

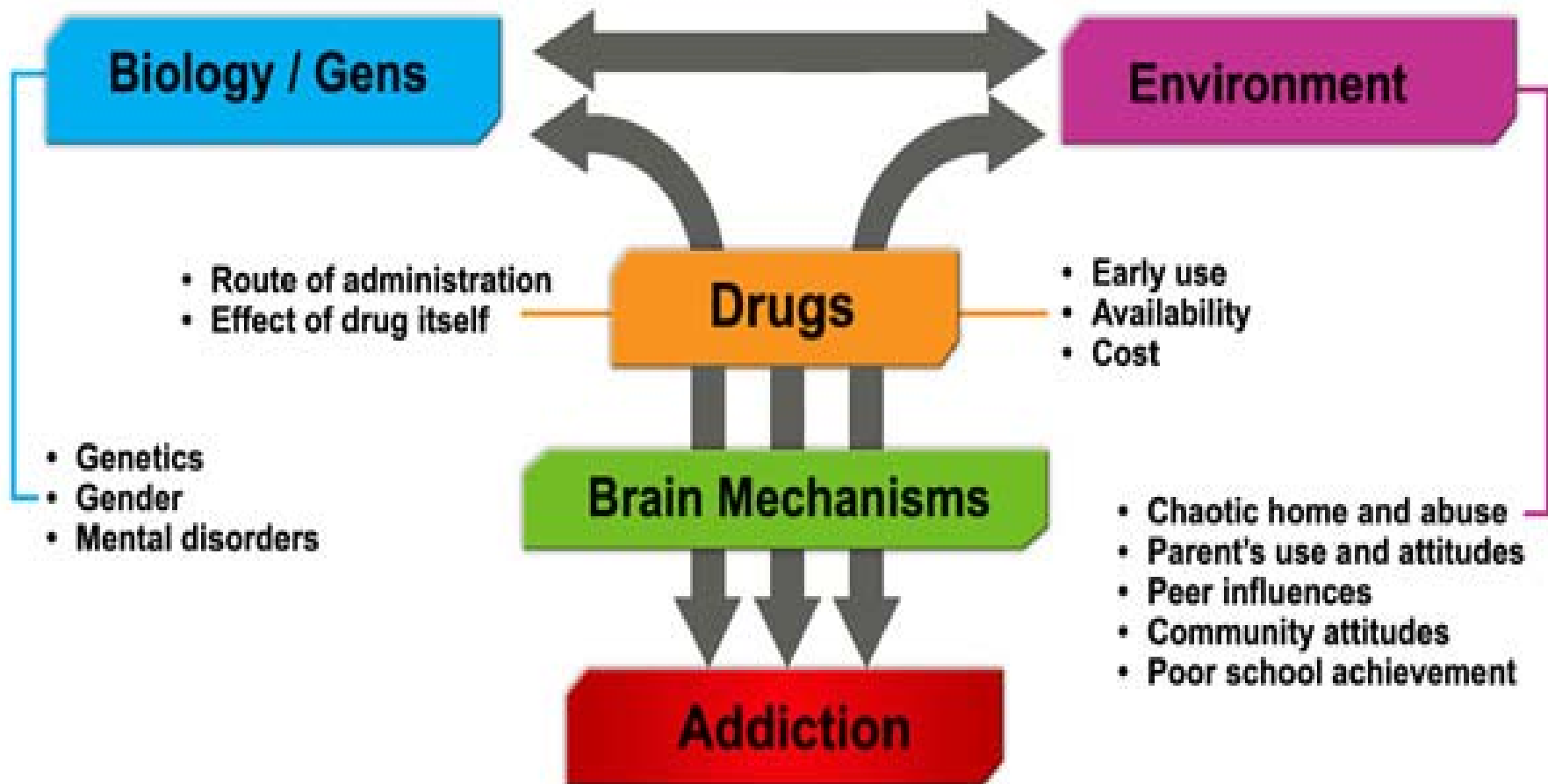
Recovery and the Treatment of Opioid Use Disorder: A Pharmacist's Perspective

