Treating Opioid Use Disorder and Risk Reduction Strategies

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Board Certified in Family Medicine

Board Certified in Addiction Medicine

Disclosure

- Mockdoc, LLC does not accept any pharmaceutical funding and has no relationships with ineligible companies.
- I have no conflicts of interest with the subject matter.
- I have no significant or relevant financial relationships to disclose.

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Learning Objectives

1. List three diagnostic criteria for OUD
2. Describe the benefits and drawbacks of each of the three medications approved to treat OUD
3. Identify two methods of buprenorphine initiation

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Thinking about Language

- Opioid use disorder
- Buprenorphine initiation
- People who use drugs
- Return to use
- Other favorite examples of preferred language

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Opioid Use Disorder (OUD)

Key Points from American Society of Addiction Medicine

- Addiction is a Disease
- Evidence-based Treatments are Available
- Recovery is Possible
- A Qualified Workforce is Essential

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Diagnosing Opioid Use Disorder Using DSM-5 Criteria

- A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least TWO of the following, occurring within a 12-month period [Mild=2-3, Moderate=4-5, Severe=>5]:

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Diagnosing Use Disorders

- Impaired control
- Social Impairment
- Risky Use
- Pharmacological properties

Diagnosing Opioid Use Disorder Using DSM-5 Criteria

Impaired Control
•Larger amounts or longer than intended
•Unsuccessful efforts or desire to cut down or control use
•Excessive amounts of time to obtain, use, recover from use
•Craving

Social Impairment
•Work/school/home role impairment
•Social/interpersonal problems exacerbated by use
•Social, recreational, occupational activities reduced or given up

Adapted from: Diagnostic and Statistical Manual of Mental Disorders,
5th Edition, American Psychiatric Association. Copyright 2013.

Diagnosing Opioid Use Disorder Using DSM-5 Criteria

Risky Use

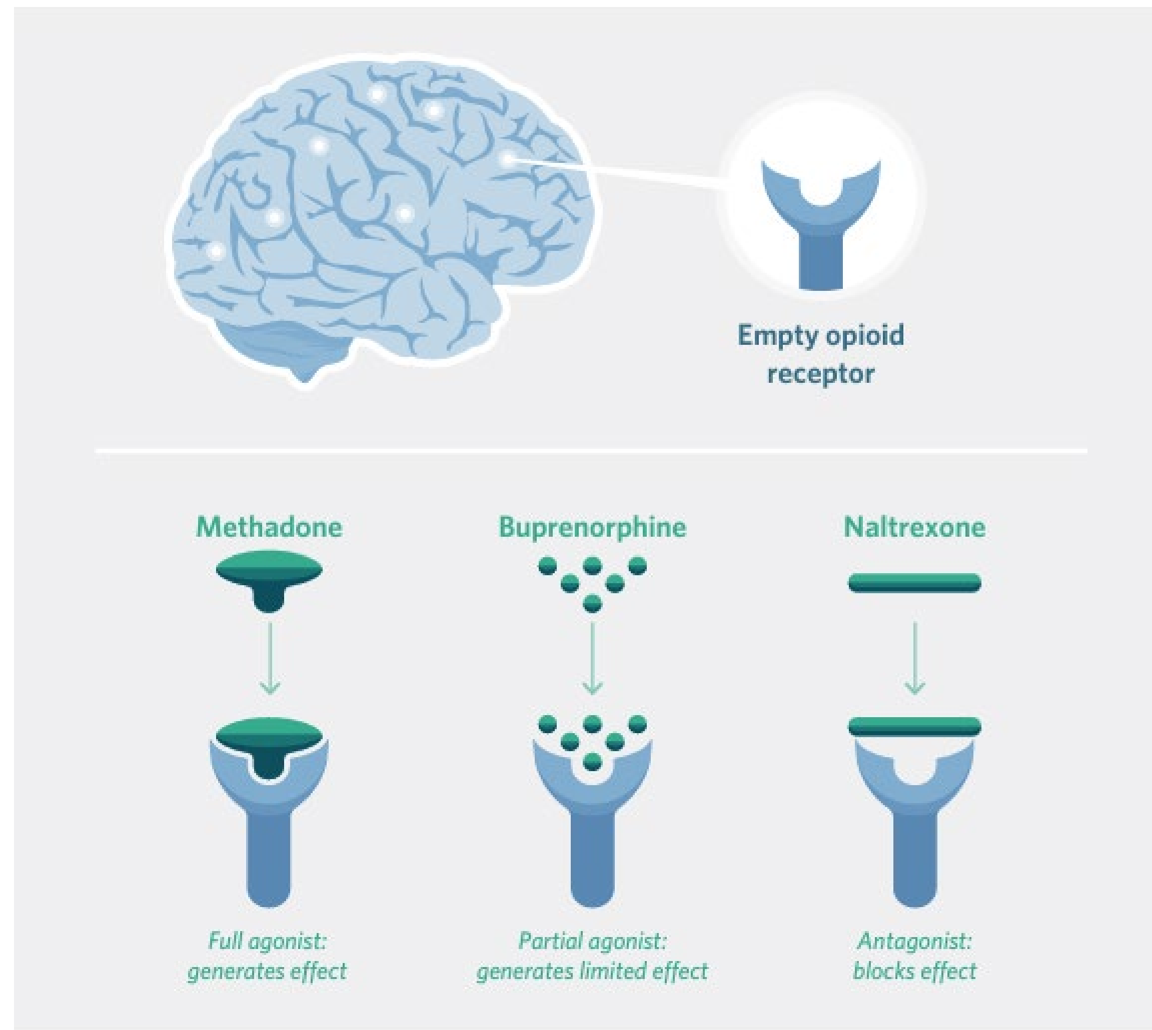
- Use in physically hazardous situations
- Continued use despite physical or psychological problem caused by use

