CIPC

Project ECHO®

Barre Family Health Center
Massachusetts

UMassMemorial Health Care

University of Massachusetts Medical School

umassmed.edu

Bassett Healthcare & Project ECHO

Introduction to Medication Assisted Treatment of Opioid Use Disorder *for* Primary Care Clinicians

Amber Hewitt, PsyD
Stephen Martin, MD, EdM

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University of Massachusetts Medical School
umassmed.edu

8:30-9:00	Introductions; Describe Collaboration and Goals What We've Learned from Our Patients	Hewitt Martin
9:00-9:30	— The Opioid Epidemic in Rural New York State — Opioid Use Disorder (OUD) as a Chronic Disease	Martin
9:30-10:00	Introduction to Harm Reduction	Hewitt
10:00-10:20	Treatment Options for Patients with OUD	Hewitt Martin
10:20-10:40	Break	Group
10:40-11:00	Basics of Buprenorphine Pharmacology	Martin
11:00-11:30	Responding to Relapse and Trauma Informed Care	
11:30-12:15	Mental and Physical Health Needs of Patients with OUD	Hewitt Martin
12:15-1230	Reflections and Next Steps	Group

Introductions

Steve

South Boston

CHCs

Barre

Amber

Working in primary care

Experience with Buprenorphine care

Teaching residents

Group …

Who is here?

What is left of the est of
Laura Gardner Shaw (mother
of Harriet Shaw Brown)

The Story Goes

Gray and large fat pawned
by Uncle P. to buy alcoholic
beverages

Prior Experiences Caring for Patients with Addiction?

What We've Learned from Our Patients

OBITUARIES

Alexander T. Brezinski

BREZINSKI

SHELBURNE FALLS — Alexander T. Brezinski, 37, of Shelburne Falls, MA died Sunday July 24, 2016 in Stoneham.

He was born in Concord, MA December 28, 1978 the son of Thomas and Ellen (Alves) Brezinski. He was a 1997 graduate of Smith Academy in Hatfield, MA.

Alex fought a long, hard fight with the disease of addiction.

He was a gentle soul with a bright aura. He made a lasting impression on everyone he met and greeted everyone with a bear hug. The beauty and uniqueness of his soul shone through in his glass blowing, an art he loved along with music.

Alex leaves his parents Thomas and Ellen Brezinski of Shelburne Falls, and two sisters, Jessica Remillard (Jeremy) and Eliza Zucco (Jason). He also leaves two beloved nieces, Lilly and Ruby and lots of aunts, uncles, cousins and many, many friends.

Calling hours will be Friday 7-29-16 at Kostanski Funeral Home, 220 Federal St., Greenfield from 5 to 7 p.m. with a time to share at 7 p.m.

In lieu of flowers memorial contributions may made to Learn to Cope, www.rally2recovery.com

Sympathy messages available at www.kostanskifuneralhome.com

Laura Constance Johnson

SOUTH DEERFIELD — Laura C. Johnson (19 years old) of 1 Allen Drive, South Deerfield, MA, died on August 26, 2015, at Quincy Medical Center in Quincy, Massachusetts.

JOHNSON

Laura was born at Cooley Dickinson Hospital on March 19, 1996, the daughter of Kathleen Johnson and David Johnson. She graduated from Frontier Regional High School in 2014. An avid musician, budding artist, writer, athlete, and lover of animals, Laura played the saxophone in the marching band for five years and studied piano, violin, and guitar. Laura was a member of the Junior Varsity and Varsity volleyball teams at Frontier from 2010-2013. After a year off to work after graduation, she planned to attend Greenfield Community College and transfer to a four-year institution to study psychology. Laura died suddenly from a heroin overdose while in a recovery program in Quincy, Massachusetts.

Laura is survived by her mother, father, and sister

Drug-recovery activists stung by volunteer's overdose death

By KELLEY BOUCHARD
Staff Writer

Greater Portland's recovery community suffered a hard blow Monday night when the brother of a leader of the Scarborough Police Department's Operation HOPE died of an apparent drug overdose.

DEVON HIGGINS

Jaime Higgins, a coordinator of the program that helps Mainers seek treatment for heroin and opiate addition, posted a heart-wrenching tribute to her 29-year-old brother, Devon, on the department's Facebook page Tuesday afternoon.

"My brother, who has been doing amazingly well in his recovery, died

. I later found
t, Harris told
ıe for the day,
talented and
d be forgiven.
Harris spent
Mike Schur on
onsider how
meone must
ain employ-
exts like this:

aking
ent.

Found a great vacant bathroom downstairs. Be back soon. You guys keep going.

Mike: I'm tweeting this if you don't get up here in 30 seconds.

Harris was very open about his struggles with drugs. On an episode of the "You Made It Weird" podcast with Pete Holmes, Harris detailed how heroin became a part of his life. It's a brutal story that only Harris could share in a way that is both heartbreaking and hilarious. You melt when you hear how, at a low point, Harris didn't care about his

city to help him stay sober. I was naïve about addiction and assumed that because he was so good about pursuing treatment, things would be fine. He always seemed so hopeful, and things were all pointed the right way. His mother, Maureen, forwarded me the final email she received from Harris, which he sent the same day he died of a heroin overdose.

i found a cool place to live in Manhattan. I feel good!! I am feeling very fortunate. Love you

Since Harris's death, I've dug deeper into his podcast history just to hear his

WHAT ARE THE MAJOR SOURCES OF STRESS IN YOUR LIFE?

Keeping people Happy.
feeding my son.
paying my bills.
my fathers health. (As I live upstairs from him, we are very close)

WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE TREATMENT?

I can stop buying street drugs/ stop using street drugs, and not be in pain from withdrawls.

IF YOU ARE NOT CURRENTLY USING DRUGS OR ALCOHOL, WHEN WAS THE LAST TIME YOU RELAPSED TO USE?

1 and five month ago couldn't get suboxone used percocet instead

WHAT 'TRIGGERS' DO YOU KNOW WHICH HAVE PUT YOU IN DANGER OF RELAPSE IN THE PAST, OR WHICH MIGHT IN THE FUTURE?

extreme stress / Anxiety

fear

WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE?

Support from my husband and knowing where I am now, and knowing I need to get better. Im tired of abusing. I need to get better.

ARE THERE ANY THINGS YOU WOULD PARTICULARLY LIKE TO DISCUSS WITH THE DOCTOR TODAY?

Just help me as soon as possible. I want my life back. I never thought I'd be here but I know I need to be.

##

WHAT 'TRIGGERS' DO YOU KNOW WHICH HAVE PUT YOU IN DANGER OF RELAPSE IN THE PAST, OR WHICH MIGHT IN THE FUTURE?

getting abused or beat up

WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE?

im a strong person

WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE?

The knowing I can stay clean with consistant care.

WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE TREATMENT?

An addiction to opiates off & on for 7 yrs. and a strong disire & need to stay clean for good.

