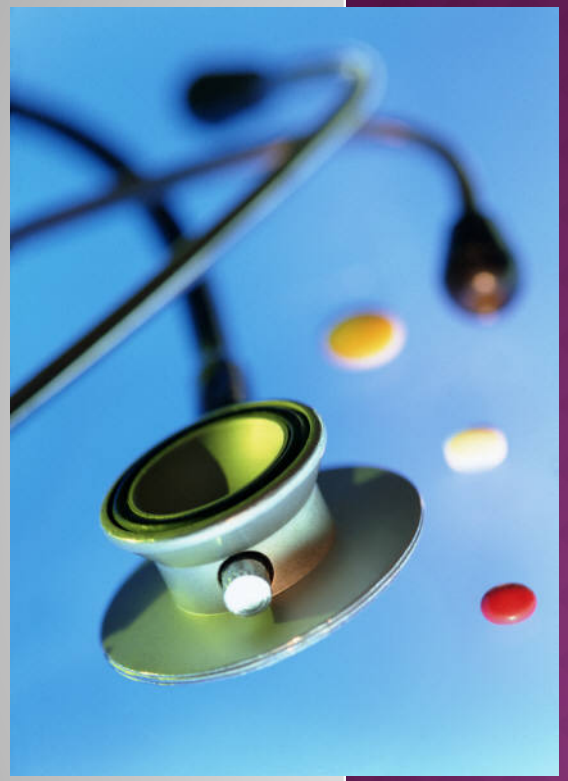

TREATMENT OF OPIOID ADDICTION

Using evidence-based treatment to respond to the opioid crisis

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- No conflicts of interest

INTRODUCTION

- 2.5 million Americans are addicted to opioids
- 1.68 million years potential life lost in 2016
- 42,000 deaths in 2016 from opioid overdoses
- That's 115 every day
- Cost to society of $504 billion in 2015*
  - The Council of Economic Advisers
  - *$1,575 per capita (pop 320 million)
  - *13% of federal budget (3.8 trillion)
  - *2.7% of GNP (18.75 trillion)

OUTLINE

- Abstinence-based vs MAT - stigma
- Using methadone in MAT
- OBOT best practices – "Next Stage"

- “The standard treatment for opioid addiction (heroin or prescription opioids) is referral to detox, followed by counseling and AA/NA for support and to learn the skills necessary to stay off drugs.”
- A commonly held belief among the lay public, medical profession, and even in the addiction treatment field.
- This is WRONG – and dangerous!

“Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 2).”

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
Recommendations and Reports / March 18, 2016 / 65(1);1–49

"Currently, three medications are approved for treating OUD: methadone, buprenorphine, and ER naltrexone. Along with psychosocial support, they comprise the current standard of care for reducing illicit opioid use, relapse risk, and overdoses, while improving social function."

The President's Commission on Combatting Drug Addiction and the Opioid Crisis. November 1, 2017. Chairman Gov. Chris Christie.

Many people, including some policymakers, authorities in the criminal justice system, and treatment providers, have viewed maintenance treatments as "substituting one substance for another" and have adhered instead to an abstinence-only philosophy that avoids the use of medications, especially those that activate opioid receptors. Such views are not scientifically supported; the research clearly demonstrates that MAT leads to better treatment outcomes compared to behavioral treatments alone. Moreover, withholding medications greatly increases the risk of relapse to illicit opioid use and overdose death. Decades of research have shown that the benefits of MAT greatly outweigh the risks associated with diversion.

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

"Strong scientific evidence unequivocally shows that for opioid use disorder, medication is the essential component of treatment, not merely one component. Despite this settled knowledge, some vocal constituents within the addiction treatment community and some policy makers dangerously continue to lobby for the treatment of opioid use disorder without medication."

Andrew Saxon, Elinore McCance-Katz, Journal Addiction Med, May/June 2016

A 32 year old female is admitted to the hospital with endocarditis with MRSA. She is given IV antibiotics. She complains frequently of pain and is administered all of the doses of prn opioids that have been ordered. She has a number of visitors and nursing suspects she may have been using her PICC line to inject street drugs. After 3 days of antibiotic treatment the patient becomes argumentative and demands to leave.