Pharmacological Properties (does not apply to prescribed opioids)

- Tolerance
- Withdrawal

Adapted from: Diagnostic and Statistical Manual of Mental Disorders,
5th Edition, American Psychiatric Association. Copyright 2013.

Medication Options



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Mechanism & Actions

	Buprenorphine	Methadone	Naltrexone
Mechanism	Partial agonist	Agonist	Antagonist
Actions	• Suppresses withdrawal & decreases cravings • Blocks reinforcing effects of misused opioids	• Suppresses withdrawal & craving	• Displaces mu agonists & blocks effects of opioids • Reinforces abstinence by preventing intoxication and physiological dependence

Pros

	Buprenorphine	Methadone	Naltrexone
Pros	• Any DEA registered prescriber can prescribe • Safer than methadone • Naloxone decreases reinforcing effects of misusing by injection • Greater accessibility	• No euphoria at stable doses • FDA approved in pregnancy • Option for severe dependence or buprenorphine treatment failures	• Any prescriber can prescribe • No misuse • No opioid side effects

Cons

	Buprenorphine	Methadone	Naltrexone
Cons	• Precipitated withdrawal • Opioid side effects • Misuse potential - uncommon	• Increased respiratory depression, sedation, QT prolongation • Only available at certified facilities with frequent visits • Misuse potential	• Precipitated withdrawal • Increased risk of fatal overdose if using opioids • Expense of the recommended IM formulation

Goals of Treatment

- Decreased use
- Stabilization of social factors
- Engagement in program/psychosocial work/peer support
- Length of treatment-can be lifelong

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Formulation/ Medication Options

- Buprenorphine-naloxone
  - Dose? Dosing interval?
- Buprenorphine monoproduct
- Injectable buprenorphine (weekly or monthly), cost
- Naltrexone
- Methadone

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Decreasing Barriers to Buprenorphine Treatment

Decreasing Barriers

- Initial access to care
- ASAM Criteria (Revised 2024)
- 4 Initiation methods-home vs clinic
- Current thinking about/experience with precipitated withdrawal
- What about state laws and rules—how do they fit (or not)?

Decreasing Barriers

- Toxicology
- Office policies
- Frequency of visits
- Labs

- Additional requirements
- Co-prescribing of other sedating medications
- Alcohol use & Marijuana use
- Street drug use (opioid or not)

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“Drug testing is a tool for supporting recovery, not a method for punishment”

Martin, S. A., Chiodo, L. M., Bosse, J. D., & Wilson, A. (2018). The next stage of buprenorphine care for opioid use disorder. *Annals of Internal Medicine*, 169(9), 628-635. https://annals.org/aim/fullarticle/2708164/next-stage-buprenorphine-care-opioid-use-disorder

Diversion & Misuse of Buprenorphine?

