

Chapter 18

Gabrielle: A Young Woman in Pain Who Is Opioid Dependent



Gabrielle is a 23-year-old, cisgender female, African-American, college student and has been a very successful athlete. Although she does well in school, with an A-average, she says she is not sure why she is in school. Still, she is a journalism major with an interest in television reporting. Gabrielle has many friends, is socially active, and is a well-regarded track athlete. In addition, she regularly attends a Baptist church at college and at home with her family. She says that “Church is a big part of my life.” She has no previous mental health history or involvement with school or legal discipline. Eighteen months ago, she was seriously injured during a track meet, involving a knee and leg injuries. Her injuries have healed, but she still experiences serious leg, hip, and lower back pain.

Gabrielle was treated with OxyContin for her pain, and the medication was continued for over a year. She still finds it effective for pain but now needs larger doses to achieve the same relief. She developed opioid-related constipation and also now has frequent headaches, as she became dependent on the OxyContin. Recently, her family, her coach, and her family practitioner recommended that she reduce her opioid use. Her pastor at the college area church also recommended she seek treatment for her opioid use. They referred her for treatment of opioid dependence. Her college health service did not provide this treatment. Gabrielle’s family is very concerned about her, but she is not sure she needs treatment since she still needs the medication for her pain. Gabrielle, saying she was uncertain about stopping the pain medication, nonetheless came for treatment.

Gabrielle denies use of nonprescription drugs vehemently, saying she’d rather not be taking any drugs. “They’re easy to find at the gym, but I do not use them. This is just about serious pain.” She reports she has had a recent general physical exam and no concerns were identified.

The social worker practices in an outpatient agency that serves both substance abuse and mental health concerns but does not provide initial detoxification services. The agency does, however, provide medication-assisted therapy [MAT] for persons seeking to end opioid use. There is, however, an ongoing waiting list for

these services. During the initial assessment, the social worker identified many strengths in Gabrielle. These include her good overall health, a strong and supportive family, her coach and teammates, her pastor and congregations both at college and at home, friends at school, and few other stressors. She is continuing to do well in college despite her opioid dependence.

While Gabrielle is ambivalent about treatment, she does not like taking medications. “I wish I could be off all of them; I don’t like them at all,” she says. “Sometimes, now, I feel like a junkie.”

Gabrielle is clear that her functioning, other than on the track and in terms of some physiological symptoms, has not changed due to the opioid use. She does not show signs of compulsive drug-taking, nor has she changed her lifestyle and goals to increase her access to opioids. She states she only uses prescribe medications but is concerned that they are less effective against her pain as she has developed tolerance to them over time. Her prescribing physician is aware of her tolerance concerns. She appears dependent but not addicted (O’Brien, Volkow, & Li, 2006).

After assessment, the steps of the EBP process guide clinicians in incorporating the best available research results into practice decision-making.

Applying the Six Steps of EBP to the Case

Step 1: Drawing on Practice Questions, Identify Research Information Needs

Gabrielle’s stated needs center on ending her use of pharmaceutical opioids. She is quite clear that this is a circumscribed need. After an assessment which affirms her opioid dependence and identifies her many strengths, the social worker decided to search for treatments and services to end or reduce opioid dependence.

Step 2: Efficiently Locate Relevant Research Knowledge

A search of the Cochrane Library using the keywords “opioid dependence” yielded 24 titles. Some were off topic, such as those involving opioid agonists for smoking cessation or problem cocaine use. More on target, Nielsen et al. (2016) completed a systematic review (SR) of the effects of maintenance agonist pharmacotherapy for the treatment of *pharmaceutical* opioid dependence. This is a type of medication-assisted treatment (MAT) and is specific to the prescription type of opioid use Gabrielle presents, rather than heroin use. The authors state that “People dependent on pharmaceutical opioids appear to differ in important ways from people who use heroin, yet most opioid agonist treatment research has been conducted in people who use heroin” (Abstract, Background). Bethany fits this profile precisely having no heroin use.