WHAT 'TRIGGERS' DO YOU KNOW WHICH HAVE PUT YOU IN DANGER OF RELAPSE IN THE PAST, OR WHICH MIGHT IN THE FUTURE?

Freinds in my last town I Lived in.

WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE?

I have the gift of desperation, I want to be clean more than anything

WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE TREATMENT?

Dependancy on pain killers is ruining my life. A friend of mine used "Subs" to help get off oxycodone and he hasnt used since

WHAT COPING METHODS HAVE YOU DEVELOPED TO DEAL WITH THESE TRIGGERS TO RELAPSE?

I havent. Thats why I am here.

Treatment with buprenorphine / Intake questionnaire for patient

WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE TREATMENT?

To get my life Back

The Opioid Epidemic in Rural New York State

The Opioid Epidemic in Rural New York State

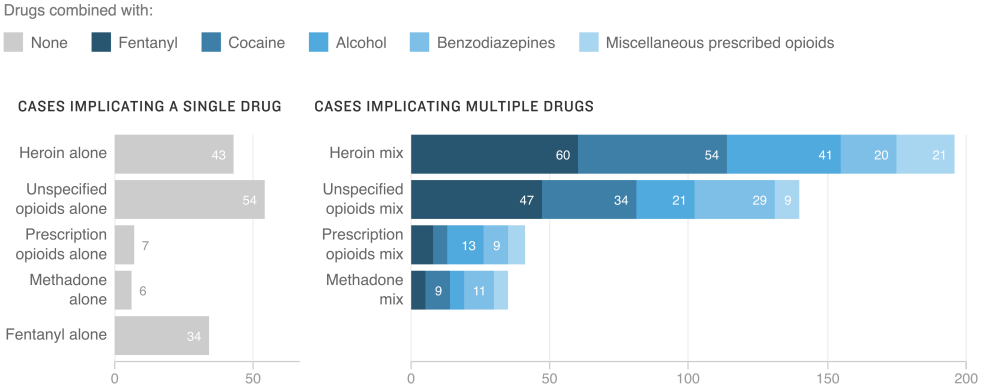
Similarities across New England and Northeast

2016 is not like 2006 … or even 2011

- Over half of young people start heroin without having used opioid pills
- 85% of Massachusetts overdose deaths in 2013-2014 involved heroin and/or fentanyl
- Fentanyl is nearly all illicitly created and comes in pill or powder form; the person using it may have no idea it is present
- Overdoses are increasingly requiring more than one dose of Narcan to reverse
- Most overdose deaths are in people 40 years old or younger
- Most overdoses involve a mix of substances, including alcohol, opioids, cocaine, and benzodiazepines

Most Overdose Deaths In Massachusetts Involve Multiple Drugs

Number of overdose deaths in Massachusetts, January through June 2014



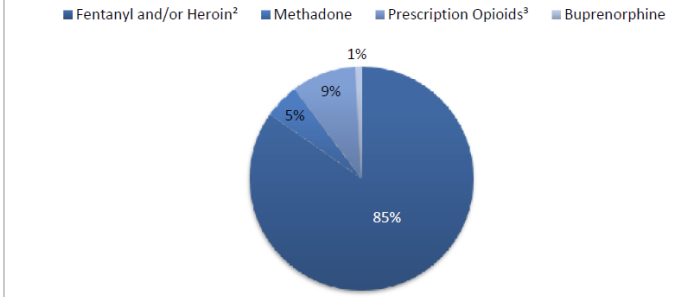
Notes

Drug combinations are classified in pairs of drugs only. Cases involving more than two drugs are counted in each category they fall under.

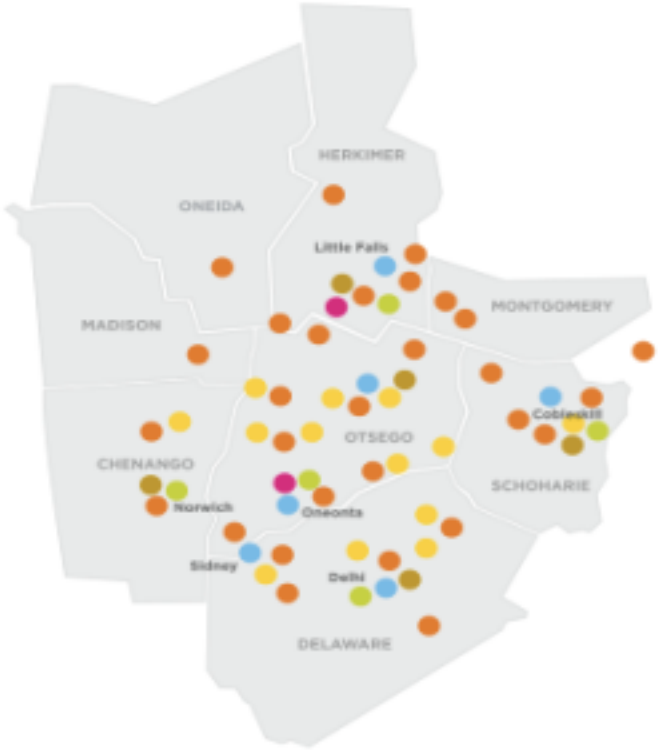
Source: Vaughan W. Rees and Christopher D. Knapp, Harvard T.H. Chan School of Public Health

Credit: Katie Park/NPR

Figure 1: Fatal Opioid-Related Overdoses
Mutually Exclusive[1] Toxicology Categories: 2013-2014



1. Opioid-related overdose deaths in mutually exclusive categories were categorized based on decreasing order of deadliness of the specific drugs (*Fentanyl and/or Heroin → Methadone → other Rx → buprenorphine*) present in the results. A person was put into a category based on the deadliest drug present in the results, regardless of the presence of other drugs. For example, if someone had Fentanyl and Methadone present, they would be in the "Fentanyl" group.
2. Fentanyl and/or Heroin includes: Fentanyl, Heroin, and Morphine (likely Heroin).
3. Prescription opioids include Hydrocodone, Hydromorphone, Oxycodone, Oxymorphone, Codeine, and Tramadol.



- Health Centers
- Hospitals
- School-Based Health Centers
- Durable Medical Equipment
- Home Health Agency
- Skilled Nursing & Rehabilitation

Heroin epidemic hit region hard in 2015

By Joe Mahoney Staff Writer Dec 22, 2015

Contributed

thedailystar.com

Subscriptions News Sports Classifieds Community Opinion Obituaries

Local police: Fentanyl is 'a huge concern'

By Jessica Reynolds Staff Writer Jun 6, 2016

Tom Gannam

Associated PressThis April 2006 file photo shows different brands and dosages of Fentanyl patches in St. Louis.


2 mL
NDC 0074-9083-32
FENTANYL Citrate
Injection, USP
100 mcg Fentanyl/2 mL
(50 mcg/mL) (0.05 mg/mL)
EYEWITNESS NEWS
TAINTED HEROIN CAUSING CONCERN
OTSEGO COUNTY
WFXV 33 HD
FALL THROUGH. * UNITED PRESS INTERNATIO
4° 10:02


HEROIN
FENTANY
INCHES
1
2
11
12
13
14
15

The Otsego County Opiate Task Force

"A small group of committed community members standing in the face of an unprecedented crisis."

