MAT TRAINING

PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Naltrexone Treatment for Opioid Use Disorder: Training for Clinicians
Part 2

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Adam Bisaga, MD, Disclosures

- Received free medication from Alkermes to support NIDA research
- Site PI on a multi-site clinical trial sponsored by Alkermes

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose thisinformation.

Target Audience

- The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Assess which patients may be good candidates for naltrexone treatment
  - Determine pharmacological strategies to initiate treatment with naltrexone
  - Discuss various pharmacological strategies to manage opioid withdrawal
  - Identify strategies to manage patients during early stages of treatment

Training Outline

Naltrexone-assisted treatment of OUD

Section 1: Introduction to treatment of OUD	**Section 2**: Patient selection and treatment Initiation	**Section 3:** Maintenance treatment and treatment logistics	**Section 4:** Special Populations
Treatment of OUD using medications	Selection of patients: individualized treatment	Long-term treatment and treatment termination	Adolescents, dual diagnosis, medically ill, pregnancy
Neurobiology of OUD and MAT	Treatment initiation scenarios	Common clinical challenges	Naltrexone in criminal justice setting
Agonist vs. antagonist: advantages and limitations	Withdrawal management and NTX induction protocols	Safety concerns	Behavioral strategies to augment effectiveness of NTX
The evidence to support use of naltrexone	Managing patients during early stages of treatment	Logistics of using injectable naltrexone	Discussing NTX and recovery with patients and families
		Demonstration of medication preparation and administration	Integrating MAT with 12-step principles and fellowship

Section 2:

Patient selection and treatment initiation

Selection of patients: individualized treatment

Patients with OUD that might be Good Candidates for Naltrexone (1)

- Patients who are not interested or able to be on agonist therapies
  - Highly motivated for abstinence from all opioids including methadone and buprenorphine
  - In professions where treatment with agonist therapy is still controversial (e.g., healthcare professionals, pilots)
- Patients who are abstinent from opioids but remain at risk for relapse
  - Released from a controlled setting (prison, residential program)
  - With increased stress or worsening of psychiatric problems
  - Moving back to neighborhood with greater exposure to drugs
- Patients who failed prior treatment with agonist
  - Continued cravings and use of illicit opioids, non-adherence with agonist medications, diverting/misusing agonists

Patients with OUD that might be Good Candidates for Naltrexone (2)

- Patients with less severe forms of a disorder
  - Short history of use, lower level of use
  - Individuals who use opioids sporadically
- Young adults living with involved parents who can supervise treatment
- Young adults unwilling to commit to longer-term agonist therapy
- Individuals who use opioids sporadically and are at risk for progression to a daily use
- Patients successful on agonist therapy who wish to discontinue medication and may seek alternative treatment

Patient-Treatment Matching

- There is no evidence for patient-treatment matching from controlled trials, only from clinical experience
- Patients who were found to have good response to treatment with oral naltrexone
  - Highly motivated patients who are committed to abstinence and engaged in recovery work
  - Older patients with long history of use and multiple relapses
  - Patients with long periods of abstinence between relapses

Treatment initiation scenarios

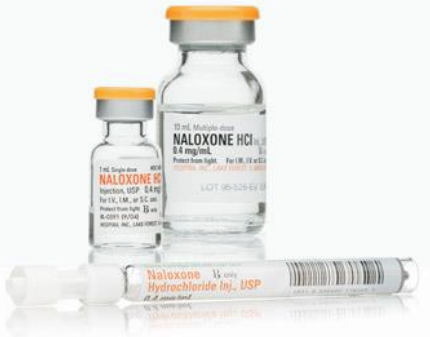
When is the Patient Ready to Receive Therapeutic Dose of Naltrexone?

- Therapeutic doses of oral or injection naltrexone will precipitate severe an prolonged withdrawal in patients who are physically dependent on opioids or have large amount of opioids in their system
- Always confirm absence of opioids and physical dependence prior to the first dose of naltrexone
  - Urine drug screen must be negative for ALL opioids (morphine, oxycontin, buprenorphine, methadone, fentanyl) BUT some opioids may not be detected on the in-office urine toxicology screen (e.g., kratom, loperamide)
  - Always perform naloxone challenge if unsure of the abstinence and the absence of physiological dependence
  - Patient must understand the risks of precipitated withdrawal if underreporting

How to Initiate Treatment with XR-Naltrexone?

