Department of Defense (DoD) Opioid Prescriber Safety Training (OPST) Program:

Behavioral Health Aspects

"Medically Ready Force…Ready Medical Force"

Presenter

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Recognize the misuse potential and Behavioral Health (BH) related problems that may occur when prescribing controlled substances including overdose, accidental death, and suicide.
2. Identify potential Substance Use and Opioid Use Disorders (OUDs).
3. Comprehend the substance use disorders (SUDs) and other BH comorbidities that occur when managing pain, the available psychotherapies, and Medication Assisted Treatments (MATs) available within DOD upon referral.

Background:
Policy and Guidelines

'Management of Opioid Therapy (OT) for Chronic Pain,' CPG 2017, *BH Aspects*

- **AVOID** starting long-term opioid therapy (LOT) for chronic pain
  - IF prescribing OT for chronic pain, recommend a short duration.
- ***Not Recommended:*** Prescribing benzodiazepines when on opioids
- ***Not Recommended:*** Long-term OT for <30 years of age:
  - higher risk of Opioid Use Disorder (OUD) and overdose
- For patients currently on LOT:
  - ongoing risk mitigation strategies
    - assess for opioid and other substance use disorder (SUD)
    - taper when risks exceed benefits
- For patients on LOT with any untreated SUD: **carefully taper & discontinue**

Selected significant risk factors for adverse effects of Long-term Opioid Therapy

CONTRAINDICATIONS: suicidality, on benzodiazepines, untreated active Substance Use Disorder, life-threatening allergy to opioids

PSYCIATRIC RISK FACTORS

- Psychiatric instability
- Depression or history of depression
- Generalized Anxiety Disorder
- Borderline or Antisocial Personality
- Post Traumatic Stress Disorder (PTSD)

OTHER

- History of drug overdose (OD); <30 years old
- History of diversion of controlled substances
- Traumatic brain injury (TBI) (post concussive syndrome)
- Sleep apnea, etc. (benzodiazepines & alcohol potentiate risks)

Risk Mitigation: Prevent OD or SUD

- Implement risk mitigation strategies upon initiation of Long-term Opioid Therapy (LOT)
  - Ongoing, random urine drug screening
  - Checking state prescription drug monitoring programs
  - Monitoring for overdose potential
  - Providing overdose education with naloxone prescribing (OEND)

- Assess suicide risk when considering initiating or continuing long-term opioid therapy

- Re-evaluating q3 months, the benefits of continued opioid therapy and risk for opioid-related adverse events

Informed Consent (IC) for LOT

- HOW executed is important: a collaborative dialogue that weighs risks and benefits; discusses alternatives

- Like any other procedure with substantial risk, written IC required

- In DOD's IC for LOT, patient is agreeing to:
  - A 'sole provider' for opioids
  - No illegal drugs
  - Random urine drug screening; refusal may cause cessation of LOT
  - Follow prescribed dosing
  - No replacements or early refills for medications "lost or stolen"

BH Comorbidities of Chronic Pain

- *Depression
  - Major Depression within 2 years of chronic pain in 16%; reverse also true…
  - Pain syndrome within 2 years of Major Depression (3x more likely)
- *Anxiety
  - Anxiety or depression diagnosis in up to half
  - Anxiety impacts pain perception
- Fatigue/lack of energy
- *Sleep disturbance
- Cognitive Impairment (limbic impacts)

Decrease in: Quality of Life, working days, active social life;

- These in turn impact activity level, mood
- Creates a downward spiral

*Evidenced-Based Psychotherapies exist

Psychological Therapies in Chronic Pain

- Cochrane review, 2020
  - Cognitive Behavioral Therapy (CBT), for outcomes of pain, distress, and disability
    - Similar effectiveness as other non-pharmacologic approaches compared to Treatment As Usual
    - Other therapies had insufficient evidence to draw conclusions
- BH Comorbidities are common in chronic pain—treat them
  - These may also be treated with meds and/or psychological therapies
  - In some BH comorbidities, the psychological therapy evidence basis is stronger than in chronic pain alone
- Refer to Behavioral Health for CBT/psychological therapy
  - If in primary care, make your Patient Centered Medical Home embedded BH Provider part of your 'treatment team'

Signs and Symptoms of Opioid Use Disorder (OUD) and other Substance Use Disorders (SUD)

Signs of Substance Use Disorder

- Using more of the drugs or using them longer than you intended
- Uncontrolled dosage escalation or inability to taper
- Increasing pattern of pursuing new prescriptions or recovering from use
- Having a strong desire or urge to use
- Using medications despite legal or social consequences
- Stopping or decreasing important activities
- Using while driving, or performing other complex activities
- Using despite physical or mental problems
- Increasing tolerance -- needing more of the drug or taking more often
- Experiencing withdrawal -- physical symptoms when you try to stop

Symptoms of OUD – Withdrawal

- Flu-like symptoms: Gastrointestinal (GI), muscle aches, runny nose, decreased appetite

- Sympathetic system symptoms
  - Anxiety, Irritability
  - Confusion
  - Enlarged pupils
  - Tremors