Nielsen et al. (2016) included RCTs examining full opioid agonist maintenance medication versus other opioids including methadone and full or partial opioid agonist maintenance versus placebo, detoxification only, or psychological treatment (without opioid agonist treatment). They found 6 RCT studies involving 607 participants. They report:

moderate quality evidence from two studies of no difference between methadone and buprenorphine in self reported opioid use (risk ratio (RR) 0.37, 95% confidence interval (CI) 0.08 to 1.63) or opioid positive urine drug tests (RR 0.81, 95% CI 0.56 to 1.18). There was low quality evidence from three studies of no difference in retention between buprenorphine and methadone maintenance treatment (RR 0.69, 95% CI 0.39 to 1.22). There was moderate quality evidence from two studies of no difference between methadone and buprenorphine on adverse events (RR 1.10, 95% CI 0.64 to 1.91). (Abstract, main results)

“Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine” (SAMSHA, 2016, para 1). Buprenorphine, also called Suboxone or Zubsolv when combined with naloxone, can be prescribed on an outpatient basis by physicians. This is in contrast to methadone, which requires initial detoxification “treatment in a highly structured clinic” (SAMSHA, 2016, para 3). The social worker’s clinic provides these services.

Mattick, Breen, Kimber, and Davoli (2014) in a Cochrane Library SR report that “Buprenorphine is an effective medication in the maintenance treatment of heroin dependence, retaining people in treatment at any dose above 2 mg, and suppressing illicit opioid use (at doses 16 mg or greater) based on placebo-controlled trials” (Abstract, Authors’ conclusions). MAT is an effective treatment for opioid dependence. Indeed, MAT is called the “gold standard” treatment for opioid dependence by Food and Drug Administration Commissioner Gottlieb (2017). Note, however, that the samples considered in this SR is persons using heroin, rather than prescription pharmaceuticals.

Comparing medication-assisted treatments such as buprenorphine to psychosocial interventions, Nielsen et al. (2016) report:

We found low quality evidence from three studies favouring maintenance buprenorphine treatment over detoxification or psychological treatment in terms of fewer opioid positive urine drug tests (RR 0.63, 95% CI 0.43 to 0.91) and self reported opioid use in the past 30 days (RR 0.54, 95% CI 0.31 to 0.93). There was no difference on days of unsanctioned opioid use (standardised mean difference (SMD) -0.31 , 95% CI -0.66 to 0.04). There was moderate quality evidence favouring buprenorphine maintenance over detoxification or psychological treatment on retention in treatment (RR 0.33, 95% CI 0.23 to 0.47). There was moderate quality evidence favouring buprenorphine maintenance over detoxification or psychological treatment on adverse events (RR 0.19, 95% CI 0.06 to 0.57).

In these few studies, MAT reduced self-reported opioid use, reduced positive urine tests for opioids, and led to better retention in treatment than did psychosocial treatment alone. MAT also had fewer adverse effects than did detoxification or psychosocial treatments. The 95% confidence intervals (CI) were small, and each included the RR (relative risk) values; this indicates that the SR results are likely to fit other persons needing treatment. However, the research was rated as of low to moderate quality.

Another SR located in the Cochrane Library completed by Minozzi et al. (2011) drawing on 13 studies including 1158 participants found no statistically significant differences between naltrexone versus placebo or no pharmacological treatments. However, they conclude that the studies they reviewed did not provide an adequate evaluation of oral naltrexone. Naltrexone alone does not appear to be part of an effective MAT.

Looking specifically at psychosocial treatment for opioid *detoxification*, Amato, Minozzi, Davoli, and Vecchi (2011a) reviewed 11 studies with 1592 participants. Questioning if psychosocial treatment could improve outcomes of MAT mainly for persons using heroin, they found that:

Compared to any pharmacological treatment alone, the association of any psychosocial with any pharmacological was shown to significantly reduce dropouts RR 0.71 (95% CI 0.59 to 0.85), use of opiate during the treatment, RR 0.82 (95% CI 0.71 to 0.93), at follow up RR 0.66 (95% CI 0.53 to 0.82) and clinical absences during the treatment RR 0.48 (95% CI 0.38 to 0.59). Moreover, with the evidence currently available, there are no data supporting a single psychosocial approach. (Abstract, Main results)

That is, combining any of five psychosocial interventions with MAT reduced treatment dropouts, opioid use, and absences from treatment *during detoxification*. However, no specific type of psychosocial treatment was preferable to any other.