- Injection of XR-naltrexone can be given immediately after confirming absence of physical dependence or passing naloxone challenge
- Though not necessary, clinician may give oral naltrexone challenge (one test dose of oral naltrexone 12.5 or 25 mg) at least 1-2 hours prior to injection to make sure that the patient tolerates naltrexone
- Alternatively, clinicians may initiate treatment with oral naltrexone first (25-50 mg/d), giving it for few days, followed by the administration of XR-naltrexone
  - This may be considered in the residential setting
  - It is recommended that XR-naltrexone is given as soon as possible to minimize risks of non-adherence to oral medication and to assure complete and extended blockade

Naloxone Challenge



- Naloxone is a short-acting opioid antagonist used to reverse overdose and to detect physiological dependence
- In dependent individuals, naloxone will precipitate withdrawal that usually emerges within 5-10 min and dissipates within 30 min
  - Severity can be measured using standard instruments (e.g., COWS)
  - Severity of withdrawal is proportional to the level of physical dependence and the dose of naloxone
  - Any change from baseline, particularly appearance of objective signs of withdrawal, evidences positive test
- Naloxone is given IM (deltoid) at the 0.8-1.2 mg dose (2-3 cc)
  - To minimize risk of significant withdrawal, may administer in 2 stages, 0.4 mg followed by 0.8 mg
- With the negative test, full dose naltrexone can be started
  - Naltrexone should not be given after the positive test (it will precipitate withdrawal lasting many hours), in that case naloxone challenge can be repeated the next day

Measuring Opioid Withdrawal

Several scales are available, objective, subjective or mixed

Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____/_____:_____

Reason for this assessment:_____

Restina Pulse Rate:_____beats/minute

Measured after patient is sitting or lying for one minute

0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

Sweating: *over past ½ hour not accounted for by room temperature or patient activity.*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Restlessness *Observation during assessment*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 Unable to sit still for more than a few seconds

Pupil size

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/ muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Runny nose or tearing *Not accounted for by cold symptoms or allergies*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

GI Upset: *over last ½ hour*

0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting

Tremor *observation of outstretched hands*

0 No tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Yawning *Observation during assessment*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Anxiety or Irritability

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Gooseflesh skin

0 skin is smooth
3 piloerrection of skin can be felt or hairs standing up on arms
5 prominent piloerrection

Total Score _____

The total score is the sum of all 11 items

Initials of person completing Assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
Source: Wesson and Ling 2003[326]

Objective Opiate Withdrawal Scale (OOWS)

Yawning	0 = no yawns 1 = ≥ 1 yawn
Rhinorrhoea	0 = < 3 sniffs 1 = ≥ 3 sniffs
Piloerection (observe arm)	0 = absent 1 = present
Perspiration	0 = absent 1 = present
Lacrimation	0 = absent 1 = present
Tremor (hands)	0 = absent 1 = present
Mydriasis	0 = absent 1 = ≥ 3 mm
Hot and cold flushes	0 = absent 1 = shivering/huddling
Restlessness	0 = absent 1 = frequent shifts
Vomiting	0 = absent 1 = present
Muscle twitches	0 = absent 1 = present
Abdominal cramps	0 = absent 1 = holding stomach
Anxiety	0 = absent 1 = mild - severe

Naltrexone Induction: Clinical Scenarios

- Abstinent, after completed opioid withdrawal
- Using opioids sporadically
- Regularly using low amounts of opioids
- Regularly using large amounts of short acting agents (heroin) or using long-acting agents (XR oxycodone, methadone)
- Patients discontinuing agonist therapy with methadone or buprenorphine

Abstinent, after opioid withdrawal

- Individuals who have completed opioid withdrawal are the easiest to start on XR-naltrexone
  - Completed outpatient opioid withdrawal and have not used any opioids for at least 7 days, not in acute withdrawal
  - Abstinent for some time but at increased risk of relapse
- Confirm absence of opioids and physical dependence
- Administer injection of XR-naltrexone

Using opioids sporadically

- Individuals who started using after a period of abstinence
- High-risk intermittent users of opioids (with or without other substance use)
- Require abstinence from opioids (2-3 days) and confirmed absence of physical dependence
  - Urine drug screen negative for all opioids
  - Negative naloxone challenge
- Administer injection of XR-naltrexone

Using daily, low amounts

- Patients who misuse opioids in the context of pain-treatment (<100mg morphine equivalents)
- Individuals using low amounts of heroin (1-3 bags/day)
- Require completion of opioid withdrawal
  - can be done on outpatient basis with daily visits for monitoring and medications
- Confirm absence of physical dependence
  - Negative urine toxicology and negative naloxone challenge
- Administer injection of XR-naltrexone

Using daily, large amounts

- Individuals using large amounts of short or long-acting opioids (IN/IV) (>5 bags heroin, oxycodone, fentanyl, methadone)
- Often using other substances (psychostimulants, alcohol, sedatives)
- Consider stabilization/maintenance on agonist as a first-line treatment
- If wishes to be treated with naltrexone consider, inpatient opioid withdrawal management (10-14 days)
- Confirm absence of physical dependence with naloxone or oral naltrexone challenge followed by injection of XR-naltrexone if tolerated
- Administer XR-naltrexone before discharge