**Jake Nichols, Pharm.D., MBA
Owner and Chief Executive Officer
Strategic Recovery Resources**

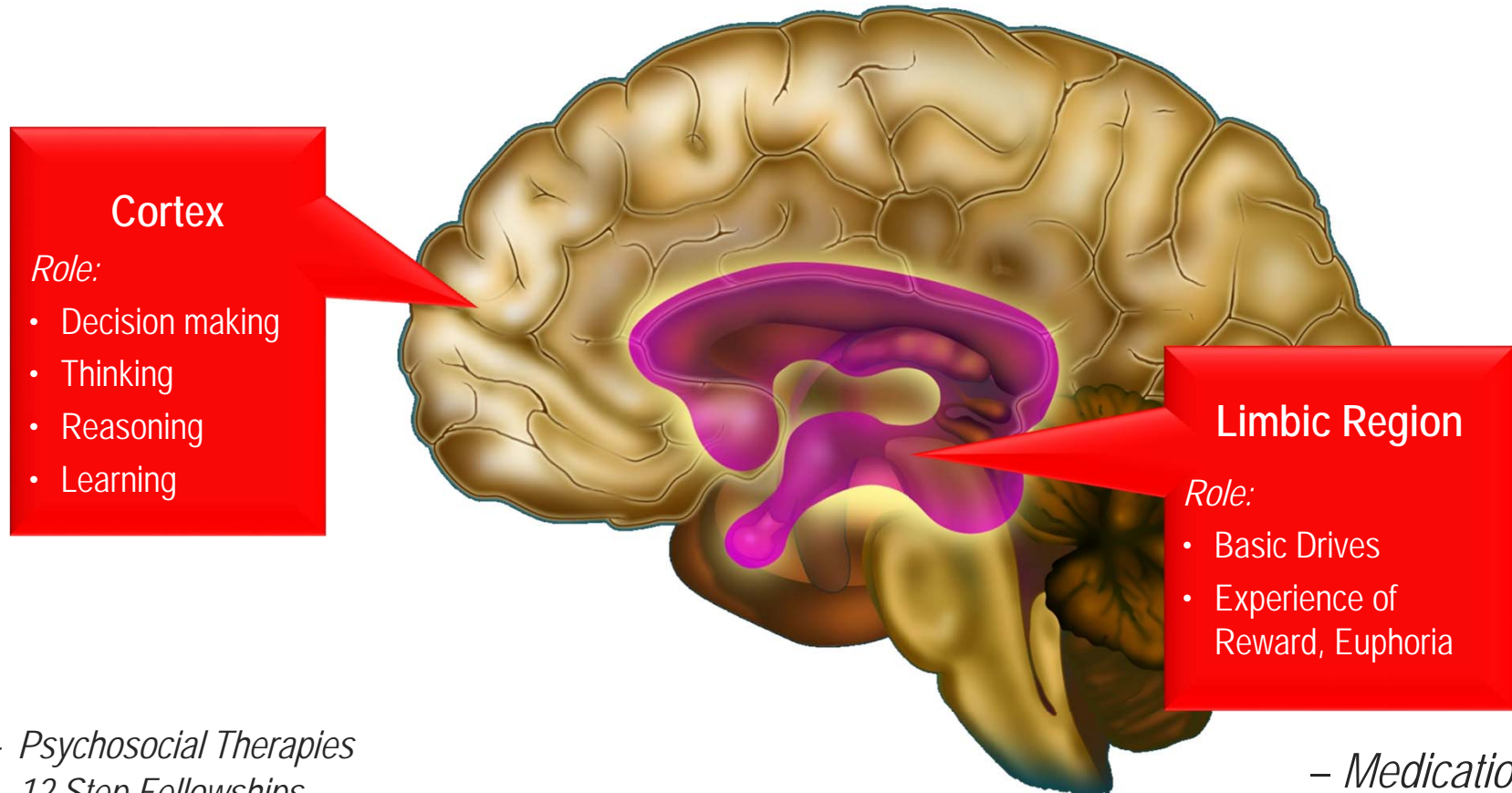
Program Objectives

1. Compare and contrast the agents commonly utilized to treat opioid use disorder (OUD)
2. Discuss clinical, legal, and public health issues regularly encountered by pharmacists relative to OUD
3. Define the term “recovery” and its associated principles
4. Compare and contrast the concept of recovery with other approaches to addressing OUD

Factors Leading to Addiction



Pathophysiology



Cortex

Role:

- Decision making
- Thinking
- Reasoning
- Learning

Limbic Region

Role:

- Basic Drives
- Experience of Reward, Euphoria

- *Psychosocial Therapies*
- *12 Step Fellowships*
- *Monitoring*

- *Medication*
 - *Agonists*
 - *Antagonists*

1. From NIDA Drugs, Brains, and Behavior – The Science of Addiction Website. Available at: <http://www.nida.nih.gov/scienceofaddiction/brain.html>. Accessed June 1, 2011.
2. Fowler JS et al. Sci Pract Perspect. 2007;3:4-16.



