



## PALLIATIVE CARE CASE OF THE MONTH

### “Addiction Treatment Options, or “What the Heck is an IOP?”

by

Julie Childers, MD

Volume 17, No. 86

December 2017

**Case:** Ms. K is a 40 year old woman with a history of depression, anxiety, and substance abuse who was admitted to the hospital with a large pelvic mass. She had a long history of IV heroin and cocaine use, and had relapsed on heroin two weeks prior to admission. She underwent a hysterectomy/salpingo-oophorectomy, lymph node dissection, appendectomy, and omentectomy, with no evidence of residual disease. The palliative care team was asked to see her after surgery, and appropriately placed her on patient-controlled analgesia. As her post-operative pain improved, they recommended an oral regimen, which she tolerated well. The plan on discharge was to provide her a short opioid taper and refer her to addiction treatment. The psychiatrist wrote in his note that the patient was referred to an “IOP”, which left the palliative care team wondering what that meant, and more generally, what options does Ms. K have for treatment of her substance use disorder.

**Discussion:** Substance use disorders (SUDs) are chronic diseases that involve many aspects of an individual’s functioning. About 8 percent of Americans have a substance use disorder, including 7.1 million individuals with problems with illicit drugs.<sup>1</sup> Palliative care clinicians frequently care for individuals with SUDs in the hospital, the outpatient palliative care clinics, and in hospice. Understanding the basics of addiction treatment will help us make better referrals for our patients who need both care for SUDs and palliative care.

Some principles of effective addiction treatment include:

1. No single treatment is appropriate for everyone. Treatment varies depending on the type of drug and the characteristics of the patients.
2. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long term drug abuse.
3. Remaining in treatment for an adequate period of time is critical. Most addicted individuals need at least three months in treatment to reduce or stop their drug use and the best outcomes occur with longer durations of treatment.
4. Behavioral therapies – including individual, family, or group counseling—are the most commonly used form of drug abuse treatment.
5. Medications are an important element of treatment for many patients, especially when combined with counseling or other behavioral therapies.
6. Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.<sup>2</sup>

Levels of addiction treatment are stratified based on treatment intensity. Individuals who are dependent on opioids, benzodiazepines, or alcohol may initially undergo **detoxification (detox)**, short-term treatment which can be done either inpatient or outpatient (with daily visits). Tapering doses of opioids or benzodiazepines are used over a few days until the individual is free of withdrawal symptoms and out of danger of serious medical consequences from withdrawal. There is some evidence that individuals who undergo detox alone are more likely to reduce substance use after discharge,<sup>3</sup> but detox is ideally only the first step in long-term treatment of a chronic disease. Options for further treatment include outpatient treatment, intensive outpatient treatment, partial hospitalization, and residential treatment.

**Outpatient treatment** may be one on one counseling or group therapy, and frequency of contact ranges from once a week to monthly. An **intensive outpatient treatment (IOP)** consists of 9 hours per week, usually three hours three times per week of group and individual sessions. In **partial hospitalization**, patients attend sessions for at least 30 hours per week. Partial hospitalization may include more services, such as monitoring of vital signs and supervision for meals, as well as group and individual therapy and psychiatric care if needed. **Residential treatment** (including **rehab**) is a period of days to weeks of intensive inpatient behavioral therapy, which may or may not be combined with medication. Residential treatment usually includes psychiatric and often medical care. There are formal criteria which counselors use to determine an appropriate level of care after evaluation of patient needs, including emotional/behavioral issues, readiness to change, and need for management of medical issues. Treatments that are more intensive and that include longer lengths of stay are more expensive, and longer inpatient stays are usually not covered by insurance. More intensive treatment is associated with improved outcome for patients who have more severe addictions or less social stability, though inpatient treatment of longer than 60-90 days has not been found to produce better outcomes.<sup>4</sup>

Many patients are also involved in **12 step groups**, such as **Alcoholics Anonymous** or **Narcotics Anonymous**, though as peer support groups, without professional involvement, these are not considered to be formal treatment. Meetings of both AA and NA occur throughout most communities day and night. Individuals who commit to the 12 step program identify one group that they attend most regularly as a home group, and develop a relationship with a sponsor, a group member of the same sex who has a number of years of sobriety and serves as a mentor to the newer participant.

Palliative care providers may encounter three different types of medication-assisted treatment that are commonly to treat opioid use disorder.

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 647-7243, pager # 8511, Shadyside, 647-7243, pager # 8513, Perioperative/Trauma Pain, 647-7243, pager # 7246, UPCI Cancer Pain Service, pager 644-1724, Interventional Pain 784-4000, Magee Women’s Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s pager 958-3844.

With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.