Patients discontinuing therapy with methadone or buprenorphine

- Individuals maintained on methadone and buprenorphine with good response may be considered for transition onto naltrexone
- Patients should be able to tolerate gradual agonist dose reduction
  - Patients maintained on methadone should be first transitioned onto buprenorphine
  - All patients should remain stable on buprenorphine 2-4 mg for at least one month before discontinuation
- Adjunctive medications may be used after buprenorphine discontinuation to alleviate withdrawal
- Initiate treatment with oral naltrexone followed by XR-NTX injection
  - May wait for urine buprenorphine screen to become negative but that is not necessary if starting with low naltrexone doses

Opioid Withdrawal and Naltrexone Induction Protocols

Opioid Withdrawal

- Naltrexone is an opioid receptor antagonist and can only be started in individuals who have completed opioid withdrawal
- When naltrexone is given to patients who are physically dependent (with or without heroin in their system) naltrexone will displace heroin off the receptor and precipitate withdrawal symptoms within 30-60 minutes
  - As opposed to a slow onset of a spontaneous withdrawal
  - Precipitated withdrawal may present with atypical signs (e.g. delirium)
- Even when urine toxicology turns negative (e.g., 48-72 hrs after the last heroin dose) patients are still physically dependent and naltrexone, especially in higher doses, will precipitate withdrawal

Main Withdrawal Approaches

- Agonist-assisted opioid withdrawal
- Symptomatic-only care
- Rapid withdrawal using antagonist
- Ultra-Rapid withdrawal under anesthesia

Agonist-assisted Withdrawal

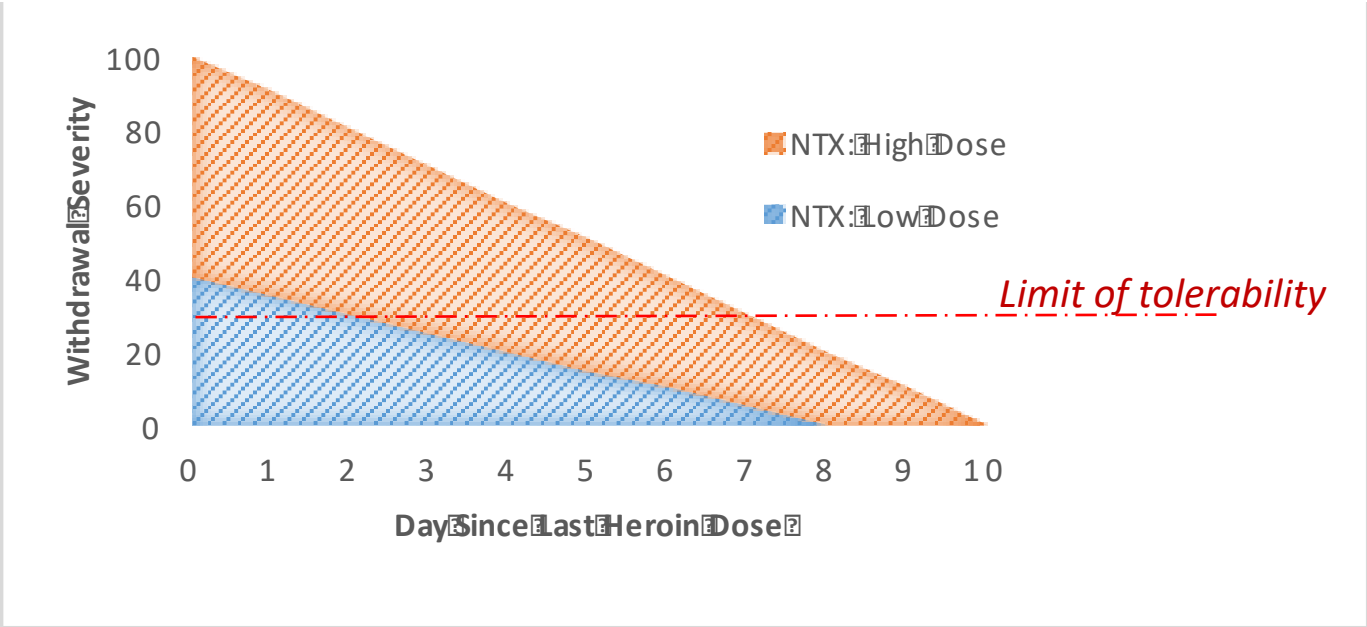
- Low doses of opioid agonist (methadone 10-20 mg or buprenorphine 4-8 mg) are given for 2-4 days to suppress severe opioid withdrawal from emerging
- Subsequently agonist is tapered off slowly to minimize the severity of emerging withdrawal
  - Adjunctive medications (e.g., clonidine, sedatives) can be used if agonist is tapered rapidly and after the last dose
  - Duration of agonist taper may be adjusted to minimize withdrawal severity in patients with high level of dependence
- Agonist-assisted withdrawal may minimize withdrawal-related complications in medically or psychiatrically ill patients, and in those with physical dependence on alcohol or sedative-hypnotics
  - If needed, slow agonist taper allows for safe completion of withdrawal over an extended period of time (weeks)