ADHERES → DISSOLVES → DELIVERS



- Bi-layered film technology
- Active drug in the mucoadhesive layer
- Backing layer facilitates unidirectional flow of drug
- Adheres to oral mucosa in < 5 seconds
- Completely dissolves within 15-30 minutes
- Minimal taste issues
- Rapid drug absorption
- Designed to optimize delivery across the mucosa

Medication Assisted Treatment (MAT)



Psychosocial Support

- Cognitive behavioral approaches
 - Reframing
 - Relapse prevention planning
 - Contingency management
- Mindfulness
- Motivational enhancement/stages of change*
 - Pre-contemplating
 - Contemplative
 - Preparation
 - Action
 - Maintenance

Peer Support/12 Step Programs

- Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)
- Highly de-centralized
- International
- Some people have great difficulty with spiritual approach
- Fellowship
- 1:1 work with sponsor
- Homework and self-help with the readings
- Ongoing process of “recovery”
- AA is not a professional treatment provider approach – it is a peer support program

Peer Support/12 Step Programs

- “Social norms” of modeling sober behavior
- Group identification and affinity groups (slogans, bumper stickers, etc.)
- Holding objects (chips)
- Structured time, focused around meetings (90 in 90)
- Normalizes behavior and decreases guilt-induced use
- Individual, group, and homework/self help interventions
- Consistency principle (if you’re gonna say it, then do it)
- Anchoring (to total abstinence)

Goals of Treatment

SHORT TERM

1. Stabilize the patient
2. Stabilize the patient
3. Stabilize the patient
4. Reduce the number of positive urine drug screens
 - Decrease or complete cessation of drug(s) of abuse
5. Allow the patient to begin engaging in a comprehensive treatment program

LONGER TERM

1. Reduce severity of the disease
2. Reduce the incidence of lapse/relapse
3. Retain the patient in treatment
4. Identification and commencement of a personalized long-term treatment program

****RECOVERY****

Medication Assisted Treatment

Clinical Benefits

- Increases patient retention in treatment
- Decreases illicit drug use
- Reduces infectious disease transmission
- Reduces criminal activity

“Soft” Benefits

- Feel well (normal) again
- Get jobs back
- Sometimes get their marriage/kids back
- Improved physical and mental health
- Self-respect
- Financial stability

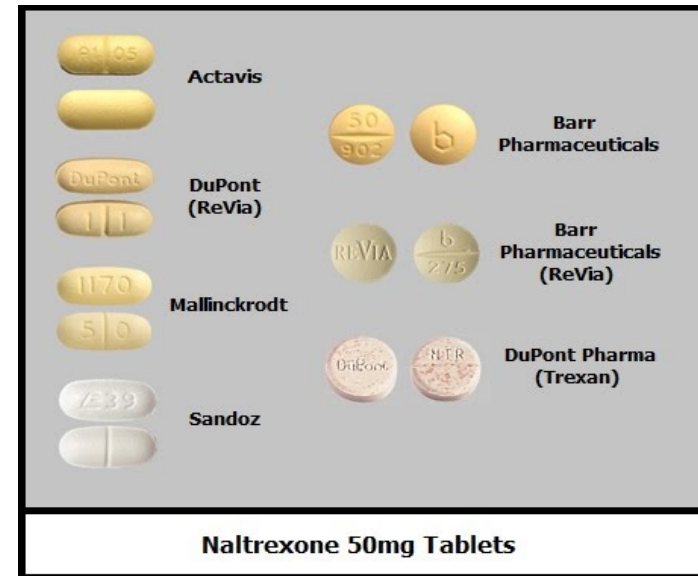
Methadone

- Full mu opioid receptor agonist
- Relieves symptoms associated with withdrawal from opiates as well as cravings
- Does not cause euphoria or intoxication itself (with stable dosing), thus allowing a person to work and participate normally in society
- Is excreted slowly so it can be taken only once a day