She has been using opioids for 14 years. She started when she sustained a lumbar compression fracture in an MVA at age 18. She was prescribed initially Percocet, then OxyContin with oxymorphone for breakthrough pain. She continued to complain of pain and to request dose increases at each visit. Eventually her dose was up to 280 MME daily.

She was cut off abruptly from her pain medication due to missing more than 2 appointments in a row.

She started buying opioids on the streets, mostly oxycodone. She turned to her family for help. They paid for her to attend a 30 day inpatient treatment program in another state. The patient left that program after 4 days for unclear reasons. The program described her as “non-compliant.”

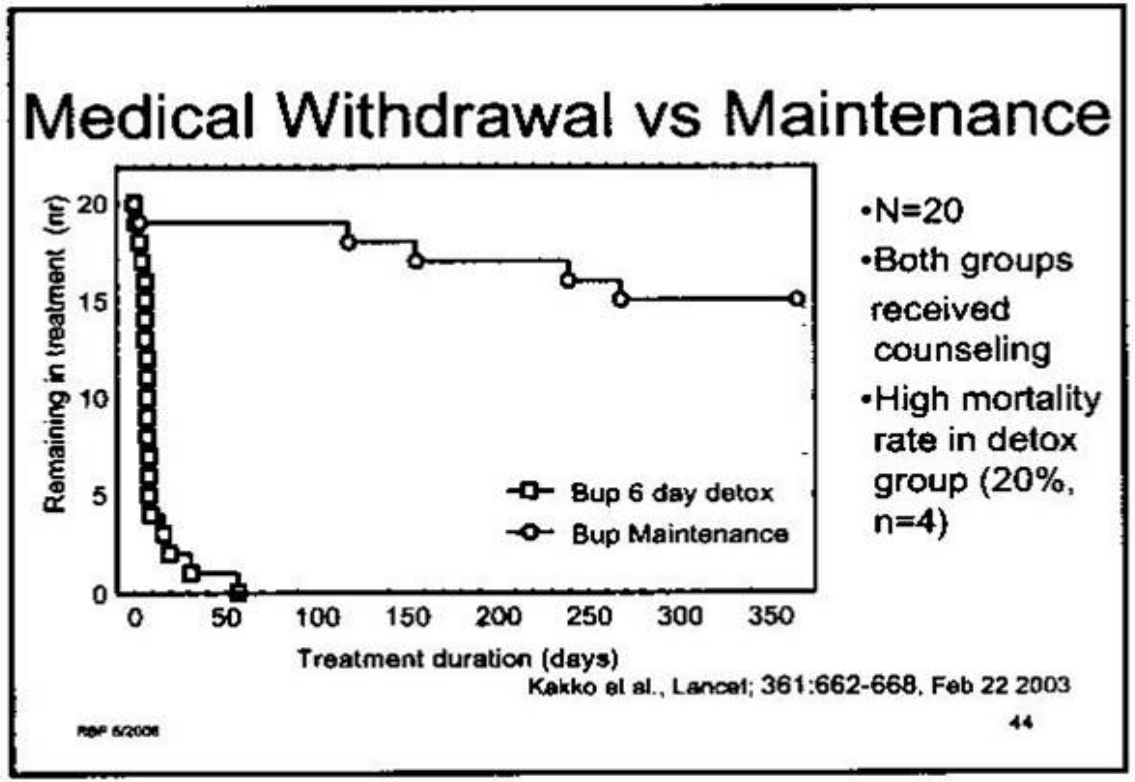
She turned to using heroin when she could not find any other opioids to relieve withdrawals.