Other Withdrawal Approaches

- Symptomatic-only treatment
  - A variety of adjunctive medications is used to decrease specific symptoms of withdrawal
- Rapid withdrawal using antagonist
  - Naltrexone is added 2-3 days after the last dose of opioid starting with very low doses (3-6 mg)
  - Emerging withdrawal symptoms are treated with adjunctive medications to minimize discomfort
- Ultra-rapid withdrawal under anesthesia
  - Withdrawal is precipitated with large doses of antagonist while the patient under a deep sedation or a general anesthesia
  - Not recommended by most guidelines (higher complications, including death, and minimal advantages)
  - May be appropriate in very selected, low risk cases after careful evaluation of risks and benefits

Naltrexone During Acute Withdrawal

Administering naltrexone during the first week after stopping heroin will precipitate withdrawal with the severity depending on the time and dose



Administering low doses of naltrexone 2-3 days after last dose of heroin will NOT produce intolerable withdrawal but will accelerate time to reach the full dose of naltrexone

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Medications used during opioid withdrawal

Withdrawal Symptoms	Drug Class
Autonomic arousal (sympathetic)	α_2-Adrenergic agonists
Anxiety/restlessness	Benzodiazepines
Insomnia	Sedating antidepressants Non-benzodiazepine hypnotics Sedating atypical neuroleptics
Musculo-skeletal pain	NSAIDs Aniline analgesics (acetaminophen)
GI Distress (nausea, vomiting, diarrhea)	Oral hydration Antiemetics Miscellaneous

α_2-Adrenergic Agonists

Clonidine

- 0. 2 mg po, every 4-6 h to max 1.2 mg/d if tolerated
- 0.1 mg every 6 h if low weight, low hydration, women
- Standing dose will prevent withdrawal, more effective than using *as needed* doses to decrease existing withdrawal
- May add 0.1 mg for additional symptoms relief if vital signs are stable
- Check vital signs before each dose, hold the dose if SBP<100, DBP<60, HR<60,
- Caution in people who vomit or have severe diarrhea, do not administer if there is a postural hypotension (SBP drop of >20, DBP>10; a frequent result of volume depletion), assure continuous hydration (electrol.sol>juice>water)
- Medication reduces physical withdrawal but not craving for opiates
- Side-effects are sleepiness, dizziness, fainting, headache

Lofexidine: similar profile but less blood pressure effects

Anxiety/Restlessness (1)

- Clonazepam: start with 0.5 mg po every 4-6 h to max 3 mg/d if needed for symptom relief
  - More medication in the evening may help with insomnia
- Start with a high dose and begin reducing after day 3-4
- Use as a *standing* doses to prevent symptoms rather than *as needed* doses to alleviate symptoms
- People who are also regular users of sedatives may need higher doses and slower taper
- Alternatively use other long acting agents (e.g., diazepam, chlordiazepoxide)

Anxiety/Restlessness (2)

- Safety:
  - Medication is generally safe, well tolerated and effective during opioid withdrawal
  - Side-effects are sleepiness, incoordination, dizziness, slowed respiration, headache, rare risk of initiating sedative use disorder
- Other, longer-acting agents are preferred alternatives
  - Diazepam (10 mg PO q 4–8 h)
  - Oxazepam (15–30 mg PO q 4–6 h)
  - Lorazepam if parenteral dosing needed
- Alternative, non-benzodiazepine agents
  - Diphenhydramine (50–100 mg PO q 4–6 h)
  - Hydroxyzine (100–150 mg PO q 6 h)

Insomnia

- One of the most troublesome symptoms of withdrawal
  - generally poorly responding to medications therefore managing expectations is very important
- Benzodiazepines can offer some relief
- Sedating antidepressants
  - trazodone 100 mg, doxepin 3-6 mg or 25 mg
- Atypical neuroleptics
  - quetiapine (50-200 mg at HS)
- Non-BDZ hypnotics: zolpidem 10 mg

Pain (musculo-skeletal)