Naltrexone

- Opioid receptor antagonist
- Reduces positive urine drug screens
- Increases self-reported “opioid free” days
- Retains people in treatment longer
- Increases “time to relapse”
- Reduces cravings





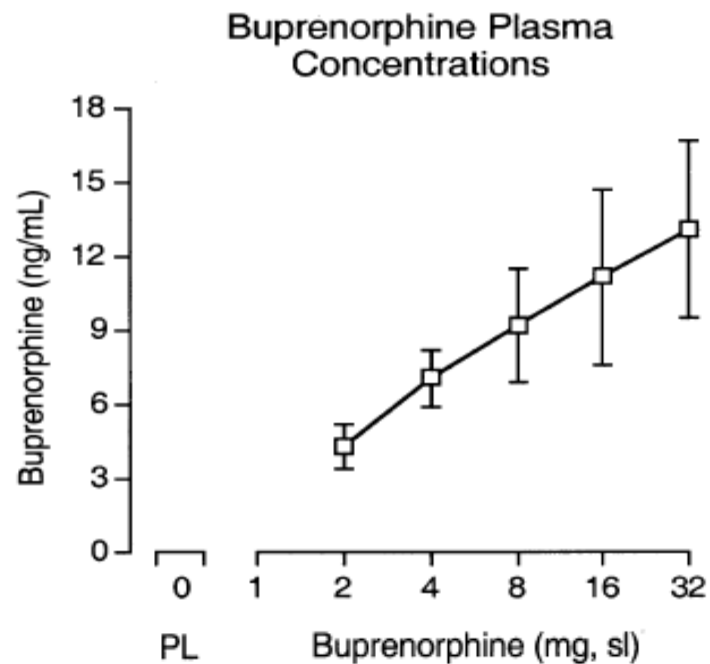
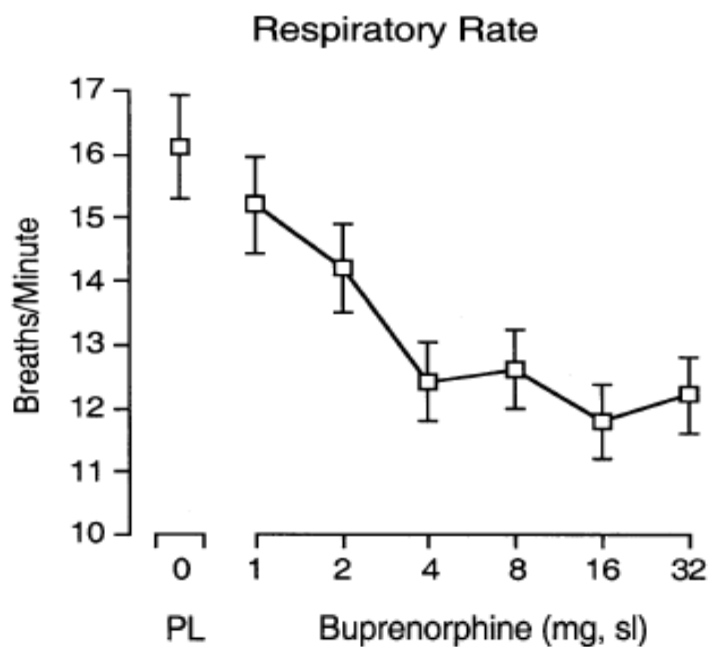
Buprenorphine



Pharmacologic Properties

- Mixed agonist/antagonist opioid
 - Partial agonist at the mu receptor, and an antagonist at the kappa receptor
- It has high binding affinity at both receptors and competes with other agonists, displacing most when administered concurrently
- Opioid agonist effects of buprenorphine are less than the maximal effects of full opioid agonists, such as morphine, and are limited by a 'ceiling' effect.