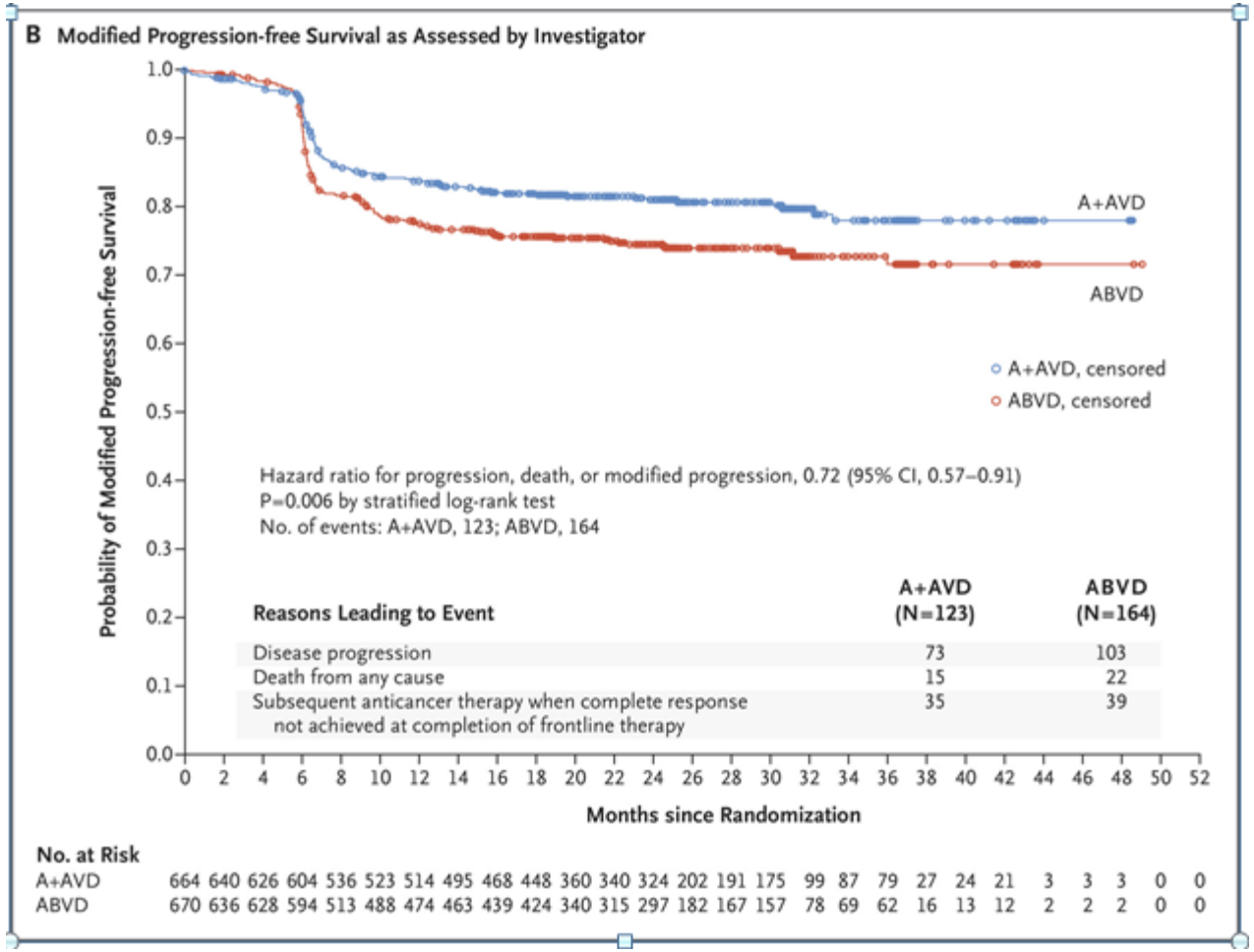
Over the next few years she went to 4 other inpatient treatment programs, staying as long as 90 days, but invariably relapsed to heroin use within a few days or weeks of leaving the program. Her family cut her off and refused to talk to her any more or give her any money for treatment.

She was referred to office-based buprenorphine therapy. She did well on 16 mg of buprenorphine/naloxone daily for 3 months, but was discharged after she tested positive for methamphetamine.

Lately she has been injecting heroin 1-2 grams per day, using 5 or more times daily.