- Anti-inflammatory agents (non-steroidal) are very useful:
  - ibuprofen: 400 mg po q4-6 h, max 2400 mg/d
  - aspirin: 650 mg po q4-6 h, max 4,000/d
  - diclofenac: 50 mg q6-8 h, max 200 mg/d
  - ketorolac 30 mg IM q 6 h, max 120 mg/d for 5d
- Other analgesics/antispasmodics:
  - acetaminophen 500-1000 q8 hr, max 3,000/d caution in patients with liver disease
  - cyclobenzaprine (5–10 mg PO q 4–6 h)
  - baclofen, tizanidine, methocarbamol

GI Disturbances

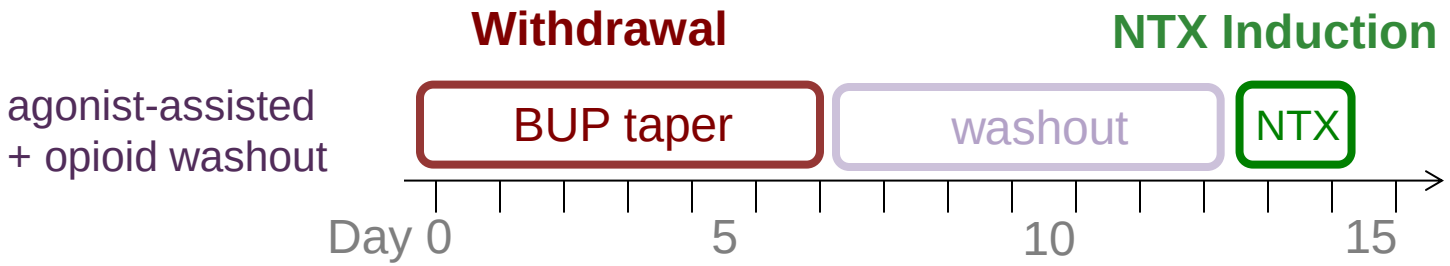
- Nausea/vomiting:
  - Metoclopramide: 10-20 mg po/im q4-6 h
  - Promethazine (25 mg PO or IM q 4–6 h)
  - Dimenhydrinate: 50-100 mg po/im q4-6 h
  - Ondansetron (8–16 mg PO or IM q 8–12 h)
- Gastric pain/irritation:
  - Cimetidine: 200-400 mg at bedtime, (ranitidine)
  - Antacid preparations
- Diarrhea
  - Lomotil (atropine/diphenoxylate): as needed
  - Loperamide (imodium): 2-4 mg after each bm, max 16 mg/d

Other Strategies

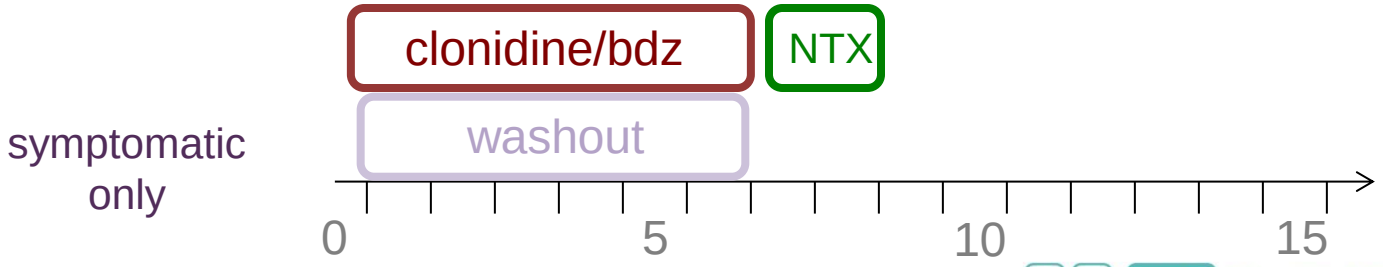
- Dehydration is very common (fluid loss, no appetite) therefore actively encourage oral fluid intake
  - electrolyte drinks (e.g., Gatorade, Pedialyte, diluted juice)
- Monitor vital signs often including postural blood-pressure changes (>20/10 mmHg drop on standing)
- Administer multivitamins
- Allow food if tolerated but liquid food (e.g., clear soups) is better if nauseous
- Hot baths can help with pain, anxiety

Initiating Naltrexone (1)

- Two phases of treatment: 1) acute withdrawal, 2) naltrexone induction
- Current FDA-sanctioned method involves 7-10 days “washout” period between the last dose of opioid and first dose of naltrexone (NTX)



