OAT, OUD, OMT, OAD … And that’s just the beginning of the problem.
Making sense of Opioid Use Disorder with the PEER Guidelines

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Learning Objectives
At the end of this session, participants will be able to:
• Understand the best available evidence on OUD management in primary care.
• Describe methods used to identify patients with OUD.
• Compare and contrast available treatments for OUD.

TOP QUESTIONS
• Where should OUD be managed?
• How is OUD best diagnosed?
• What is the efficacy and safety of pharmacotherapy for OUD including:
  – Buprenorphine-naloxone
  – Methadone
  – Naltrexone
  – Cannabinoids
• What is the evidence for prescribing practices including
  – contracts, urine drug screens and witnessed ingestion
• What is the evidence for the tapering of opioids or OAT?
• Do psychosocial interventions improve outcomes for patients already on pharmacotherapy?
• Does residential treatment improve outcomes?
• How do we manage comorbidities in patients on pharmacotherapy for OUD (acute and chronic pain, ADHD, anxiety and insomnia)
Opioid Use Disorder Guideline

**Process**

**OUD Committee**
- 3 generalist GPs (TK, DK, EO)
- 2 inner-city GPs (JM, TM)
- 1 addiction & pain GP (NW)
- 1 psychiatrist (WL)
- 1 social worker (KR)
- 1 community support worker (CB)
- 2 non-voting pharmacist project managers (AJL, BT)

**Evidence Review Committee**
- 4 GPs (MA, MK, TK, SG)
- 5 Pharmacists (AL, JT, BT, ND, RT)
- 1 nurse (DP)
- 2 medical students (CF, PY)

**External Peer Review**
- 60 Peer Reviewers

**Final Guideline**

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**Outcomes we Care About**

- Morbidity and Mortality
- Societal Outcomes
- Quality of Life
- Treatment Retention

**What we Found**

### Morbidity and Mortality

- Street opioid abstinence
  - 53% vs 35% specialty care; NNT=6

### Societal Outcomes

- Street opioid abstinence
  - 53% vs 35% specialty care; NNT=6

### Quality of Life

- Street opioid abstinence
  - 53% vs 35% specialty care; NNT=6

### Treatment Retention

- Street opioid abstinence
  - 53% vs 35% specialty care; NNT=6

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**Where is OUD best managed?**

**OAT in primary care vs specialty care (3 RCTs, mean 42 wks)**
- Retention in treatment (3 RCTs, 287 patients):
  - 86% vs 67% specialty care; **NNT=6**
- Street opioid abstinence (3 RCTs, 313 patients):
  - 53% vs 35% specialty care; **NNT=6**
- All trials included some element of additional training, consultant availability and team support

**OAT vs Waitlist**
- Retention in treatment (3 RCTs, 458 patients)
  - 68% vs 22%; **NNT=3**

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**Identifying the OUD patient in your chronic pain population**

**OAT versus Waitlist**

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**Additional Limitations**

- Inconsistent terminology
  - eg “heroin abuse”, “opioid use”, “addiction”
  - ORT, OST, OAT, OMT…
  - “Usual care”

- Small studies, very high drop-out rates

- Multiple outcomes assessed, only positive findings reported
  - ie urine drug screens at 1,2,4,8,12,16,32 weeks...

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*“Fourteen male patients were enrolled... Only males were selected because the rate of opioid abuse is thought to be negligible among females.” Indian J Psychol Med 2017;39:445-9*
How do I Diagnose OUD?

Searching for tools to help identify OUD:
- Found 14 systematic reviews with 6-50 studies
  - 16 different tools studied.
  - 23 different diagnostic criteria used for comparison.
- Only 2 compared to the “gold standard” DSM
  - COMM – 40 pt scale with 17 questions
    - Positive LR 3.35 (Small help ruling in)
    - Negative LR 0.30 (Small-moderate help ruling out)
  - POMI – 6 question checklist
    - Positive LR 10.3 (Large help ruling in)
    - Negative LR 0.20 (Moderate help ruling out)
    - POMI completed in patients using prescription opioids

To Taper or Not to Taper?
- **Tapering to discontinue prescribed opioids:** No RCTs
- **Switch to OAT and Taper:** 3 RCTs
  - 1 aimed for 60 pain pts, stopped – all randomized to taper or not
  - 6/57 (11%) of taper pts remained group
- **Observational Data:** 10 yrs, 25 500 patients
  - 2.5% successfully tapered off methadone
  - >52 wk more successful than <12 wk taper
  - OR 6.68

