Opioid Agonist Therapy: The Duration Dilemma

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Q: I have read 40 mg of methadone stops withdrawal, so why don't we start at 30mg and maybe later in the day add 10mg?

A: *Federal Regulations stipulate that 30mg is the maximum first dose in an Opioid Treatment Program (OTP), and with proper documentation, an additional 10mg may be given later the first day.*

Q: Can quantitative levels of buprenorphine or norbuprenorphine urine toxicology be used to monitor compliance, rule out diversion?

A: *Somewhat. The presence of norbuprenorphine means that the urine specimen was obtained from someone—hopefully the patient—who had taken buprenorphine and it metabolized to norbuprenorphine. With maintenance the norbuprenorphine levels should be higher than the buprenorphine levels.*

Q: Regarding the POATS study: I am wondering what the additional counseling was, such as the treatment modalities, methods, evidence based approaches, etc.?

A: *The additional counseling was manual-guided opioid dependence counseling. The sessions lasted 45—60 minutes, and initially were two times per week, and decreased as the study progressed. For more detailed information the reference is: Weiss R. Arch Gen Psych, 2011;68(12):1238-1246*

Q: Could a return to normal phospholipid balance be an indicator of neural readiness to be successfully weaned from opioid substitution (and perhaps switched to antagonist maintenance)?

A*: All the data I showed demonstrated significant relapse after tapering. Whether transfer to IM naltrexone would be effective is not known.*

Q: Are there studies showing 50-60% of buprenorphine treated patients stop the drug within a year because of side effects such as feelings of being high or blunting of emotion?

A*: I am not familiar with such studies. Generally buprenorphine, after proper dose stabilization, is well tolerated.*

Q: What is optimal dose for buprenorphine maintenance?

A: *I'm not trying to be coy, but the optimal dose is the correct dose for each individual patient. Generally it is between 4—16mg daily, but it can be higher or lower.*

Q: Addiction is a chronic brain disease, so should the duration of OAT be for life?

A: *Since the vulnerability cannot be "cured," and relapse is so common, I think indefinite maintenance is the best strategy. Please read the Dole Lasker Award reference on the last slide.*

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Q: Will a long-acting buprenorphine form help diminish the stigma or diversion risk?

A: *Yes a depot formulation will be a significant advance in decreasing abuse, misuse and diversion, which is extraordinarily important. The formulation does not impact the stigma.*

Q: Is buprenorphine/naloxone really safer and less abused than buprenorphine (mono product)?

A*: Results are mixed on this issue, but the use of the "combo" formulation, except for pregnant women, is the current recommendation.*

Q: What biologic markers we have to determine who will benefit from methadone or buprenorphine and for how long?

A: *We have no biologic markers, but we have a voluminous 50-year evidence-based literature on the effectiveness of opioid agonist therapy for the treatment of opioid use disorder.*

Q: A lot of our local buprenorphine treatment programs have a rule to discharge after three "dirty" urines. Is this a reasonable practice? What is a reasonable involuntary discharge protocol from buprenorphine clinic?

A: This is a difficult question to answer in this format. Certainly if a patient is violent, is selling their medication, or stealing prescription pads, it is hard to see how treatment continues. With other issues like urine drug tests that show non-prescribed or illicit drugs (the term "dirty urines" is no longer used), clinical judgment and individualization is required. We would probably first recommend more counseling and closer monitoring, not discharge. Many patients continue occasional opiate abuse during the early phases of treatment. This has no implications for long-term outcome. These complex clinical matters are best discussed with a clinical mentor, which you can access at the PCSS-MAT website.

Q: What about the new stimulants, e.g. bath salts; those in OMT are more prone in "liking" them because of the "speed ball of the poor effect ". What can we do?

A: *Other drug use has always been a problem in the OTPs. Research shows decreases in the use of other drugs with time. Counseling and, if needed, in-patient rehabs are helpful. Psychiatric consultation should be considered.*

Q: Can you discuss why methadone is not available for addiction treatment by any physician, why only through "clinics"?

A*: This has been a Federal Regulation since 1972. Methadone for the treatment of opioid use disorder can only be accessed via federally regulated clinics. The idea was to provide multidisciplinary services, maintain security over the medication, and avoid "pill mills."*

Q: What about methadone or buprenorphine patients who are asking for sedating meds like benzodiazepines, antipsychotics and anticonvulsants. Are they still drug-seeking?

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A: *Patients with opioid use disorders have high rates of psychiatric co-morbidity. Most addiction medicine specialists try to avoid long-term use of benzodiazepines. The other medications you mention should be prescribed by a properly trained clinician, in an appropriate clinical scenario.*

Q: How do you deal with the insurance company that "requires monthly counseling and U-tox" to accept giving buprenorphine on a person stable on this medication for 14 years?