“Ceiling Effect”



Pharmacokinetic Properties

- Highly lipophilic
 - Facilitates crossing into the blood-brain barrier
 - Enhances intranasal bioavailability
 - May contribute to long duration of action
- Excretion
 - About 70% of an intravenous buprenorphine dose is excreted in the feces
 - Buprenorphine and its glucuronide metabolite appear in the urine for 1-2 days
 - Norbuprenorphine and its glucuronide metabolite appear for 1-4 days

Buprenorphine Diversion

- Law enforcement consistently expresses concerns about the amount of buprenorphine finding its way to the “streets”
 - Some studies suggest that up to 25% of dispensed buprenorphine is diverted
 - Very little evidence to suggest that diverted drug is being used for the purpose of “getting high”
- Clinicians have mixed opinions about the importance of the issue
 - May be due to lack of availability of treatment
 - No evidence to suggest that areas of high diversion also demonstrate increased incidence of buprenorphine-related deaths

Aberrant Behaviors

- Behaviors More Suggestive of an Addiction Disorder:
 - Selling prescription drugs
 - Prescription forgery
 - Stealing or “borrowing” drugs from others
 - Injecting/snorting oral formulations
 - Obtaining prescription drugs from nonmedical sources
 - Concurrent abuse of alcohol or illicit drugs
 - Multiple dose escalations or other noncompliance with therapy despite warnings

Aberrant Behaviors

- Multiple episodes of prescription “loss”
- Repeatedly seeking prescriptions from other clinicians or from emergency rooms without informing prescriber or after warnings to desist
- Evidence of deterioration in the ability to function at work, in the family, or socially that appear to be related to drug use
- Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug

Aberrant Behaviors

- Behaviors Less Suggestive of an Addiction Disorder:
 - Aggressive complaining about the need for more drug
 - Drug hoarding during periods of reduced symptoms
 - Requesting specific drugs
 - Openly acquiring similar drugs from other medical sources
 - Unsanctioned dose escalation or other noncompliance with therapy on one or two occasions
 - Unapproved use of the drug to treat another symptom
 - Reporting psychic effects not intended by the clinician
 - Resistance to a change in therapy associated with “tolerable” adverse effects with expressions of anxiety related to the return of severe symptoms

Portenoy RK, Payne R. Acute and chronic pain. In Lowinson JH, Ruiz P, Millman RB (eds): Comprehensive Textbook of Substance Abuse, 3rd Edition. Baltimore: Williams and Wilkins; 1997: Table 57.1, Page 564.

Harm Reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

- Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users “where they’re at,” addressing conditions of use along with the use itself.
- Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

Harm Reduction?

wbur | CommonHealth

As Opioid Epidemic Rages On, Massachusetts Medical Society Backs Supervised Injection Rooms

03:57 [🔗](#)

April 29, 2017

By [Martha Bebinger](#) [🐦](#)



Recovery

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

SAMHSA's WORKING DEFINITION OF RECOVERY: 10 GUIDING PRINCIPLES OF RECOVERY. Available at: <http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF>

10 Guiding Principles of Recovery

Hope	Relational
Person-Driven	Culture
Many Pathways	Addresses Trauma
Holistic	Strengths/Responsibilities
Peer Support	Respect

SAMHSA's WORKING DEFINITION OF RECOVERY: 10 GUIDING PRINCIPLES OF RECOVERY. Available at: <http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF>

Lapse vs. Relapse

Lapse

- Impulsive
- Short Duration
- Relatively Low Consequences
- Desire to Return to Abstinence