The partner organizations:

- Oneonta PD
- Catholic Charities
- Crossroads Inn
- Friends of Recovery DO
- Bassett Healthcare
- Otsego County Probation
- LEAF Council on Alcoholism and Addictions
- Otsego County Community Services
- Otsego County Health Department
- Jail Ministries of Otsego County
- Central New York Prevention Resource Center
- SUNY Oneonta (Faculty and Student Services)
- Hartwick College
- Members of the Recovering Community
- Private Therapist
- Otsego County Drug Treatment Court
- Family Members
- Members of the community at large

Core Team:

Julie Dostal, Chair
Executive Director
LEAF Council on Alcoholism and Addictions

Susan Matt
Director
Otsego County Community Services

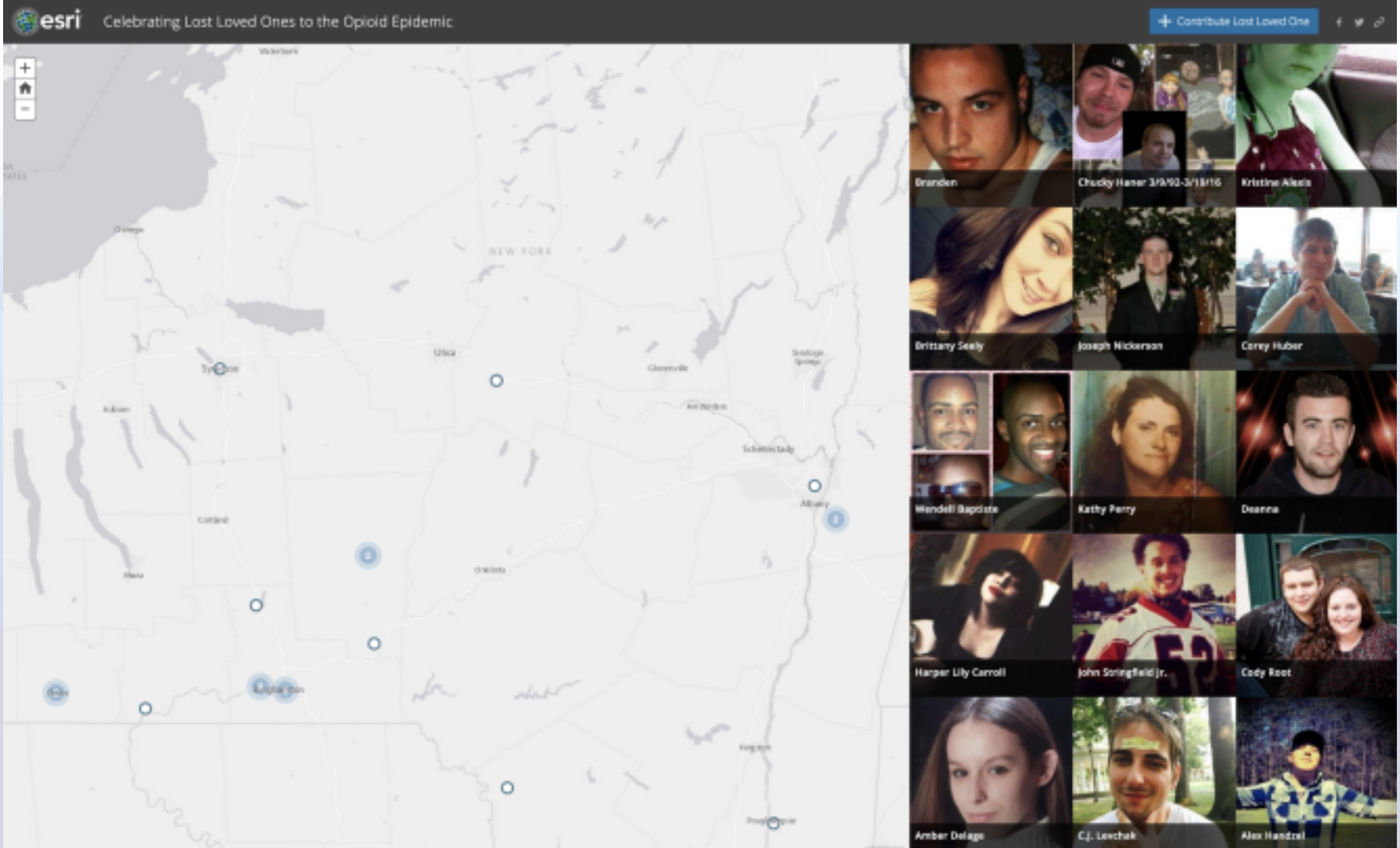
Heidi Bond
Director
Otsego County Health Deparment

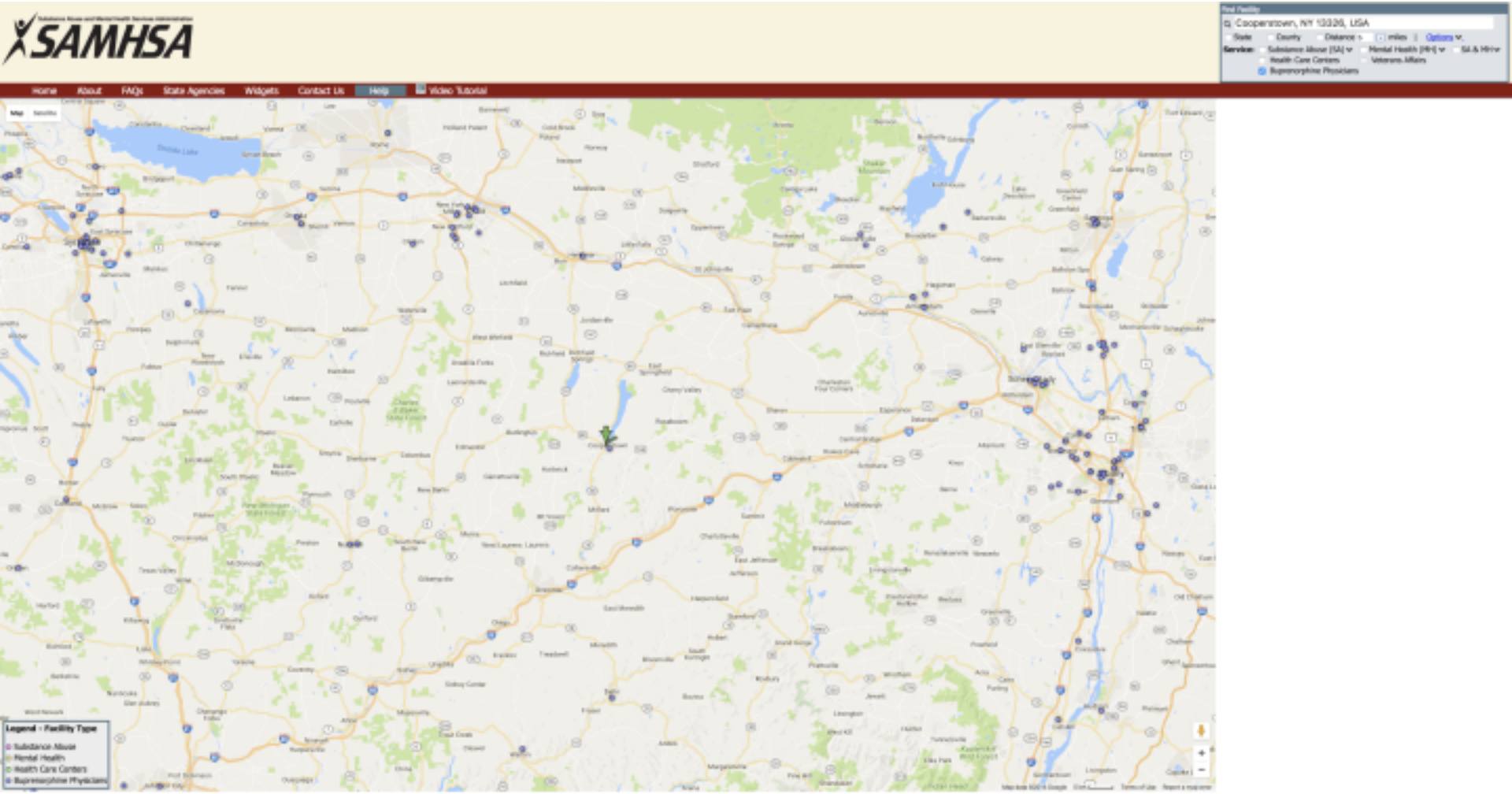
- The Problem: Significant increase in opiate related harms to Otsego County Residents
- Who is affected: The highest impacts are being seen in the 18 to 34 year old age group.