A: *Big Problem. Vexing Problem. I request a one-on-one review with the medical reviewer. Most of the time they tell me they never knew such long-term patients existed; then they approve.*

Q: Excellent talk.

A: Best question so far☺

Q: Is Baclofen for alcoholism perhaps analogous?

A: *There are data on Baclofen for alcohol withdrawal treatment and for maintenance. I'm not familiar enough with the outcomes to say anything definitive, but as I said: All Treatments Work for Some Patients.*

Q: Are there any data regarding length of habit as a factor in how long people should be treated, or whether it is first or subsequent treatment episode?

A: *This intuitively sounds reasonable, but I don't think the data support the concept. In my own practice I look at the vulnerability factors—genetics and environment—and the person's liking of the opioids as the significant risk factors. But as long as the patient is closely monitored, you can start with any treatment you and the patient agree is best.*

Q: The duration is life-long.

A: I agree with the statement.

Q: How often do you check for liver transaminases on a patient who is stable on OAT?

A: *In someone with no other reason to check LFTs, such as Hep C, other drug therapy, etc, I don't check at all. The data is that neither methadone nor buprenorphine are hepatotoxic.*

Q: What about healthcare professionals who have opioid use disorders and they are working with the public?

A: Physicians and other health care providers with opioid use disorders who are in a stable recovery program should function well and provide excellent care to their patients.

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Q: There are actually only two states left where there is no methadone maintenance - Wyoming and North Dakota.

A: *This is real progress. A few years ago seven states prohibited methadone.*

Q: Why do medical committees reject methadone and buprenorphine for addicted physicians and place them on naltrexone?

A: *They rightly claim that physicians have excellent outcomes with naltrexone or drug- free treatment. In addition there are no well conducted studies of physician performance while taking either methadone or buprenorphine. Some state monitoring programs are allowing physicians to be maintained on buprenorphine.*

Q: What do you do when patients are not willing to do anything other than taking high doses of buprenorphine/naloxone?

A: *It depends on so many factors. This is a perfect question for a mentor-mentee conversation. You can access a mentor at the PCSS-MAT website, www.pcssmat.org*

Q: As a managed care medical director, I can't get "detox" programs to quit detoxing from opiates and can't seem to overcome resistance to referral to medication assisted treatment. Comments?

A: *These programs are potentially at legal risk for providing non-evidenced based treatments to their patients. You should suggest that they listen to this webinar and others on the PCSS-MAT website.*

Q: Can you say more about buprenorphine doses to prevent withdrawal vs. buprenorphine doses to create blockade?

A: *I recommend you read the reference: Drug and Alcohol Dependence, 144(2014) 1-11. It's a complicated analysis, but definitely worth reading.*

Q: When patients are diverting their prescribed buprenorphine, is there an alternative other than sending them to methadone treatment?

A: *Unless you can do directly observed therapy, no. They can get buprenorphine in some Opioid Treatment Programs (OTPs). I understand that depot buprenorphine formulations are on the horizon, and should solve this problem. Shorter prescriptions and lower doses, plus more counseling may also be helpful.*

Q: What do you recommend regarding the concurrent use of buprenorphine and benzodiazepines?

A: *Trying alternative strategies, both pharmacologic and non-pharmacologic, to deal with anxiety.*

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Q: Aside from patient preference, what might be objective indicators for antagonist treatment instead of OAT/OBOT? Would benzodiazepine misuse be one such indicator because of the danger of synergism?

A: *There are two excellent webinars on antagonist therapy: one by Dr. Adam Bisaga and one by Dr. Sullivan. The session recordings can be accessed at www.pcssmat.org*

Q: In reference to discharging clients, there are some who continuously test positive on each and every drug screen. Doesn't this show the risk of overdose while in the program which may raise a risk for the licensed persons providing treatment? Unfortunately, not each client responds or engages treatment the first time. Some clients say the concern about being discharged or placed in a higher level care had a positive impact on their taking action to make change.

A*: Maintaining a stable buprenorphine dose may be protective against the risk of an overdose with a full agonist. However, mixing buprenorphine with benzodiazepines or other sedatives will increase the risk of lethal overdose. A specific answer can't be provided without more information on the specific patient.*

Q: Is sedation a myth of MMT?

A*: With the following provisos sedation on MMTP is a myth: Stable dose taken daily. Dose that has been titrated to maximal functional capacity of the patient. No illicit or non-prescribed drugs in the UDT. No obstructive sleep apnea, or other reasons for drowsiness.*

Q: Given the treatment limit of 100 patients in an area where there are very limited buprenorphine providers, when do you draw the line on patients who are relapsing or less compliant to give others a chance? Alternatively way to look at this is that those who are struggling are the ones who really need it.

A: *Great question. It needs a policy solution, like extending the patient cap, at least selectively.*