- Craving for the drug
- Rapid breathing
- Yawning
- Goosebumps
- Sweating

It is essential to assess and screen for OUD in patients prescribed opioids at every encounter

Treatments for OUD

Medication Assisted Therapies (MAT) for Opiate Use Disorder*

- Methadone
  - Only for use in certified clinics; none in DoD for OUD MAT
- Buprenorphine
  - Requires additional DEA certification
  - Available at DOD pharmacies
  - Suboxone (= buprenorphine + naloxone); is sublingual (SL) med
    - naloxone via Intravenous is an antagonist; but SL route is not absorbed
    - added to Suboxone prevent 'diversion'
- Naltrexone
  - Available as oral and long-acting injection
  - Less effective
- All these medications complicate the treatment of acute pain
  - Active Duty Service Member are non-deployable while on MAT
  - DOD limits non-deployability to 12 months FOR ANY REASON, this limits duration of MAT in Service Members

*See resource page

Naloxone (Narcan)

- Treats acute intoxication
- Reverses Opioid overdose; can be life-saving
- SHORT ACTING
  - only 30-60min
  - Requires monitoring and reassessment after administration
- Any patient that meets the following risk criteria should be prescribed naloxone:
  - Risk Index for Overdose or Serious Opioid-induced Respiratory Depression (RIOSORD) >32
  - Morphine Equivalent Daily Dose (MEDD) >50
  - Opioid/Benzodiazepine combination use
  - On long-term opioid therapy

Opioid Withdrawal

Medications to manage symptoms of Opioid withdrawal*

- Buprenorphine with/without naloxone [Suboxone]
- Methadone--may not be used for 'protracted withdrawal/maintenance in DOD
- Clonidine, etc.
  not considered 'first line' in civilian setting; does not address sustained craving or the negative symptoms of 'protracted withdrawal'
  use more common in DOD since it is a non-opioid and many OUD cases' are less chronic and severe.

*See resource page

Addiction is a brain disease; treatment takes TIME

- Disrupted reward center: dopamine, endorphin
  - 'Feel too good' hunger, relationships, even sex--cannot compete
  - But, eventually 'burns out'

- Disrupted executive functions / Pre-Frontal Cortex
  - Can't follow thru--including on 'plans to cut down

- Disrupted 'stress center' of the brain
  - 'Fight or Flight' is revved up → feeling bad increases
  - Irritability, dysphoria, low stress tolerance
  - Protracted withdrawal: period of most 'relapses'

- Paradox of addiction:

  From using 'to feel good' → using 'to STOP feeling bad'

SUDs
How talking/behavioral therapies help

- Manage Cravings to use
- Assist with follow thru: build healthy actions, thoughts relationship network
  - External support to impaired executive functioning
- Recognize and avoid triggers that lead to relapse
  - Reward center overstimulation promotes very ‘deep wiring’
  - ‘out of awareness’
- Support during stress; treat emerging co-morbidities of depression, anxiety, PTSD

Slippery Slopes of Accidental Overdose

Defense Health Agency

Opioids, alcohol, benzodiazepines, & accidental overdose

- Chronic Pain [psychiatric co-morbidities]
  - Opioids + Alcohol → temporary 'escape from pain'
  - Disrupted sleep
    + Alcohol 'potentiates' the hypnotic effects of opioids
    + Benzodiazepines …
    - Negatively synergistic: Hypnotic, Respiratory depressive effects
  - Also dangerous if patient:
    - Increases doses on their own
    - Is using Illicit/unknown substances e.g. fentanyl
    - Especially if 'recently detoxed'

*Lab monitoring for alcohol use disorder Alcohol often used to potentiate opioid effects

- Ethyl Glucuronide (EtG)
  - Test for complete sobriety; remains in urine for several days
  - Often used on Monday's in rehabilitation programs

- Carbohydrate Deficient Transferrin (CDT)
  - For sustained heavy drinking
  - Blood: 1.5 weeks

- From standard labs (lower sensitivities and specificities)
  - Gamma-glutamyl Transferase (GGT), Alanine Aminotransferase (ALT)/ Aspartate Aminotransferase (AST) > 2:1, MCV (macrocytosis)

- Voluntary Care: per Secretary Army Directive MAR, 2019,
  - Soldiers who self refer may pursue alcohol treatment without being Command-enrolled in mandatory treatment *See resource page

Treating Co-morbid Alcohol Use Disorder

- Evidence Based Treatment (EBT) for Alcohol Use Disorder (AUD)
- Psychotherapies
  - CBT, Twelve Step Facilitation, Behavioral Couples Therapy, Motivational Enhancement, and the Community Reinforcement Approach
- Medications
  - Naltrexone, long-acting naltrexone
  - Acamprosate
  - Topiramate
  - Antabuse
  - Gabapentin: 'second line,' familiar to primary care providers; 1800mg/day; abuse potential in very high doses; abuse is more common in OUD.

Key Takeaways

- Providers and Pharmacists must counsel patients on risks, benefits, and alternatives to opioid pain medications
- Having Naloxone (Narcan) readily available can be life-saving for those identified as high-risk for opioid overdose
- Early identification of OUD, or other co-morbid Substance Use Disorder, is essential and will reduce morbidity and mortality

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