In another SR, Amato, Minozzi, Davoli, and Vecchi (2011b) examined the effectiveness of psychosocial treatment combined with MAT in *maintenance* opioid dependence treatment provided after detoxification. They reviewed 35 studies with 4319 participants who were involved in 13 different psychosocial treatment combined with MAT. In these ongoing services, they found that:

Comparing any psychosocial plus any maintenance pharmacological treatment [MAT] to standard maintenance treatment, results do not show benefit for retention in treatment, 27 studies, 3124 participants, RR 1.03 (95% CI 0.98 to 1.07); abstinence by opiate during the treatment, 8 studies, 1002 participants, RR 1.12 (95% CI 0.92 to 1.37); compliance, three studies, MD 0.43 (95% CI -0.05 to 0.92); psychiatric symptoms, 3 studies, MD 0.02 (-0.28 to 0.31); depression, 3 studies, MD -1.70 (95% CI -3.91 to 0.51) ... and participants abstinent by opioid, 3 studies, 181 participants, RR 1.15 (95% CI 0.98 to 1.36). Comparing the different psychosocial approaches, results are never statistically significant for all the comparisons and outcomes. (Abstract, Main results)

In ongoing, maintenance MAT, adding a psychosocial treatment showed no additional benefit.

Despite these differing Cochrane SR results, the US National Institute on Drug Abuse argues that “Medications should be combined with behavioral counseling for a “whole patient” approach” (2016, para 2).

SAMSHA states that “ideal candidates for opioid dependency treatment with buprenorphine have been objectively diagnosed with an opioid dependency, are willing to follow safety precautions for the treatment,” have been medically cleared for any health conflicts with using buprenorphine, and understand alternative treatment options (SAMSHA, 2016, para 15). These recommendations fit well within the EBP process.

Step 3: Critically Appraise the Quality and Applicability of This Knowledge to the Client's Needs and Situation

The results of the Nielsen et al. (2016) SR fit Gabrielle very well, though there is no information regarding gender or race in the SR report abstracts. Locating such information often requires one to review the individual articles on which the SR is based to identify specific characteristics of the study sample. In many reports this information is simply not provided. The other SRs are based on somewhat different populations, mainly heroin users. Other SR results suggest that psychosocial services may be helpful in competing MAT, which may be a lengthy process, though the research support for these services is limited. For Gabrielle, it is unclear how long the treatment might take.

The social worker's clinic administratively requires that all persons in MAT have a therapist or a case manager. The clinic's perspective is that such services enhance treatment effectiveness and are also a practical way to ensure clients are followed and supported.

Step 4: Actively and Collaboratively Discuss the Research Results with the Client to Determine How Likely Effective Options Fit with the Client's Values, Preferences, and Culture

Gabrielle is both smart and well educated. Still, the technical details of the SR's include statistics and research design commentary that may be unfamiliar to her. The plain language summaries of the SRs can provide a useful starting point for informing the client about the research results. Yet even the plain language summaries may include unfamiliar terms and concepts for many clients.

Gabrielle was disappointed that the best treatment option appeared to be another medication. Given the limited support for psychosocial services alone as being effective for reducing opioid use, she was open to trying them.

Gabrielle asked for information about the Cochrane SRs and was provided their URLs for access. She said in the next session that the materials made sense but did not seem to say much about individual differences. She also wondered how treating ongoing pain would fit with MAT or any other treatment, noting this was not addressed by the SRs.

Step 5: Synthesizing Client Needs and Views with Relevant Research and Professional Expertise, Develop a Plan of Intervention

Gabrielle was open to trying MAT though she hoped it was not just “switching one medicine for another.” She asked that a schedule to taper off be part of her treatment plan, which appeared wise. She was open to counseling and noted that “many people” in her life would be watching how she did. A referral for MAT was made, and a roughly 2 month wait for starting treatment was the initial reply. Gabrielle was willing to continue in counseling but disappointed.

Step 6: Implement the Intervention

While the social worker’s clinic provides MAT services, there is often a waiting list for services. (In many parts of the country, access to MAT may require an extended wait or be unavailable.) Gabrielle says she is willing to wait—“a short while”—so she and the social worker agreed to stay in telephone contact during the waiting period.

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