Opioid Agonist Therapy 101:
An Introduction to Clinical Practice Workshop

Withdrawal of Treatment

Marina Reinecke MBChB, CCFP, (AM)

Faculty/Presenter Disclosure

- **Faculty:** Marina Reinecke
- **Relationships with commercial interests:** None

LEARNING OBJECTIVES

At the end of this learning activity, the participant will be able to:

- Discuss a practical approach to the 3 most common scenarios involving withdrawal of treatment
- Discuss a practical approach to re-entry into treatment after involuntary withdrawal of treatment.

3 Scenarios

- 1. Voluntary – patient and clinic staff agree it is time to taper and attempt to stop treatment
- 2. Voluntary – Patient insists on tapering off although clinic staff are concerned
- 3. Involuntary – Staff decide that for reasons of safety (for the patient, public or staff) that the patient should not continue in treatment

Scenario 1 – Ready to taper

- 1. social stability
- 2. emotional stability
- 3. no acute physical/psychiatric concerns
- 4. has left drug life behind – no cocaine or methamphetamines, no benzodiazepines, no street access, support from non-using family and friends
- 5. recognizes risks and benefits of taper and plans accordingly
- 6. recovery supports – honesty, 12 steps, demonstrated stress tolerance strategies

Scenario 1 – Ready to taper

- 1. discuss potential problems and how the taper might feel
- 2. together decide on pace of step-down; **small steps!!**
  - i) methadone 2 – 5 mg every few weeks
  - ii) buprenorphine/naloxone 2mg at a time ...or less?

  Pay attention to the overall dose/picture
- 3. patient and staff assess progress and watch for problems
- 4. patient can phone to stop taper or to increase dose to stabilize

Denise

- As a teen, shy and lonely, eating disorder
- Was living with grandparents and grandpa was put on palliative care morphine – Denise started using his meds by injection
- Stabilized nicely at methadone clinic, really liked NA, did counselling

Denise's taper

- Tapered down slowly from 90 to 35 mg. without complaint, looked well
- Did not discuss with clinic staff that she had started intermittent injection
- Admitted to hospital with staph aureus empyema and septic hip
- Restabilized, treated this as a learning experience and tapering again

Maureen

- Wild teenager with extreme polysubstance abuse, multiple overdoses, cutting – on Volume 4 of HSC chart
- Started to inject IV opioids
- Was clearly treated as an adult, with no positive response to borderline behaviour
- Did better than expected in treatment

Maureen's taper

- After three years in program – had done lots of "growing up" and learned many new life skills
- Successfully tapered off over 14 months and still doing well

End of Taper

- Addiction is chronic illness – is patient prepared with plans to address emotional crisis, or if medical illness requires opioids?
- Consider offering follow-up for 3 – 6 months after methadone or buprenorphine/naloxone treatment ends.
- Review risk of cross - addiction (alcohol, cocaine etc..)

Insists on Taper - ?Not Ready

- discuss risks with patient repeatedly
- The patient will often refuse to recognize that problematic behaviour is occurring – e.g. - ongoing use of opioids or cocaine
- patient has right to decide
- Slow taper is best but some patients will insist on rapid taper

Tapering, ? Not Ready

- Try to discuss but recognize when to stop the struggle
- Instead focus on your partnership
- Remind patient that it is never too late to "change your mind"
- There is value to letting the patient "crash and burn" – patient returns to program with different expectations and behaviour
- Consider need for behaviour agreement if accepting back into treatment – raise the bar

John's Taper

- He had failed 4 tries at abstinence and sadly started methadone – immediately felt normal
- Insisted as soon as he felt stable that he needed a step down – never actually stopped using opioids – would not "listen to reason"
- Relapsed, spent entire inheritance, back to OAT

Involuntary Withdrawal

- Staff feel that for overall risk/benefit situation or safety reasons that patient should not continue with program
- Examples
- - proven diversion of methadone or buprenorphine/naloxone
- - threatens staff, pharmacist or other patients
- - reckless use of benzodiazepines, opioids, alcohol
- - erratic attendance at clinic

Involuntary Withdrawal

- Clinics have different thresholds (high tolerance vs. low tolerance) – staff should have common principles and be able to discuss cases
- Offer the patient referral to a different OAT clinic, if possible and reasonable

Pace of Involuntary Stepdown

- Rapid or slow - depends – may use outside pharmacy - warn pharmacy!!!
- If aggressive or difficult behaviour persists, rapidly stop treatment
- Actual threats or aggressive behaviour – consider police report

Jay

- Bright, always argumentative – fighting the rules – behaviour contract on chart
- Used foul threatening language to his case manager – team decision for involuntary withdrawal
- Rapid step down, at outside pharmacy
- Given name of alternate clinic and within 2 weeks enrolled there – “I know I need it”

Requests Return to Program?

- Clinic staff decide – behaviour is sometimes much better – but some clients are so difficult, return to program will not occur
- A waiting period may be beneficial – patient recognizes consequences are definitely in place

Just Wait….

- They often return older and wiser and ready to work – and ready to follow the rules

Questions?