- Not using agonist during withdrawal, shortens duration of induction



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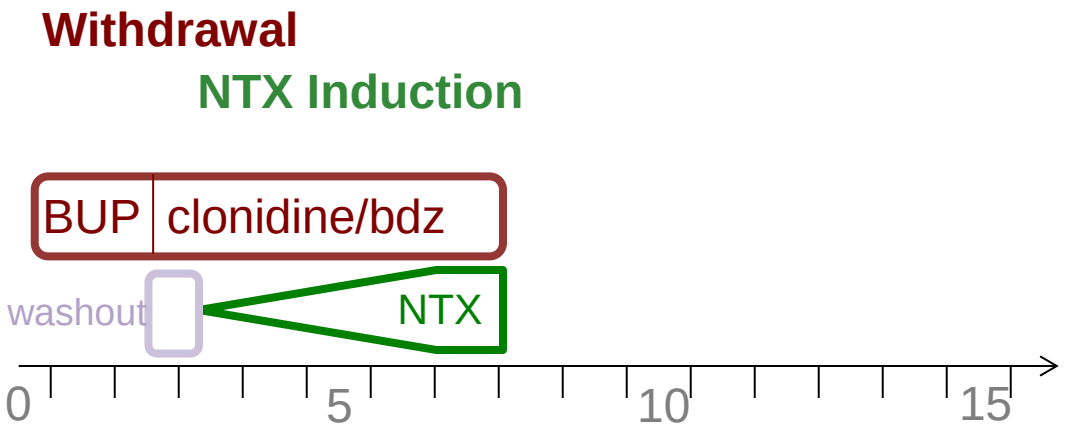
Initiating Naltrexone (2)

- Two phases of treatment: 1) acute withdrawal, 2) naltrexone induction
- Withdrawal and naltrexone induction can occur at the same time: rapid withdrawal/naltrexone induction
- Introducing low-doses of naltrexone during withdrawal accelerates the process of induction (i.e., readiness for XR-naltrexone)



Initiating Naltrexone (3)

- No single best method but rather a set of approaches/tools that can be individualized to each patient and matched with treatment team experience
- Ability of the team can influence outcome
  - to expect and respond to emerging complications
  - to maintain enthusiasm and confidence in the method
- Effective suppression of withdrawal, accomplished with a range of adjunctive medications, is essential to the success
- Effective method will balance the degree of discomfort and the duration of treatment
  - unnecessary delay to the first dose of XR-naltrexone increases the risk of dropout

Predictors of Withdrawal Severity

- It is important to be prepared for withdrawal severity which depends on:
  - Daily amount used
  - Rapidity with which drug is withdrawn
  - Type of opioid used, dose, pattern, route of administration
  - Prior withdrawal experience, expectancy, settings for withdrawal
- Some patients may have more difficulty completing withdrawal:
  - Active medical problems (hypertension, diabetes, asthma, infections)
  - Intense sadness, anxiety, or psychotic symptoms (paranoia, mania)
  - Physical condition (poor self-care, poor nutritional status)

Naltrexone Induction Algorithms (Sigmon et al., 2012)

	Severity (physical dependence/anticipated withdrawal)	
	NONE Already abstinent (completed buprenorphine taper and has abstained for 7-10 days, exiting controlled environment)	**MILD** H: 1-2 bags/day; OXY: <50mg/day
Setting	**Outpatient**	**Outpatient or partial hospital**
Buprenorphine Dose	None	None or 4mg, day 1
Clonidine	None	0.1-0.2 mg TID to QID
Clonazepam	None	0.5 mg BID
Ancillary medications	None	Sleep, pain (e.g. NSAID)
Hydration	Routine	Aggressive oral hydration
Time to first NTX dose	Day 1	Day 3
Initial oral NTX dose	25-50 mg	12.5 mg QD
Time to XR-NTX injection	Days 1-2	Day 4; (or Day 5-6 after titrating oral naltrexone to 25-50mg QD)

Rapid Naltrexone Induction Algorithm *(continued)*

	Severity (physical dependence/anticipated withdrawal)	
	MODERATE H: 3-6 bags/day; OXY (50-100mg/day); following short-term methadone or buprenorphine taper	**SEVERE** > 6 bags/day; illicit methadone; severe prescription opioid use (>100 mg/day); significant medical problems
Setting	**Partial hospital with with inpatient backup**	**Inpatient or partial hospital with inpatient backup**
Buprenorphine Dose	4-8 mg, day 1 or 2	8 mg, day 1 or 2, or >8 mg as needed
Clonidine	0.2 mg (TID to QID)	0.2-0.3 mg QID
Clonazepam	1.0-2.0 mg (TID to QID)	1.0-2.0 mg QID
Ancillary medications	Sleep, pain, GI distress	Sleep, pain, GI distress
Hydration	Aggressive oral hydration	Aggressive oral or IV hydration
Time to first NTX dose	Days 3-4	Day 4-5 (later if needed)
Initial oral NTX dose	6 mg BID	3-6 mg QD-BID
Time to XR-NTXinjection	Days 4-5; or days 5-7 after titrating oral naltrexone to 25-50 mg QD)	Day 5-6; (or Day 6-7 after titrating oral naltrexone to 25-50mg QD)