Aim Statement: From 1/01/15 to 12/31/15 reduce harms associated with opiate use in Otsego County so that:

  - Arrest rates for heroin and opiate misuse are reduced by 20%
  - Opiate using peer influencers in the teen and young adult population are identified more frequently by Schools, DSS and Healthcare providers
  - Community members have greater awareness of opiate use and risk factors associate with use through use of the "Hunger Heart Film Tour."

Although this is a countywide initiative, the main focus is behavior change and risk factor reduction in the 18 to 34 year old age group.


esri
Celebrating Lost Loved Ones to the Opioid Epidemic
+ Contribute Lost Loved One
NEW YORK
Utica
Schenectady
Albany
Cortland
Branden
Chucky Haner 3/9/92-3/18/16
Kristine Alexis
Brittany Seely
Joseph Nickerson
Corey Huber
Wendell Baptiste
Kathy Perry
Deanna
Harper Lily Carroll
John Springfield Jr.
Cody Root
Amber Delage
C.J. Lewchak
Alex Handzel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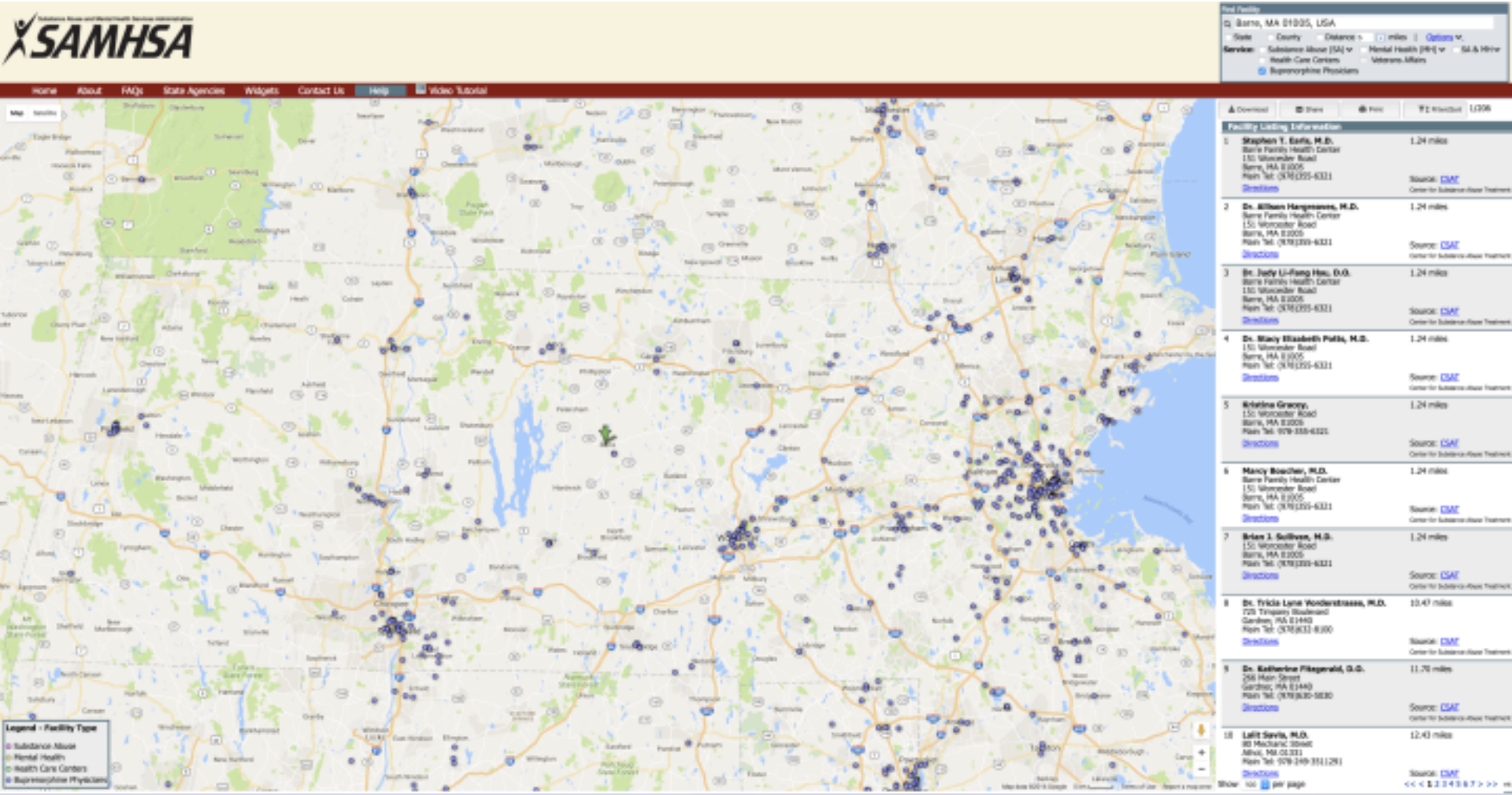
Health Care Centers
Buprenorphine Physicians