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Misuse-Large Survey in 2019

- Study based on National Survey of Drug Use and Health 2019
- Prevalence of buprenorphine misuse trended downward from 2015-2019
- In 2019, hydrocodone + oxycodone were “much more commonly” misused
- 75% did not misuse their prescribed buprenorphine
- Top reasons for misuse: “because I am hooked” + “to relieve physical pain”
- Race/ethnicity, health insurance status, family income NOT associated with misuse

Misuse Article-Reflections

- Health inequity: white persons and persons with private insurance are more likely to receive OUD treatment
- Rural counties are associated with low buprenorphine dispensing vs metropolitan areas
- Other studies referenced which also show self-treatment of craving and withdrawal symptoms is predominant motivation for using nonprescribed buprenorphine

Han B, Jones CM, Einstein EB, Compton WM. Trends in and Characteristics of Buprenorphine Misuse Among Adults in the US. *JAMA Netw Open.* 2021;4(10):e2129409. doi:10.1001/jamanetworkopen.2021.29409

"Thus, the illicit buprenorphine market and diversion of legitimately prescribed buprenorphine may be partly driven by individuals who are not in formal OUD or MAT programs. Potential reasons individuals may choose to self-treat their addiction to opioids with buprenorphine includes insufficient access to prescribed buprenorphine, cost of care, stigma associated with addiction and illegal drug use, or lack of access to opioids of choice when withdrawal symptoms begin."

Reference: Chilcoat HD, Amick HR, Sherwood MR, Dunn KE. Buprenorphine in the United States: Motives for abuse, misuse, and diversion. J Subst Abuse Treat. 2019;104:148-157. doi:10.1016/j.jsat.2019.07.005
Summarized in: Aegis Corporation clinical update, August 2021, https://www.aegislabs.com/resources/clinical-update/aug21

COVID Era Changes to MOUD

- Methadone
  - Higher initiation doses
  - Quicker up titration
  - Quicker take home doses
- Buprenorphine
  - Telehealth prescribing-paused requirement to see pt in person
  - 2025 DEA Telehealth final and proposed rules
  - COVID era extensions (most recent 12/31/25->12/31/26)

Other Changes in Buprenorphine Treatment in Past 10 Years

Buprenorphine Care: Previous Approaches compared with new findings and recommendations

Previous Approach	New Findings and Recommendations
A medical setting is needed for induction.	Home initiation is also safe and effective.
Benzodiazepine and buprenorphine coprescription is toxic.	Buprenorphine should not be withheld from patients taking benzodiazepines.
Relapse indicates that the patient is unfit for buprenorphine-based treatment.	Relapse indicates the need for additional support and resources rather than cessation of buprenorphine treatment.
Counseling or participation in a 12-step program is mandatory.	Behavioral treatments and support are provided as desired by the patient.
Drug testing is a tool to discharge patients from buprenorphine treatment or compel more intensive settings.	Drug testing is a tool to better support recovery and address relapse.
Use of other substances is a sign of treatment failure and grounds for dismissal from buprenorphine treatment.	Buprenorphine treatment does not directly affect other substance use, and such use should be addressed in this context.
Buprenorphine is a short-term treatment, prescribed with tapered dosages or for weeks to months.	Buprenorphine is prescribed as long as it continues to benefit the patient.