Naltrexone initiation during withdrawal: Rapid Naltrexone Induction Procedure

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine	admission	4 mg bid					
Naltrexone				3 mg	6 mg	25 mg	50 mg po 380 mg im
Supportive medications	clonidine 0.1-0.2 mg qid, clonazepam 0.5-1.0 mg tid, prochloperazine, zolpidem, trazodone						

- Protocol may be modified depending on the level of physiological dependence
- Low starting doses of naltrexone (1-3 mg) will minimize precipitated withdrawal while accelerating time to the full dose
  - At present, low-dose naltrexone is only available from compounding pharmacies
- Approximately 70% of patients complete inpatient and 60% complete outpatient procedure and accept naltrexone injection

(Bisaga et al., 2015; Sullivan et al., 2017)

Buprenorphine Bridge (after heroin) prior to Rapid Naltrexone Induction

	Day 1-10	Day 11-15	Day 16-20	Day 21-25	Day 26-30	Day 31	Day 32	Day 32	Day 33	Day 34	Day 35
Buprenorphine	8 mg	6 mg	4 mg	3 mg	2 mg						
Naltrexone								1-3 mg	6-9 mg	12-25 mg	380 mg im
Supportive medications					clonidine 0.1-0.2 mg qid, clonazepam 0.5-1.0 mg tid, zolpidem, trazodone						

- An outpatient procedure appropriate for patients with severe use disorder (e.g., injecting large doses of heroin) and those who are not able to tolerate more rapid transition onto naltrexone
- A period of treatment with buprenorphine allows patients to stabilize (stop) their drug use first prior to undergoing opioid withdrawal

Transition from Buprenorphine Maintenance to Naltrexone

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine	2 mg qd						
Naltrexone				1-3 mg	6 mg	25 mg	50 mg po 380 mg im
Supportive medications	clonidine 0.1-0.2 mg qid, clonazepam 0.5-1.0 mg tid, Prochloperazine, zolpidem, trazodone						

- Many people who are unable to taper off buprenorphine may have a greater sensitivity to withdrawal symptoms or an anxiety disorder both of which can benefit from ancillary medications and support
- Some of patients who stop buprenorphine maintenance experience protracted withdrawal (anxiety, low energy, or amotivation) that may benefit from symptomatic treatment

Protracted Withdrawal: Naltrexone “flu”

- Patients who start naltrexone right after withdrawal commonly experience a “flu-like” symptoms (low-grade withdrawal)
  - Somatic complaints: insomnia, GI distress, hyperalgesia, anergia
  - Anxiety, irritability, dysphoria, anhedonia
  - Symptom severity correlated with naltrexone dose and timing
  - Severity may be lower if naltrexone initiation is postponed (but relapse risk)
- Partially alleviated with aggressive symptomatic treatment,
  - Insomnia (v. frequent, often severe): zolpidem, trazodone, quetiapine
  - GI distress: H2 blockers
  - Anxiety/hyperarousal: clonazepam, clonidine, gabapentin
- Most of these symptoms remit by 2-4 weeks
  - True prolonged symptoms are rare and likely reflect additional psychopathology

Managing Patients during Early Stages of Treatment

Strategies for Engaging and Retaining Patients During Withdrawal

- Educate patient on the withdrawal process
- Use support systems: family, friends, patient advocates
- Use strategies to enhance motivation
- Foster therapeutic alliance
- Maintain a drug-free environment

Enhancing Motivation to Remain in Treatment

- Individualize treatment, focus on the patient's strengths
- Show respect for a patient's decisions and autonomy; respect should be maintained at all times, even when the patient is intoxicated
- Empathize with the patient, make an attempt to understand the patient's perspective and accept his or her feelings
- Accept treatment goals that involve small steps toward ultimate goals
- Assist the patient in developing an awareness of discrepancies between her or his goals or values and current behavior
- Avoid confrontation
- Avoid the “labeling trap.” Do not use labels that depersonalize the patient, such as “junkie”

Fostering Therapeutic Alliance: Clinician's Characteristics

- Is supportive, empathic, and nonjudgmental
- Can establish rapport with any patient
- Respects and discusses confidentiality issues
- Acknowledges challenges on the road to recovery
- Is consistent, trustworthy, and reliable
- Remains calm even when a patient is upset
- Is confident but humble
- Sets limits without engaging in a power struggle
- Recognizes the patient's progress toward a goal
- Encourages self-expression on the part of the patient

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PCSS-MAT Mentoring Program

- PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS-MAT Mentors are a national network of providers with expertise in **medication-assisted treatment and addictions**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