SAMHSA
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Facility Listing Information
Legend - Facility Type
Substance Abuse
Mental Health
Health Care Centers
Buprenorphine Physicians

Opioid Use Disorder as a Chronic Disease

OUD as a Chronic Disease

	Diabetes	Ventricular Arrhythmia	AIDS	AUD	OUD
Epidemic	X		X	X	X
Predominantly Younger			X		X
Lethality		X	X	X	X
Abruptly Lethal		X		X*	X
Highly Effective Treatment		X	X		X
Stigma and Social Upheaval			X	X	X
Medically Complex			X	X	
Successful Treatment Generally Depends on Longitudinal Caring Relationship	X		X	X	X

Drug Dependence, a Chronic Medical Illness

Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O'Brien, MD, PhD
Herbert D. Kleber, MD

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

JAMA. 2000;284:1689-1695 www.jama.com

MANY EXPENSIVE AND DISturbing social problems can be traced directly to drug dependence. Recent studies[1-4] estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems.[2-4] These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem that requires interdiction and law enforce-

WELLNESS

John Green on Mental Illness: 'There Is Hope'

By John Green
Feb. 4, 2016

John Green is the author of The Fault In Our Stars and 5 other books.

COURTESY OF JOHN GREEN

But then I got better. Having been sick before and being in the privileged position of having access to excellent health care, I was surrounded by people who told me my pain would end, that I would not always feel how I felt at my sickest. There is hope, even if getting good treatment is difficult, especially in a health-care system that too often fails to acknowledge the seriousness of mental illness. People get better every day. Of course, they get sick, too. The metaphors we most often employ when discussing disease—that it is an enemy to defeat, or a hurdle to jump and put behind us—don't really apply to chronic illness. Instead, you live with it. You get better. You get worse. You get better again. Sometimes you're driving the bus and sometimes you aren't, but the bus rumbles along regardless.

You go on.

~~OUD as a Chronic Disease~~

OUD as a Chronic, Lethal, Stigmatized Disease

OUD as a Chronic, Lethal, Stigmatized Disease: Implications and Principles of Care

- Harm reduction
- Chronic condition model
- Caring and compassion
- Longitudinal
- Nimble
- Trauma-informed for patients and as a team

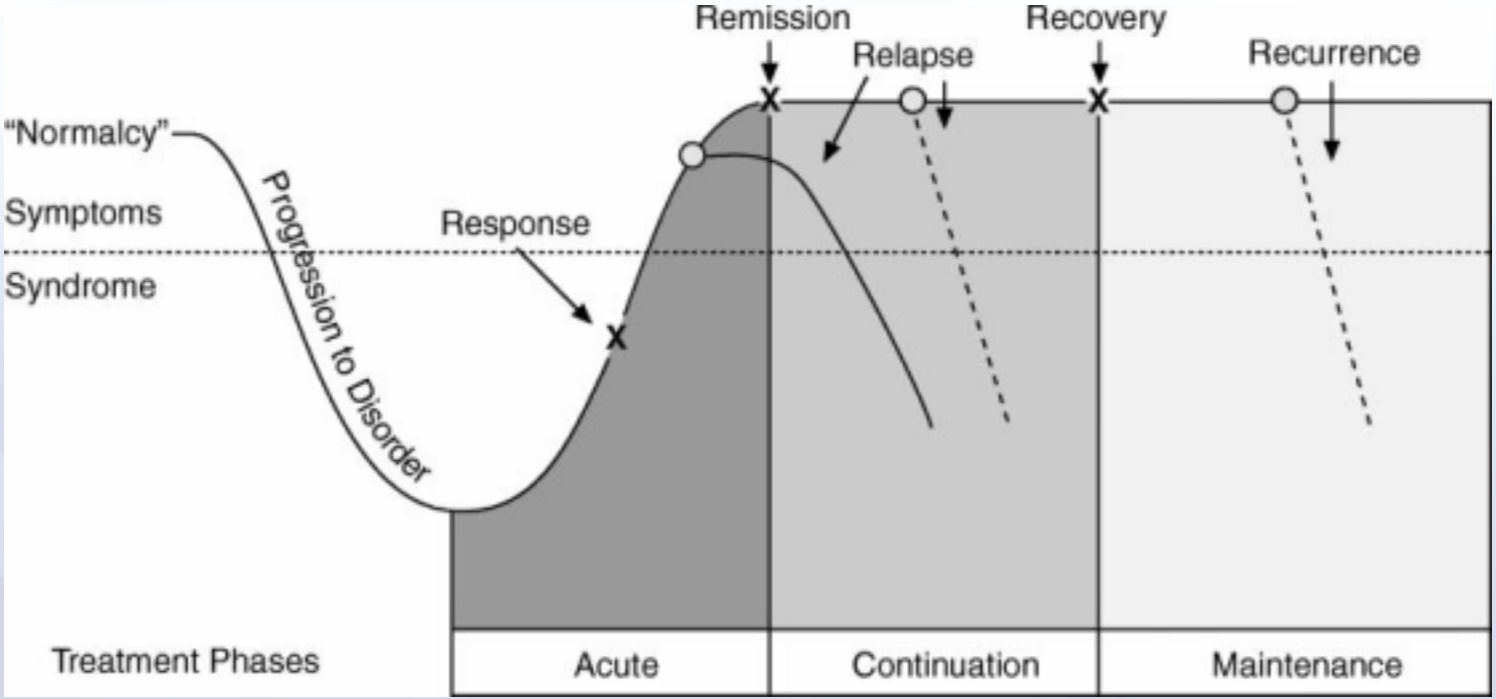


Fig. 1. Definition of response, remission, recovery, relapse, and recurrence (Kupfer, 1991). Note that acute phase treatment aims to promote a response as well as some level of remission. Continuation phase treatment aims to sustain remission, prevent relapse, and promote recovery. Maintenance phase treatment aims to foster or sustain recovery and prevent recurrence.

Table 1.
Definitions of change points in depression (adapted from Frank et al., 1991).

Term	Definition
Index Episode	Major Depressive Episode (MDE), as defined by a diagnostic system such as the DSM-V (American Psychiatric Association, 2013), lasting at least 2weeks, and from which decisions about response, remission, recovery, relapse and recurrence are made.
Response	A reduction in symptom severity relative to baseline status (usually 50%) that is often taken to imply that acute-phase treatment is having an effect.
Remission	A period of time (often defined as two months or longer) when symptoms have largely normalized and the patient can be thought of as well. (Note that remission precedes both recovery and recurrence).
Stable remission	A sustained interval in which depressive symptoms are absent or quite minimal.
Unstable/partial remission	An interval during which some level of depressive symptoms are present (partial) or only sporadic (unstable).
Recovery	The end of the index episode following an extended period of remission (e.g., 6–12months). The notion here is that the patient is no longer in episode.
Relapse	The reemergence of symptoms of depression (presumably part of the index episode) following some level of remission but preceding recovery.
Recurrence	The onset of a new episode of depression following an extended period of remission of sufficient duration to assume that recovery had occurred.

