review: evidence for psychosocial interventions

Psychosocial and pharmacological treatments versus pharmacological treatments for opioids detoxification

- Total of **11 studies** (**1592 participants**) were included in this review
- A range of different psychosocial interventions were used and two pharmacological treatments (methadone and buprenorphine)
- Overall, compared with any pharmacological treatment alone, the association of any **psychosocial intervention with pharmacological treatment was shown to**:
  - Improve the number of people who completed the treatment **(RR 1.47)**
  - Reduce the use of opiates **(RR 0.82)**
  - Increase abstinence from opiates at follow-up **(RR 2.43)**
  - Halve the number of failures to attend clinic absences **(RR 0.48)**

RR: Relative risk

Amato et al. *Cochrane Database Syst Rev* 2011;7(9):CD005031.

Evidence for psychosocial interventions (I)

Study design:

Patients were randomly assigned into one of the following groups:

Standard treatment
Counselling usually provided with detoxification treatment which focuses on the disease model of addiction, problem solving issues and concerns the patient has

Intensive role induction (IRI)
Focuses on psychoeducation about detoxification, addresses misperceptions, concerns and barriers to continued involvement in treatment, e.g. focusing on how detoxification medicines will help

Intensive role induction and case management (IRI + CM)
Similar to IRI but with additional assistance from the counsellor in accessing community resources that will support their recovery

All three interventions consisted of **one weekly individual session** for the first **5 weeks of treatment**

Following detoxification, all participants could receive **at least one weekly individual counselling and once weekly group counselling**

Katz et al. *Drug Alcohol Depend* 2011;117(1):24–30.

Evidence for psychosocial interventions (II)

Outcomes:

- Individuals receiving both IRI (intensive role induction) and IRI + CM (intensive role and case management) **attended more individual counselling sessions** during detoxification in comparison to those receiving standard treatment
- Individuals **receiving IRI** (67.9%) but not IRI + CM were **more likely to complete detoxification** in comparison to those receiving standard treatment (49.4%)
- Individuals **receiving IRI were more likely to attend at least one post-detoxification treatment** session in comparison to those with IRI + CM and standard treatment
- IRI but not IRI + CM participants were **retained in treatment for more days following detoxification** than patients receiving standard treatment

Why was IRI + CM not as effective?

- Potentially due to counsellors having difficulties in providing two separate interventions with different goal within the same timeframe
- The counsellor providing CM is dependent on the collaborative nature of community agencies they have no control over

Katz et al. *Drug Alcohol Depend* 2011;117(1):24–30.

Benefits of psychosocial interventions

When combined with pharmacological treatment, psychosocial interventions:

- ✓ Reduce treatment dropouts
- ✓ Reduce the use of opiates during treatment and the follow-up period
- ✓ Reduce the number of clinical absences during the treatment period

Amato et al. *Cochrane Database Syst Rev* 2011;7(9):CD005031.

Conclusion

- **Detoxification is not suitable for all patients** – specific criteria must be met and the individual must provide consent
- **Coerced detoxification can negatively impact on the individual**, increasing the risk of relapse, blood-borne viruses and overdoses
- **Methadone and buprenorphine are commonly used for detoxification** and have similar levels of efficacy
- **Naltrexone can be prescribed to highly motivated patients** who want to continue abstinence from opioids
- **Psychosocial interventions are varied and beneficial** to individuals undergoing detoxification. These should be offered alongside pharmacological interventions