Relapse

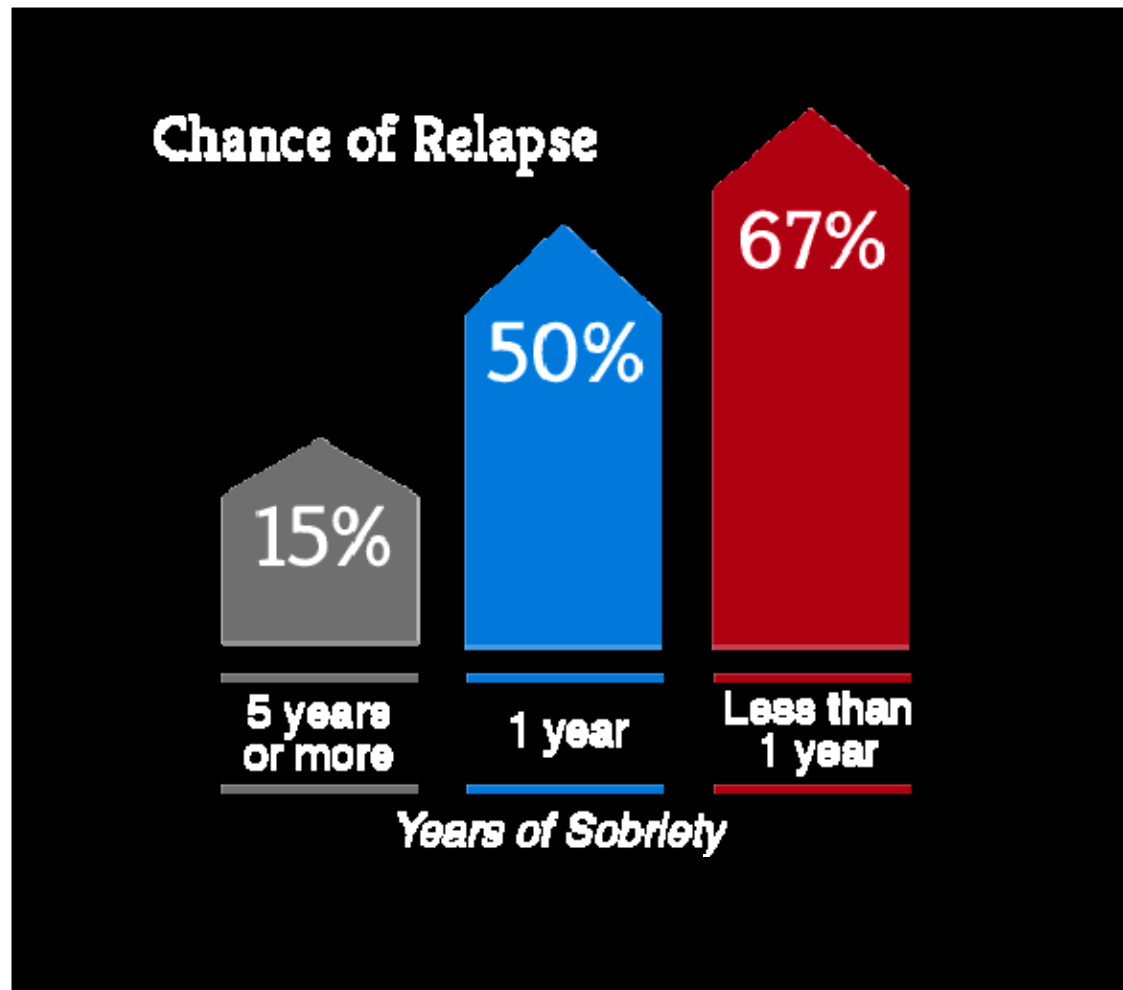
- Continuing Period of Use after a period of maintained abstinence
- High Defensiveness/ low guilt
- Relatively High Consequences
- Ambivalences re: Return to Abstinence

Relapse

Factors of Relapse



Relapse



Building Collaborative Relationships

- Clinics/Clinicians
 - Personal intro
 - Development of “thresholds”
 - Express concerns
 - Regular dialogue
 - Point person
 - Collaborative practice agreements
- Patients
 - Show empathy
 - Ask questions
 - Play the role of a “student”
 - Be clear that you are there to help them
 - Offer resources
 - Be clear as to what your rules are

The Pharmacist's Oath

"I promise to devote myself to a lifetime of service to others through the profession of pharmacy. In fulfilling this vow:

- I will consider the welfare of humanity and relief of suffering my primary concerns.
- I will apply my knowledge, experience, and skills to the best of my ability to assure optimal outcomes for my patients.
- I will respect and protect all personal and health information entrusted to me.
- I will accept the lifelong obligation to improve my professional knowledge and competence.
- I will hold myself and my colleagues to the highest principles of our profession's moral, ethical and legal conduct.
- I will embrace and advocate changes that improve patient care.
- I will utilize my knowledge, skills, experiences, and values to prepare the next generation of pharmacists.

I take these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public."

Contact Information

Jake Nichols, Pharm.D., MBA
Owner & Chief Executive Officer
Strategic Recovery Resources
Jnichols@strategic-recovery.com
617-529-6312 (cell)