Addressing benzodiazepine use

Introduction: Given the potential lethality of opioids and benzodiazepines, special attention needs to be given to patients taking both classes.
Excerpted from Management of Benzodiazepines in Medication-Assisted Treatment [44]:
"Generally:
1. Individuals must be agreeable to engage in a plan to address their benzodiazepine use before beginning MAT.
2. [*The evidence base does not support the use of chronic*] benzodiazepines in a person presenting for MAT with methadone or buprenorphine is contraindicated. It presents an extremely high risk for adverse drug reaction involving overdose and/or death during the induction process. [*A closely supervised, short-term benzodiazepine taper is indicated in this instance.*]
3. CNS [*central nervous system*] depressant use is not an absolute contraindication for either methadone or buprenorphine, but is a reason for caution because of potential respiratory depression. Serious overdose and death may occur if MAT is administered in conjunction with benzodiazepines, sedatives, tranquilizers, anti- depressants, or alcohol.
4. Individuals who use benzodiazepines, even if used as a part of long-term therapy, should be considered at risk for adverse drug reactions including overdose and death….
6. If a person presenting for MAT will not allow a clinician to coordinate care, he or she [*is not*] appropriate for methadone and/or buprenorphine

Managing Relapse

Introduction: Relapse is an anticipated event in the process of recovery. Nonetheless, there are practices that prescribers can adopt that are more likely to promote recovery than others. Best practices to address relapse are detailed here.

Excerpted from APA guidelines [2]: "Because individuals with substance use disorders are often ambivalent about giving up their substance use, it can be useful to monitor their attitudes about participating in treatment and adhering to specific recommendations. These patients often deny or minimize the negative consequences attributable to their substance use; this tendency is often erroneously interpreted by clinicians and significant others as evidence of dishonesty. Even patients entering treatment with high motivation to achieve abstinence will struggle with the reemergence of craving for a substance or preoccupation with thoughts about attaining or using a substance. Moreover, social influences (e.g., substance- using family or friends), economic influences (e.g., unemployment), medical conditions (e.g., chronic pain, fatigue), and psychological influences (e.g., hopelessness, despair) may make an individual more vulnerable to a relapse episode even when he or she adheres to prescribed treatment. For these reasons, it can be helpful for clinicians and patients to anticipate the possibility that the patient may return to substance use and to agree on a corrective plan of action should this occur. If the patient is willing, it can be helpful to involve significant others in preventing the patient's relapse and prepare significant others to manage relapses should they occur.

Supporting patients in their efforts to reduce or abstain from substance use positively reinforces their progress. Overt recognition of patient efforts and successes helps to motivate patients to remain in treatment despite setbacks. Clinicians can optimize patient engagement and retention in treatment through the use of motivational enhancement strategies [45, 46] and by encouraging patients to actively partake in self-help strategies. Monitoring programs, such as EAPs and impaired-physician programs [47-49], can sometimes help patients adhere to treatment.

Early in treatment a clinician may educate patients about cue-, stress-, and substance-induced relapse triggers [50, 51]. Patients benefit from being educated in a supportive manner about relapse risk situations, thoughts, or emotions; they must learn to recognize these as triggers for relapse and learn to manage unavoidable triggers without resorting to substance-using behaviors. Participation in AA or similar self-help group meetings can also support patients' sobriety and help them avoid relapse. Many other strategies can also help prevent relapse. Social skills training is targeted at improving individual responsibility within family relationships, work related interactions, and social relationships. During the early recovery phase, it can be helpful to encourage patients to seek new experiences and roles consistent with a substance-free existence (e.g., greater involvement in vocational, social, or religious activities) and to discourage them from instituting major life changes that might increase the risk of relapse. Facilitating treatment of co-occurring psychiatric and medical conditions that significantly interact with substance relapse is a long- term intervention for maintaining sobriety [52-54]. Therapeutic strategies to prevent relapse have been well studied and include teaching individuals to anticipate and avoid substance-related cues (e.g., assessing individual capacity to avoid relapse in the presence of substance-using peers), training individuals how to monitor their affective or cognitive states associated with increased craving and substance use, behavioral contingency contracting, training individuals in cue extinction and relaxation therapies to reduce the potency of substance-related stimuli and modulate craving intensity, and supporting patients in the development of coping skills and lifestyle changes that support sobriety [55, 56]. Behavioral techniques that enhance the availability and perceived value of social reinforcement as an alternative to substance use or reward for remaining abstinent have also been used [57]. If relapse does occur, individuals should be praised for even limited success and encouraged to continue in or resume treatment. Clinicians may help patients analyze relapses as well as periods of sobriety from a functional and behavioral standpoint and use what is learned to adjust the treatment plan to fit the individual's present needs. For chronically relapsing substance users, medication therapies may be necessary adjuncts to treatment."

Obtaining informed consent concerning all available opioid use disorder treatment options, including risks and benefits of each option.

Introduction: The informed consent process should ensure that each patient voluntarily chooses their treatment and that relevant facts concerning the use of the medications (including non-opioid medication treatment options) are clearly and adequately explained, such as follows :

Opioids are drugs that stimulate mu-receptors in the brain to produce a wide range of effects including pain relief, sedation, euphoria, addiction, and, with high enough doses, death. Opioids include heroin, morphine, methadone, oxycodone, hydrocodone, buprenorphine, tramadol and others. An opioid use disorder (i.e. addiction) is diagnosed when opioids are used in a compulsive, uncontrolled way producing negative physical, mental and social consequences. Treatment options for opioid addictions are compared below.