Martin SA, Chiodo LM, Bosse JD, et al. The next stage of buprenorphine care for opioid use disorder. Ann Intern Med 2018;169(9):628-35

Buprenorphine Initiation Methods

- Low dose initiation (Microdosing or Cross tapering)
- Classical
- High dose initiation (Macrodosing)
- Quick start/Post opioid reversal agent

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Buprenorphine Initiation Methods

	Microdose	Low Dose	High Dose	QuickStart
Time since last use	None	1-2 days	12 hours	None
Initiation period	One week +	2 days +	2-3 hours	30 minutes
Is tapering required?	Yes	No	No	No
Expected withdrawal	None, but withdrawal can still occur	Must be in moderately severe withdrawal to start	Must be in moderate withdrawal to start	Short, but moderately severe once the process has begun (<30min)
Total transition time	On average, 8–14 days	2 days +	~15 hours	1 hour

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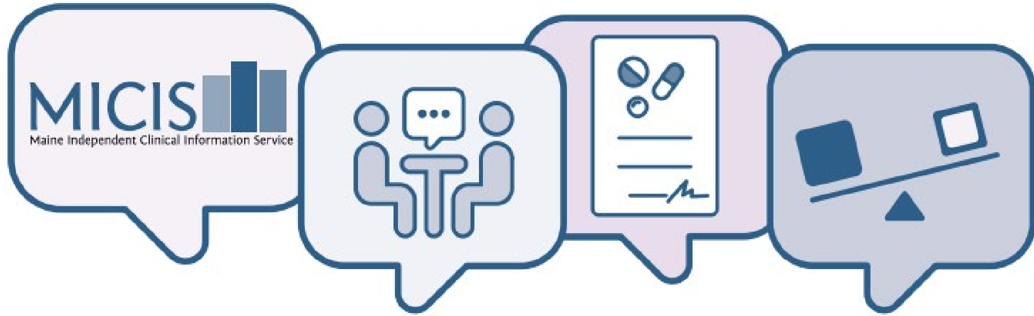
https://www.boulder.care/



Maine Independent Clinical Information Service (MICIS)
Maine's Academic Detailing Program

1000 LIVES
CAMPAIGN FOR MAINE

Maine Substance Use Disorders Learning Community

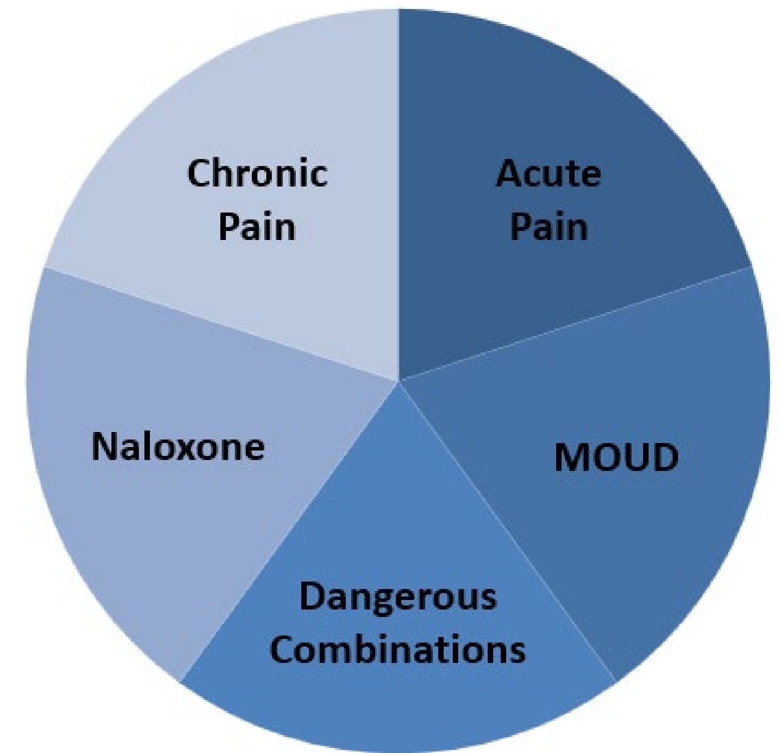
Treating Opioid Use Disorder as a Chronic Condition

A PRACTICE MANUAL FOR FAMILY PHYSICIANS

How Healthcare Providers Can Actively Participate in Risk Reduction

- Naloxone prescribing and distribution
- Syringe service programs
- Treating Hep C
- Testing for infections
- Discussing ‘relapse’ prevention planning
  - Knowing the street supply
- Primary prevention
  - Educating colleagues
  - Educating patients & community