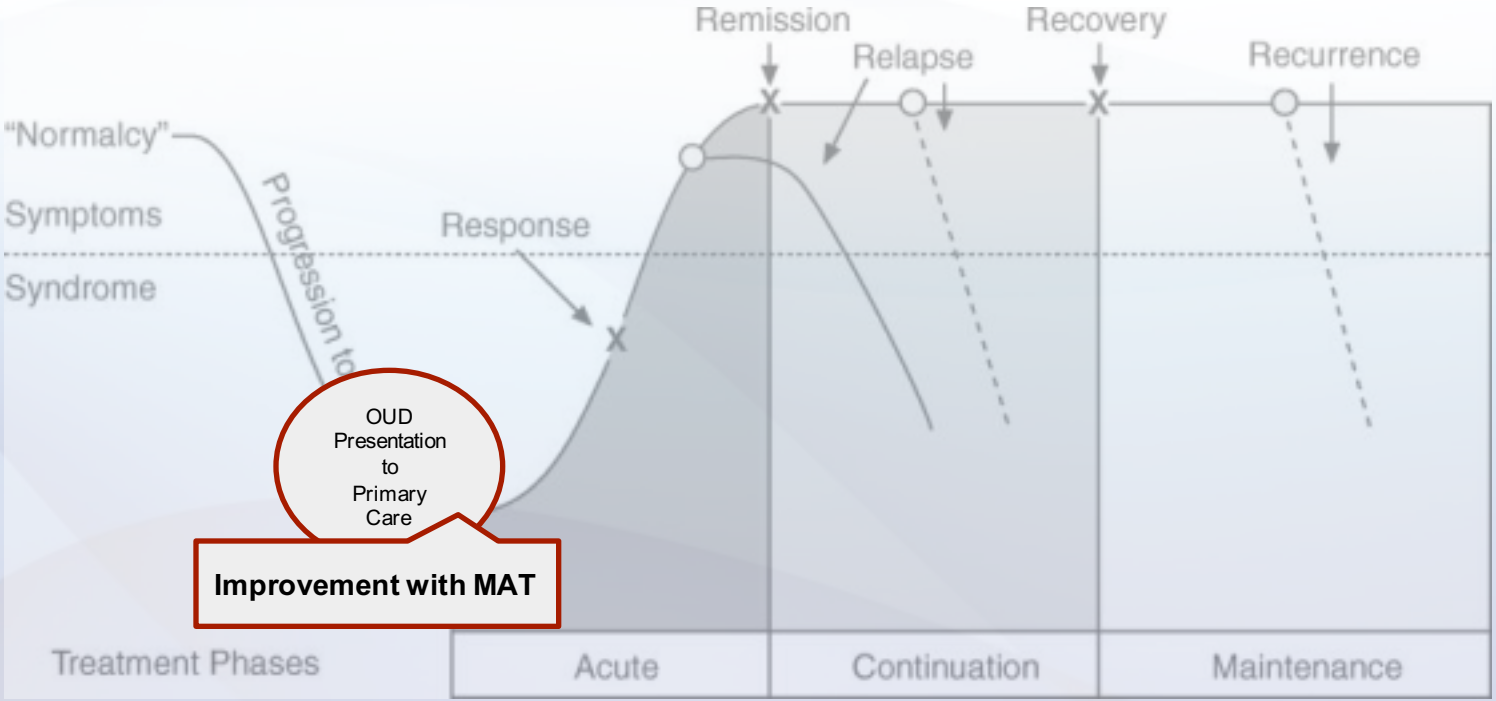
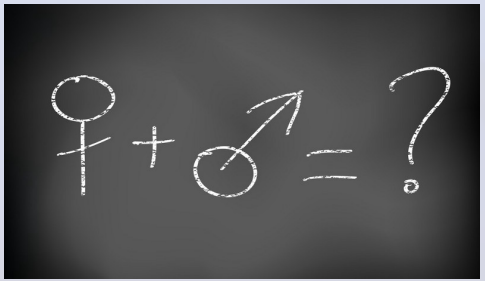


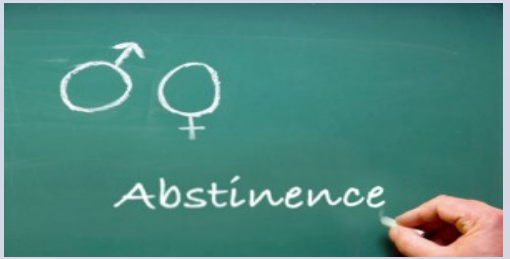
Fig. 1. Definition of response, remission, recovery, relapse, and recurrence (Kupfer, 1991). Note that acute phase treatment aims to promote a response as well as some level of remission. Continuation phase treatment aims to sustain remission, prevent relapse, and promote recovery. Maintenance phase treatment aims to foster or sustain recovery and prevent recurrence.

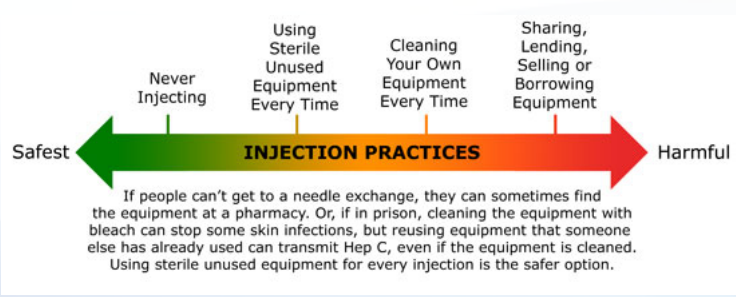
Harm Reduction

Top-down, abstinence driven policy with limited integration of user-driven experience

Time and effort spent on eradicating intractable human behaviors can be better spent working with affected individuals to find ways to **reduce the associated negative consequences**.
(Harm Reduction Coalition, 2010)







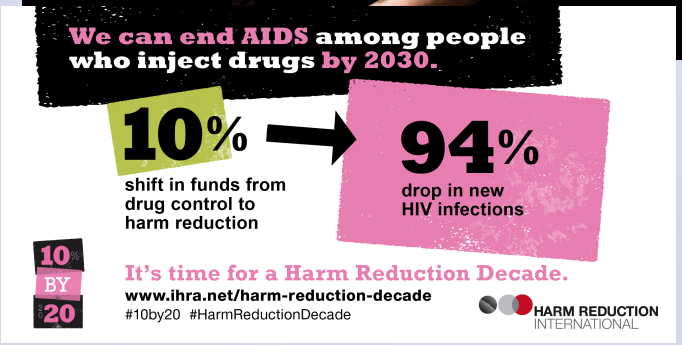
needle

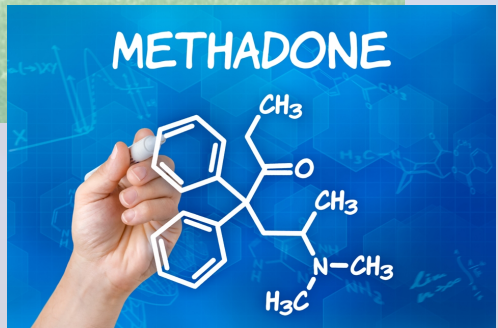
syringe

Needle Syringe Programs have been demonstrated to reduce transmission of HIV.