Behavioral Interventions: Behavioral interventions are recommended to accompany any addiction treatment.
Benefits and advantages:
Capable of addressing a host of contexts associated with addiction (e.g., depression or pain)
No medication costs or side effects, except in the case of adolescents, where groups have been shown to worsen prognosis
Risks and downsides:
The long-term chance of quitting opioids is low without taking medication like those listed below.
Group therapies involve some compromise of confidentiality and can be time consuming.

Methadone: Methadone is an opioid dispensed by a government regulated Opiate Treatment Provider (OTP).

Benefits and advantages:

Scientifically proven to reduce withdrawal, illicit opioid relapse, psychiatric, legal, medical, social and financial consequences of opioid addiction.
Clients are monitored closely for progress.

Risks and downsides:
Requires ongoing use of opioids
Requires daily, often early morning visits to the OTP in the first months.
OTPs typically focus on only opioid addiction and do not treat other co-occurring addictions and mental illnesses.
OTP/Methadone treatment is generally not covered by public/private insurance. Only 13 OTP clinics and the Veteran's Administration in Indiana--so may need to drive long distances.
Methadone can cause serious side effects with high doses, or when mixed with alcohol, benzodiazepines, barbiturates or certain muscle relaxants; Can cause irregular heartbeat, cessation of breathing and death.
Stopping methadone, as with any opioid, causes opioid withdrawal sickness. Accidental ingestion by children can be fatal.

Buprenorphine (Suboxone, Subutex, Zubsolv, Bunavail): Buprenorphine is an opioid prescribed by an OTP or a doctor with a special prescribing certification. It has many of the same benefits and risks as methadone. However there are several key differences listed as follows.

Benefits and advantages:
Buprenorphine treatment (outside of an OTP) typically requires fewer treatment appointments than methadone to receive medication.
Buprenorphine treatment is more often covered by public and private insurance. Risk of lethal over dose is much less than with methadone or other opioids.
Babies born to mothers maintained on Buprenorphine have less risk of experiencing NAS.

Risks and downsides:
May not work as well as methadone in certain patients with severe opioid addiction. Lack of highly structured treatment programming with buprenorphine does not serve some people well.

Naltrexone (Revia, Vivitrol): Naltrexone is a prescription drug that blocks the effects of opioids in the brain. Naltrexone comes as a pill that is taken one or two times a day or as a shot given by a nurse once a month. You cannot take opioids for about two weeks before starting naltrexone. Naltrexone is also used to treat alcohol addiction.

Benefits and advantages:
Does not require the use of an opioid to facilitate recovery Increases adherence to psycho-social treatment.
Significantly reduces cravings for opioids.
Will not result in respiratory depression if taken in excess Covered by most insurance plans.
Treats alcohol addiction too.

Risks and downsides:
Naltrexone may cause opioid withdrawal symptoms if started before someone has detoxed from opioids.

Can cause serious liver problems, although this is more likely when taking high doses of the oral form. Opioid pain medications will not work as well when taking naltrexone. The injection can cause some discomfort, rarely could become infected. Individuals can still overdose on opioids, while taking naltrexone.

Should not be started during pregnancy.

This information has been reviewed with the client, by the signing physician.

Signature of Client: date:

Signature of Physician: date:

Drug Testing

Introduction: Testing biological samples for the presence of drugs of abuse is an essential part of the treatment of OUDs. Best practices of drug screening are detailed here.

Excerpted from APA[2]: "Urine drug testing, or other reliable biological tests for the presence of drugs, during the initial evaluation and frequently throughout treatment, is highly recommended. Results from some studies have indicated that more intensive monitoring of substance use may increase recovery rates from a substance use disorder…There are a variety of toxicology tests available, some with greater and lesser reliability and validity. Urine testing is useful for detecting substance use over the preceding 5-day period for common substances of abuse (cocaine, opiates, cannabis, amphetamines, benzodiazepines, and PCP); however, certain opioids (buprenorphine, oxycodone, hydrocodone, and fentanyl) cannot be detected with routine methods and require special assays. [*It is important to screen for the metabolites of the prescribed opioid agonist (e.g. norbuprenorphine), to ensure compliance with the treatment. Point of care testing (e.g., urine testing) is needed to make rapid clinical decisions, supplemented by "send out," confirmatory laboratory values.*] The person who is interpreting these labs should be very familiar with the methodology and the reliability.
There is little research on the optimal frequency of testing, [*however, random drug testing is ideal.*]….The frequency of drug testing will be determined by a number of factors, including the stability of the patient, the type of treatment, the treatment setting, and the half-life of drugs in the matrix being tested. Patients will likely require more testing early in treatment or during periods of relapse. Patients participating in office based treatment with buprenorphine may be tested at each office visit.

Opioids are detectable in the urine for 1–3 days after use. A negative urine test combined with no history of withdrawal may indicate a lack of physical dependence.

However, a negative urine test does not rule out opioid use, disorder, or physical dependence. Urine testing is also helpful to identify
(1) use of other psychoactive substances.
(2) If a patient tests positive for an illegal drug…or a controlled substance that the patient is not taking as part of the treatment plan, then the provider needs to review the treatment plan and consider changes with the goal of opioid abstinence."

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