*Prescribing Considerations



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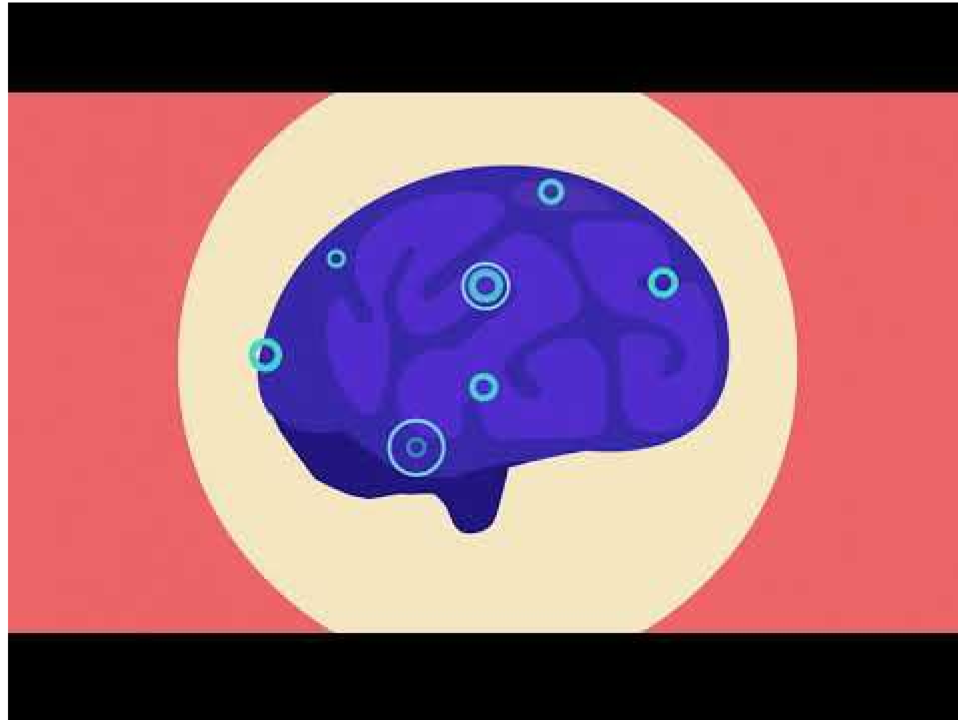
SAMHSA naloxone video



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https://www.youtube.com/watch?v=RcAaZQQqd50

Different Naloxone Products and Doses

- Intranasal (3mg, 4mg, 8mg), IM, IV
- Over the counter or prescription
- State specific Good Samaritan laws
- State specific 3rd party prescribing and use
- State specific low/no cost distribution
- State specific pharmacy access

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Do you have naloxone at your office or work place?

Where is it?

Do all staff know when and how to use it?

Key Takeaways

- Opioid use disorder is a chronic disease which often requires long-term treatment. Patients have increase morality risk life-long.
- Medications for addiction treatment retain ~ 50% of patients at one year, while abstinence-based recovery retains ~10%
- Any prescriber with a DEA registration can prescribe buprenorphine
- MICIS offers private sessions about bup prescribing
  - https://micismaine.org/contact/

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Additional Topics for Potential Consideration

- Pain management challenges (acute & chronic)
- Adding addiction care to primary care vs adding primary care to addiction care
- Co-managing behavioral health conditions
- Pros and cons of telehealth
- Special populations: pregnant people, adolescents

Resources (videos <4 min)

- https://youtu.be/Eaptdcvb9aI the Yankowsky’s Story (Affected parents)
- www.youtube.com/watch?v=7p_SU6zcvbA Overdose prevention education (NIDA)
- www.youtube.com/watch?v=RcAaZQQqd50 Naloxone mechanism (SAMHSA)

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Resources

- https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline (updated guidelines expected late 2026)
- https://mainephysicians.org/1000-lives-campaign-for-maine/
- https://micismaine.org/education-topics/clinical-toolkit/
- https://micismaine.org/wp-content/uploads/2025-MICIS-OUD-one-pager-20250506.pdf
- https://mesudlearningcommunity.org/
- https://www.aafp.org/family-physician/patient-care/clinical-recommendations/opioid-use-disorder-clinical-guidance.html
- https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/treating-opioid-use-disorder.pdf

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