Support your local NSP today.

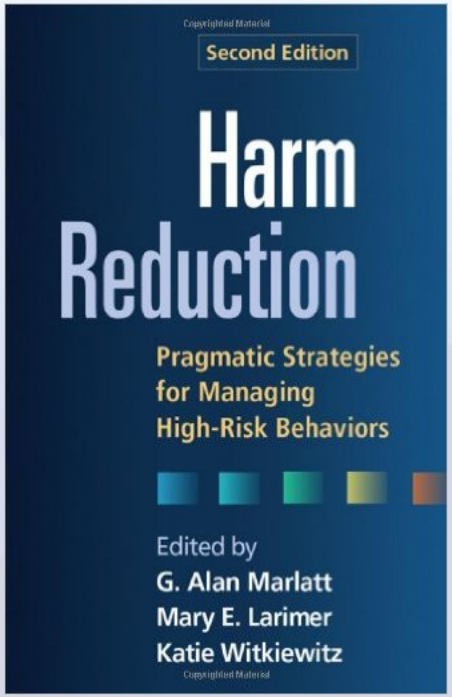
program





G. Alan Marlatt, PhD (1941 – 2011):

Pioneer in the Harm Reduction Movement and Addiction Treatment,
Addiction Behaviors Research Center, University of Washington



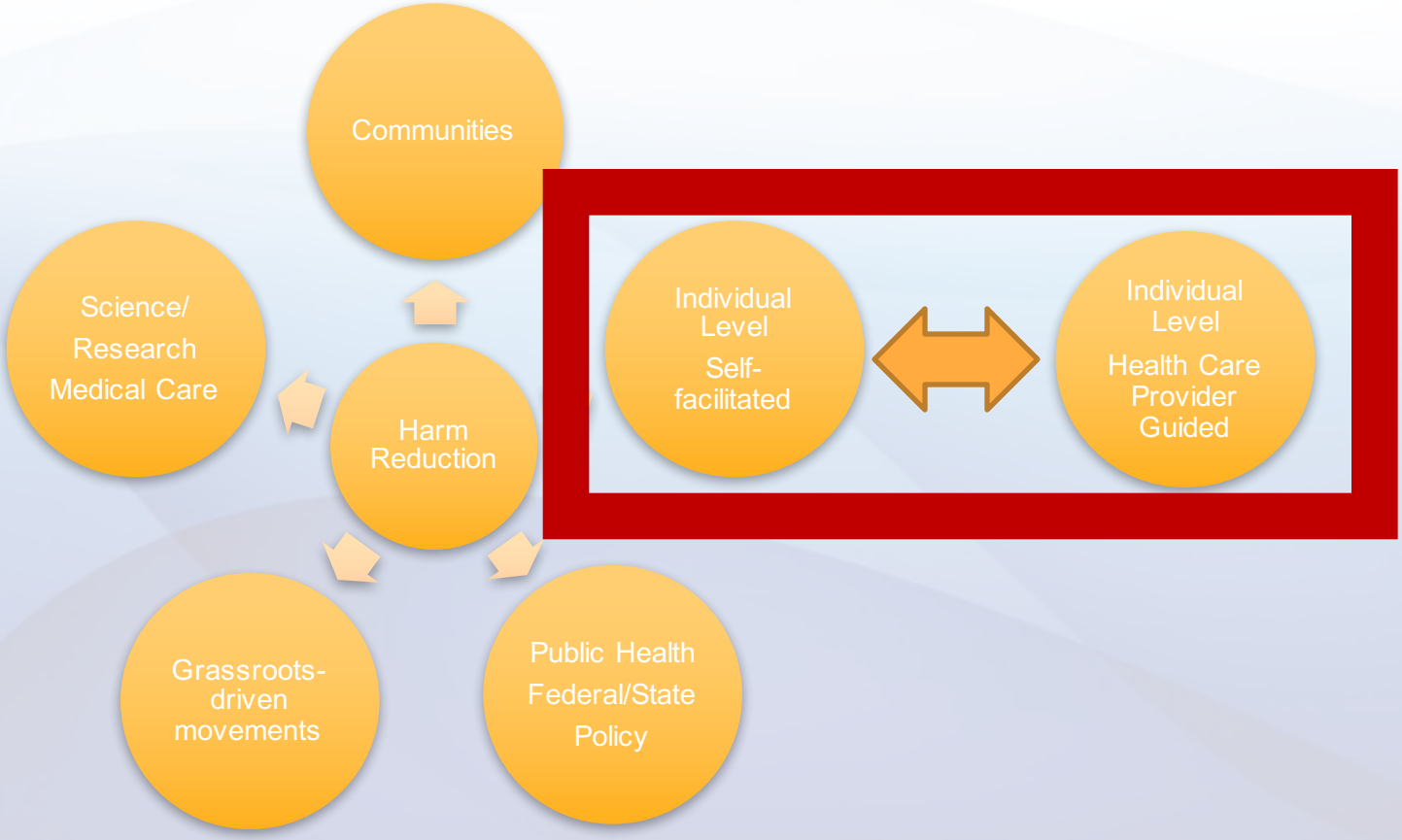
Defining Harm Reduction…

"…harm reduction as a set of **compassionate and pragmatic approaches** for reducing harm associated with high-risk behaviors and **improving quality of life (QoL)**."

"… harm reduction is more of an **attitude** than a fixed set of rules or regulations… A **humanitarian stance** that accepts the inherent **dignity of life**… And appreciates the **complexity and nuance of human behavior**."

"empower patients to devise **their own means to reducing harm** and defining their own ends as to what harm reduction will comprise… harm reduction approaches can more flexibly accommodate affected individuals' and communities' specific needs than other top-down, theory-oriented approaches."

"Harm reduction… deemphasizes general theory and ideology and seeks out **acceptable, feasible, and effective solutions** that are applicable to **specific situations**."