Opioid Agonist Therapy for OUD

<table>
<thead>
<tr>
<th>Treatment Retention</th>
<th>RCTs</th>
<th>Follow Up</th>
<th>Tx</th>
<th>Control</th>
<th>NNT</th>
<th>Quality of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine vs placebo</td>
<td>9 RCTs</td>
<td>30-52 wks</td>
<td>65%</td>
<td>40%</td>
<td>4</td>
<td>Moderate</td>
</tr>
<tr>
<td>Methadone versus no Methadone</td>
<td>6 RCTs</td>
<td>45-84 wks</td>
<td>73%</td>
<td>22%</td>
<td>2</td>
<td>Moderate</td>
</tr>
<tr>
<td>Methadone vs Buprenorphine</td>
<td>24 RCTs</td>
<td>2-52 wks</td>
<td>60%</td>
<td>40%</td>
<td>7</td>
<td>Moderate</td>
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<tr>
<td>Abstinence</td>
<td></td>
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<tr>
<td>Buprenorphine vs placebo</td>
<td>3 RCTs</td>
<td>206 patients</td>
<td>60%</td>
<td>39%</td>
<td>5</td>
<td>Moderate</td>
</tr>
<tr>
<td>Methadone versus no Methadone</td>
<td>4 RCTs</td>
<td>753 pts</td>
<td>47%</td>
<td>22%</td>
<td>4</td>
<td>Moderate</td>
</tr>
<tr>
<td>Meth vs Bup</td>
<td>6 RCTs</td>
<td>566 pts</td>
<td>30%</td>
<td>28%</td>
<td>NSS</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
Reduction in overdose mortality with expanded access to OAT (France)

Corriere et al., 2006

So...what about Mortality?

- Rarely reported in RCTs – only 10 pharmacotherapy trials included data on deaths
  - Trials comparing buprenorphine, methadone or naltrexone to placebo or no intervention
- Deaths occurred in 6/10 trials
  - 13/472 deaths in control group
  - 4/463 deaths on pharmacotherapy

Reduced Mortality with OAT?

OR=0.34
(CI 0.10 – 0.95)

Bottom Line: Exploratory analysis suggests that OAT may reduce mortality in patients with OUD.

Opioid Antagonist - Naltrexone

- Naltrexone (oral + injectable) compared to placebo or usual care
  - Improves treatment retention
  - Decreases re-incarceration
  - 33% versus 25%, NNT=13, 8 RCTs
  - 24% versus 33%, NNT=12, 4 RCTs
- Compared to buprenorphine
  - Oral naltrexone worse for treatment retention
  - 2% versus 32%, NNH = 4, 1 RCT
  - Injectable no significant difference in retention
- Requires 7-10 day opioid free period
  - In most studies patients had undergone detoxification (i.e. incarcerated patients)
  - Injectable formulation not currently available in Canada.

Which of the following has evidence for improved outcomes?

- Contracts/Treatment Agreements
- Routine urine drug testing
- Positive Contingency Management
- Negative Contingency Management
- All of the above
Contingency Management

Psychosocial Interventions for Patients on OAT

And now our recommendations

Insufficient Evidence

- There is insufficient evidence to create a recommendation for or against the use of residential treatment for patients with OUD
- There is insufficient evidence to create recommendations for the following co-morbidities:
  - chronic pain
  - acute pain
  - Insomnia
  - anxiety
  - ADHD

Weak Recommendations

- Clinicians could consider the use of a simple tool such as the POMI if assistance is needed identifying chronic pain patients who may have OUD
- Clinicians could consider take-home doses (i.e. 2 to 7 days) as an option when need and stability indicate
- Clinicians could consider urine drug testing as part of the management of patients with OUD
- Clinicians could consider treatment agreements (i.e. contracts) in the management of OUD for some patients

Strong Recommendations

- We recommend that management of OUD be performed in primary care as part of the continuum of care
- We recommend clinicians discuss use of buprenorphine-naloxone or methadone with their patients
- We recommend against initiation of OAT with the intention to discontinue in the short-term. OAT is intended as long-term management.
- We recommend the addition of counselling to pharmacotherapy where available
- We recommend against punitive measures involving opioid agonist treatment (i.e. reduction in dose or loss of carries), unless safety is a concern
Practice pearls

- Consider training in skills such as communication and counseling
- Encourage patients to seek support from others
- Monitor progress and adjust treatment as needed
- Provide incentives for adherence
- Monitor for signs of relapse
- Foster a supportive environment

Buprenorphine/Naloxone (B/N) Induction Flow Diagram

Day 1

- Patient should be Offered Multidisciplinary Support (O/M and NTPs for opioid use disorder)
- Offer treatment with a licensed clinician (e.g., physician or nurse practitioner)
- Identify the potential for abuse
- Assess eligibility for treatment
- Begin treatment with a low dose of buprenorphine
- Monitor for adverse effects

Day 2

- Monitor for adverse effects
- Assess progress
- Adjust dose as needed
- Provide additional support as needed
- Monitor for adherence

Day 3

- Continue to monitor for adverse effects
- Assess for readiness to maintain treatment
- Adjust dose as needed
- Provide additional support as needed
- Monitor for adherence

Questions from the Audience

Thank You