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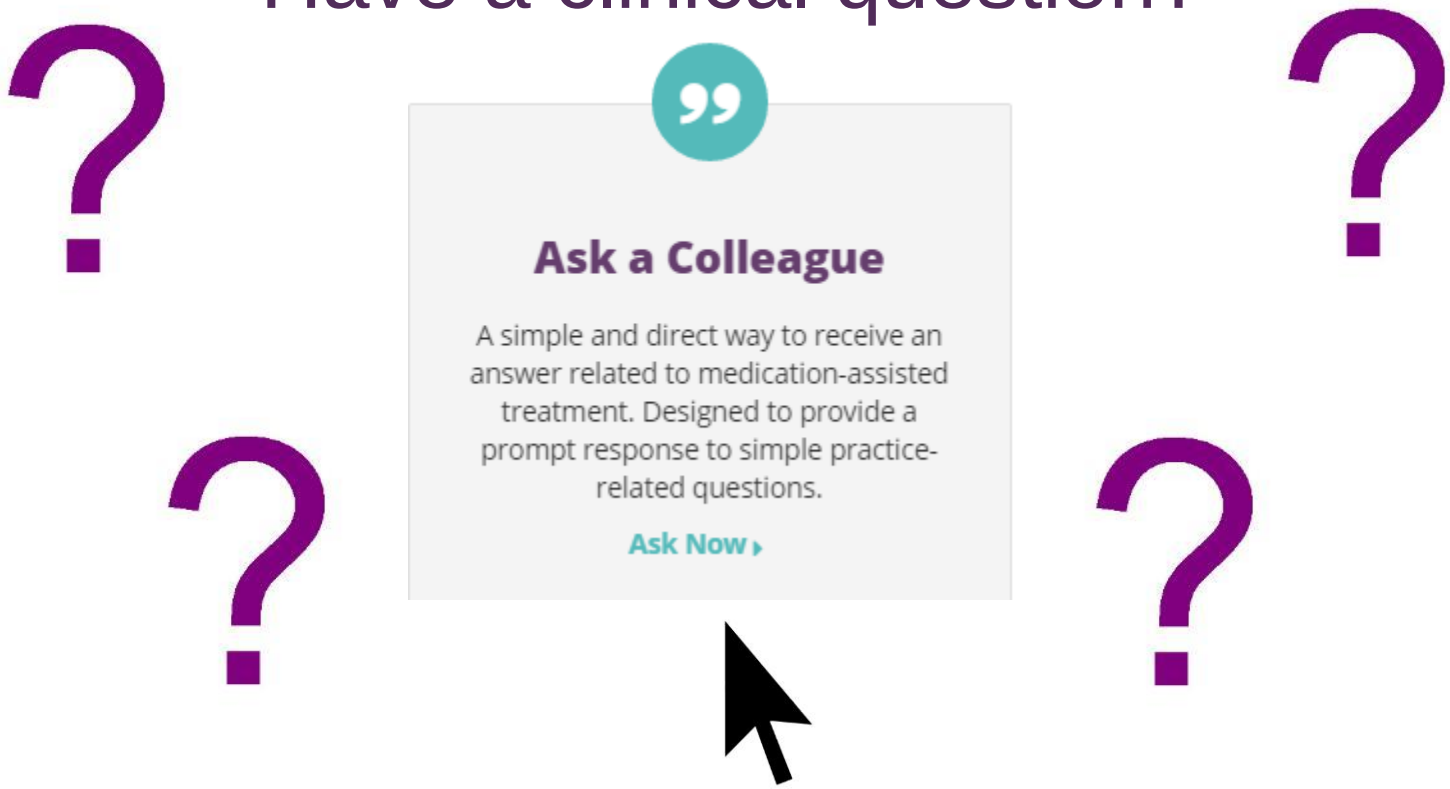

PCSS MAT TRAINING

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PCSS-MAT is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with the: Addiction Technology Transfer Center (ATTC); American Academy of Family Physicians (AAFP); American Academy of Pain Medicine (AAPM); American Academy of Pediatrics (AAP); American College of Emergency Physicians (ACEP); American College of Physicians (ACP); American Dental Association (ADA); American Medical Association (AMA); American Osteopathic Academy of Addiction Medicine (AOAAM); American Psychiatric Association (APA); American Psychiatric Nurses Association (APNA); American Society of Addiction Medicine (ASAM); American Society for Pain Management Nursing (ASPMN); Association for Medical Education and Research in Substance Abuse (AMERSA); International Nurses Society on Addictions (IntNSA); National Association of Community Health Centers (NACHC); and the National Association of Drug Court Professionals (NADCP).

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Funding for this initiative was made possible (in part) by grant no. 1U79TI026556-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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