(Discussion Continued)

**Methadone** is an opioid agonist that is prescribed for addiction only in opioid treatment programs (OTPs) that are regulated by the federal government. The usual starting dose of methadone for addiction is up to 40 milligrams per day, given in liquid form, and the average dose for maintenance is 80 to 120 milligrams per day.<sup>5</sup> Patients receiving higher doses of methadone have better outcomes. Addiction professionals recommend continuation of treatment as long as the patient continues to benefit (often for years or even decades), as discontinuation of methadone treatment is strongly associated with relapse, increased deaths from overdose, and an increase in infectious diseases such as HIV and hepatitis C.<sup>6</sup> Initially, patients must visit the methadone program daily for observed dosing. As their treatment progresses, if they are adherent to treatment and abstinent from opioids and other illicit substances, they may be allowed “take homes”, and visit the methadone clinic as infrequently as once per week. Clinicians caring for patients in a methadone program should be aware that methadone dispensed through an OTP is not reported through prescription drug monitoring programs. Patients with advanced disease such as cancer who require opioids for their pain may often receive prescribed opioids for pain in addition to the methadone they receive in the OTP, with the agreement of the medical director of the OTP.

**Buprenorphine** is a partial opioid agonist that may be prescribed by any physician, nurse practitioner or physician assistant who has gone through required training and applied for a waiver. Buprenorphine is usually combined with naloxone (as in Suboxone) to deter patients from injecting their medication (naloxone is not absorbed when taken sublingually). Doses of buprenorphine range from 4 to 24 milligrams per day, with 16 milligrams thought to occupy nearly all opioid receptors in most individuals. Buprenorphine is as effective in reducing illicit opioid use as methadone maintenance, though methadone may have better outcomes for treatment retention.<sup>7</sup> Patients receiving buprenorphine in the outpatient setting are often restricted from receiving other opioid prescriptions.

**Naltrexone** is an opioid antagonist that is available in pill format, and also can be given in a once-monthly injection (Vivitrol). Naltrexone is FDA-approved for alcohol-use disorder as well as opioid-use disorder. Naltrexone has the advantage of being a non-opioid treatment, making it easier to discontinue naltrexone treatment without the need to taper, and there is no possibility for diversion. A recent study found that it was non-inferior to buprenorphine in terms of retention in treatment and reduction in opioid use in patients who had successfully completed detoxification.<sup>8</sup> However, for patients with pain, it provides few advantages, as it provides no pain relief itself, and it is more difficult to overcome its antagonism in settings where opioid treatment might be required.

**Return to Case:** Ms. K was discharged from the hospital with a few days of oxycodone for post-op pain. On her follow-up appointment with palliative care, she had continued to use heroin sporadically since discharge, and complained of generalized aches and pains. There was no evidence of ongoing pain from her cancer or from surgery. Along with non-opioid treatment for her pain and treatment of her mood disorder, the palliative care clinician referred her to a local treatment program for an assessment of the appropriate level of care for her opioid use disorder.

#### References:

1. Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52).
2. Excerpted from the National Institute on Drug Abuse, *Principles of drug addiction treatment: a research-based guide*, 3<sup>rd</sup> ed. Rockville, MD: NIDA (NIH Publication No. 12-4180) 1999:2-5.
3. Teesson M, Havard A, Ross J, Darke S. Outcomes after detoxification for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS). *Drug Alcohol Rev.* 2006 May;25(3):241-7.
4. Harris AH, Kivlahan D, Barnett PG, et al. Longer length of stay is not associated with better outcomes in VHA's substance abuse residential rehabilitation treatment programs. *J Behav Health Serv Res* 2012; 39:68-79.
5. Joseph H, Stancliff S, Langrod J. Methadone Maintenance Treatment (MMT): a review of historical and clinical issues. *Mt. Sinai J Med* 200; 67(5-6):347-364.
6. Payte JT, Khuri ET. Treatment duration and patient retention. In: Parrino MW, ed. *State methadone treatment guidelines*. Rockville, MD: U.S. Department of Health and Human Services, 1993:119-124.
7. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev.* 2014 Feb 6;(2):CD002207.
8. Tanum, L, Klemmetsby S, Latif, Z et al. Efficacy of injectable extended-release naltrexone vs. daily buprenorphine-naloxone for opioid dependence. *JAMA Psychiatry.* -1197(12)74:017

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 647-7243, pager # 8511, Shadyside, 647-7243, pager # 8513, Perioperative/Trauma Pain, 647-7243, pager # 7246, UPCI Cancer Pain Service, pager 644-1724, Interventional Pain 784-4000, Magee Women's Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children's pager 958-3844.

With comments about "Case of the Month" call Dr. Robert Arnold at (412) 692-4834.