MAT VS. DETOX ONLY





A comparison of 2 chemo regimens for advanced Hodgkins lymphoma

MORTALITY OF OPIOID ADDICTION

- 10 year study of heroin addicts in Catalonia
- 30% died, yearly rate 3.4% and mortality ratio was 28.5

Ten-year survival analysis of a cohort of heroin addicts in Catalonia: the EMETYST project, Sanchez-Carbonell X, Seus L. Addiction 2000 Jun 95(6):941-8

- 5-8 year study of heroin addicts in Sweden
- Mortality ratio 63 times higher, 40% died over 8 years

Mortality in heroin addiction: impact of methadone treatment, Gronbladh L, Ohlund L, Gunne L. Acta Psychiatr Scand 1990: 82: 223-7

MORTALITY OF ADDICTION

- Average decrease in life expectancy:
  - Opioids – 15-20 years
  - Alcohol – 10-15 years
  - Tobacco – 5-10 years
  - Diabetes II – 5-10 years
  - Hypertension – 5 years

ABSTINENCE BASED TREATMENT INCREASES MORTALITY

- 276 patients admitted to IP treatment in Norway
- In 1st 4 weeks after discharge, death rate from OD was 16 times higher than baseline
- Elevated risk "is so dramatic that preventative measures should be taken."

Mortality among drug users after discharge from inpatient treatment: an 8 year prospective study. Ravndal E, Amundsen E, Drug and Alc Dependence. 108 (2010): 65-69

GOALS OF MEDICATION

- No withdrawals
- No other opioid use
- Blockage of the euphoric effects of opioids
  - Minimal side effects
  - Improved function

METHADONE VS. BUPRENORPHINE

Methadone

- Only in OTPs
- More effective
- More structure
- More hassle to pt
- No pt limit
- More risky in OD

(LAAM - Levo-Alpha-Acetyl-Methadol - no longer used)

Buprenorphine

- In office (with waiver)
- Equiv to ~60 mg MMT
- No daily dosing reqs
- 30, 100 or 275 pt limit
- Ceiling on respiratory effects
- More expensive

METHADONE OTP DETAILS

- Patients come to clinic initially 6 days per week for observed dosing
- Maximum initial dose 30 mg, titrate over first few weeks
- Average daily dose 100-120 mg (variable)
- Strict rules for take home doses
- Regular urine drug screening
- Each patient has a counselor with regular visits and a treatment plan
- Referrals are made as needed to medical, psychiatric, counseling, social services
- OTPs can use buprenorphine as well as methadone

MYTHS AND FACTS

- Opioid addicts get "high" off of methadone and/or buprenorphine

- MYTH

- Fact: Opioid addicts feel "normal" on MAT
  - Stabilizes abnormal brain circuits
  - No cognitive impairment in tolerant individuals
  - No significant long term organ damage
  - No need for dose escalation over time once stabilized

GENETIC POLYMORPHISM

"Genetic polymorphism is the cause of high inter-individual variability of methadone blood concentrations for a given dose; for example, in order to obtain methadone plasma concentrations of 250 ng/mL, doses of racemic methadone as low as 55 mg/day or as high as 921 mg/day can be required in a 70-kg patient."

Mol Diagn Ther. 2008;12(2):109-24.

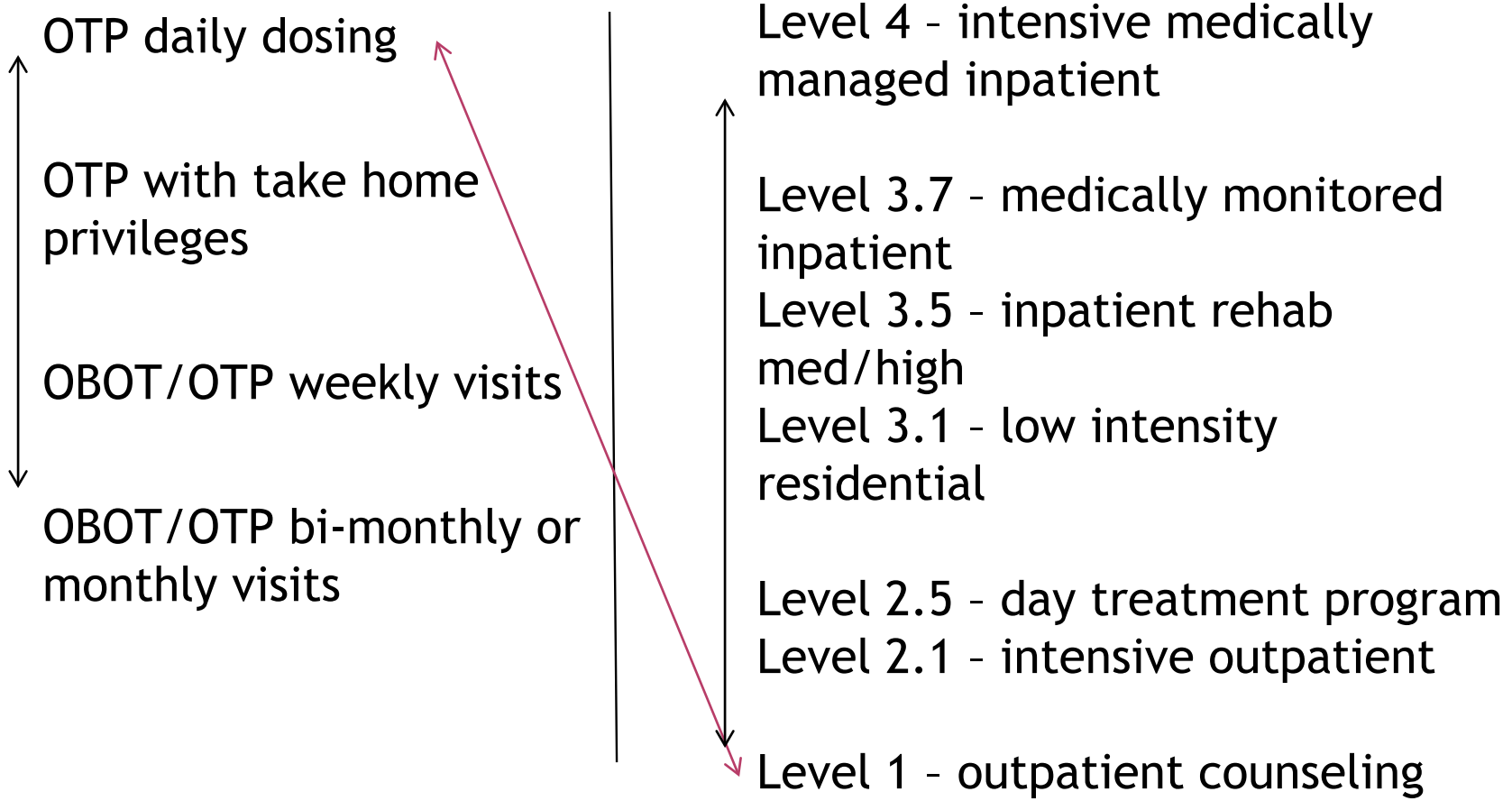
Interindividual variability of methadone response: impact of genetic polymorphism.

Li Y1, Kantelip JP, Gerritsen-van Schieveen P, Davani S.

NEXT STEP - GOALS OF TREATMENT

- "Get patient sober"
  - ~ NO
- Goal 1: Keep patient alive (decrease mortality/morbidity)
- Goal 2: Restore patient to functioning, contributing member of society
  - Stop criminal activity, stable housing, work, family relationships, regular income, etc.
  - If the patient takes a medication, or has positive UDSs, that is much less important

LEVELS OF CARE



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SUMMARY - BEST PRACTICES - OBOT - "NEXT STAGE"

- Understand harm reduction and use these principles in all patient decisions
- Admit all patients appropriate for OBOT
- Shorten time to admission and first dose
- Do not arbitrarily limit dose or time in treatment
- Do not arbitrarily require counseling or 12-step attendance
- Do not discharge for cannabis or BZ use
- Develop referral source for patients who fail OBOT (hub and spoke)
- Use Motivational Interviewing as your basic approach to patients
- Refer to empathetic counselors

Martin SA, Chiodo LM, Bosse JD, Wilson A. The Next Stage of Buprenorphine Care for Opioid Use Disorder. Ann Intern Med. 2018 Nov 6;169(9):628-635.

TREATING OUD WITH MAT

- One of the most effective and gratifying things you can do in Primary Care.
- An opportunity to save lives and have a huge positive impact for your patients.
- It is not as hard as it seems at first.
- Thanks to all of you for taking this course and getting your waiver.
- I am happy to answer any questions – contact information below.

  - Robert Sherrick – robert.sherrick@addictiontx.net
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