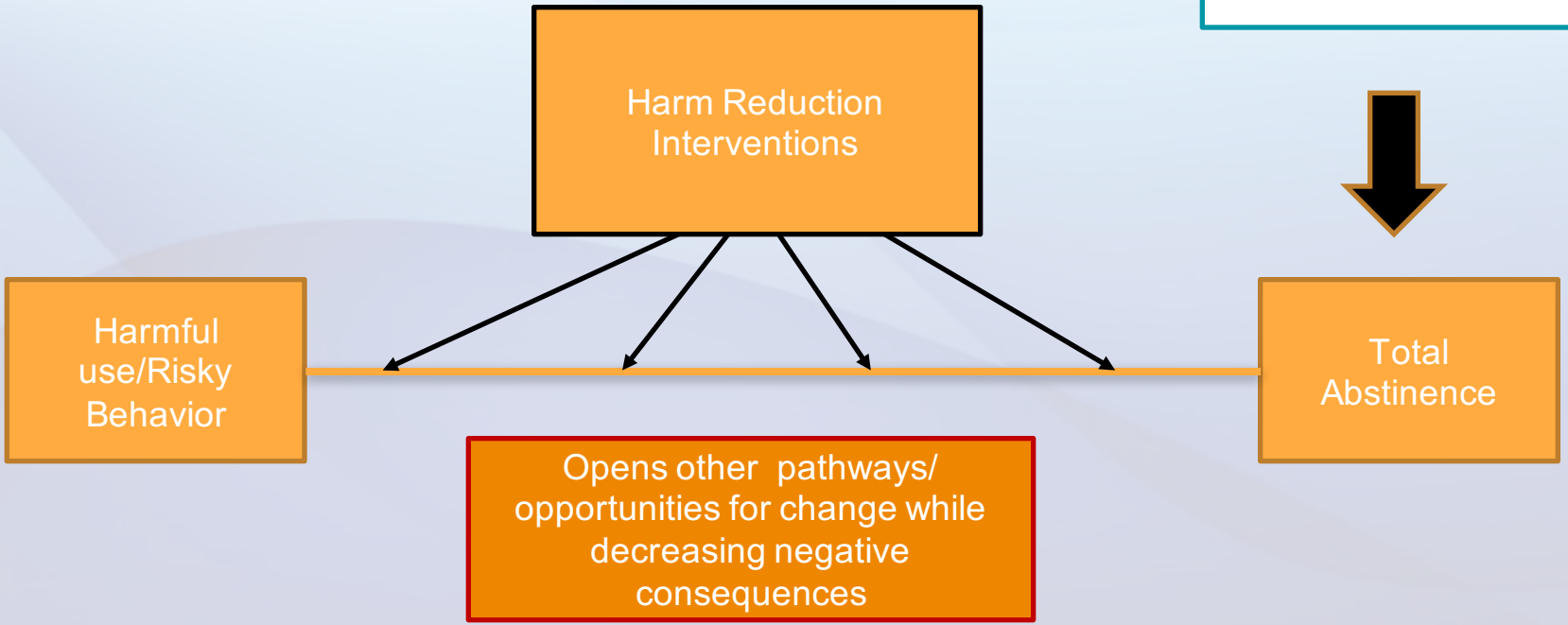

Communities
Science/
Research
Medical Care
Harm
Reduction
Grassroots-
driven
movements
Public Health
Federal/State
Policy
Individual
Level
Self-
facilitated
Individual
Level
Health Care
Provider
Guided

What Are Some Examples of Harm Reduction-based Interventions You Already Use with Your Patients (with or w/o Substance Use Disorders)?

Aceijas, C., Hickman, M., Donoghoe, M. C., Burrows, D., & Stuikyte, R. (2007). Access and coverage of needle and syringe programmes (NSP) in Central and Eastern Europe and Central Asia. Addiction, 102, 1244–1250.

Bennett, S. E., & Assefi, N. P. (2005). School-based teenage pregnancy prevention programs: A systematic review of randomized controlled trials. Journal of Adolescent Health 36, 72–81.

It'd be nice… but we're working with the human condition…



Abstinence only housing programs → Housing First Initiatives

Sobriety

Patients with OUD presenting to primary care…

Zero use of opioids

No use of other illicit drugs

Commitment to reach sustained abstinence

“Our deeply held convictions regarding the ‘truth’ about our patients and the ‘right’ way to intervene are the products of our own cognitive schemas and overlearned behaviors as researchers and clinicians.”

Marlatt, 2012

"...Recognition of this fact can take some of the absolutism out of the way we view and treat substance use disorders. We must unpack and examine these assumptions. Only then can we put them aside, truly align with our patients, and practice harm reduction."

Marlatt, 2012

The Provider Experience

Reasons Why this Work Is Challenging for Providers and Members of the Health Care Team?

Factors that make this work challenging…

- Implicit Bias and the “Moral Model” of addiction… Is it a choice?
- Addiction is a “disease”… but people don’t think about it like cancer… Why?
- Natural discomfort in ambiguity – the grey area of human experience
- Our inherent desire for feedback from our enviornment about our effectiveness as providers

Factors that make this work challenging…

- Emotional reactions/perspectives triggered by patients connected to the life experiences of the provider (e.g., close family members with addiction)
- Our emotional investment in the wellbeing of patients
- Rigid or unrealistic expectations or perceptions – often influenced by our own fear, anxiety, experience, and genuine desire to protect the patient.
- Patients' disruptive behaviors

11 Guiding Perspectives Anchored in Harm Reduction…

(Adapted from Harm Reduction: Pragmatic strategies for managing high risk behaviors, 2012, Denning. P.)

1. Harm reduction is any action that attempts to reduce the harm of drug abuse.
2. Avoid punitive sanctions for what a person puts in their body or refuses to put in their body.
3. People use drugs for reasons and not all drug use is abuse.
4. People can, and do, make rational decisions about important life issues while still using.
5. Denial is not actually denial. It is a product of shame and punitive sanctions and is usually quite conscious.

11 Guiding Perspectives Anchored in Harm Reduction…

(Adapted from Harm Reduction: Pragmatic strategies for managing high risk behaviors, 2012, Denning. P.)

6. Ambivalence and resistance to change are “human.” As providers, it’s our job to work with someone’s ambivalence and explore it, not confront it.

7. Addiction is not a disease, but a biopsychosocial phenomenon in which the relative weight of the biological, the psychological, and the sociocultural aspects are different for each person.

8. Substance use represents a relationship, an attachment that offers significant support to the person. Treatment must offer that support, as well as respect that maybe we can’t do it as well or with such reliability.

11 Guiding Perspectives Anchored in Harm Reduction…

(Adapted from Harm Reduction: Pragmatic strategies for managing high risk behaviors, 2012, Denning. P.)

9. Motivation toward change is the mutual job of the provider and patient. People need supportive relationships, self-esteem, and self-care to increase their motivation to reduce harm or move toward “recovery.”

10. Success is any positive change—any step in the right direction.

11. Change is slow, incremental, with many setbacks. Relapse is the rule, not the exception. Plan for it. Help people stay alive and healthy and connected to treatment during their process of change and their relapses.

Treatment Options for Patients with OUD

Non-MAT Treatments/Supports for OUD

Residential treatment programs “beds”	12-step programs
Intensive Outpatient Programs	NA/AA groups Self-help support groups
Partial Hospitalization Programs	Transitional Housing State funded work/school programs
Case/care management	Peer supports
Social skills training	Outpatient Programs

ORIGINAL RESEARCH

OPEN

A Systematic Review on the Use of Psychosocial Interventions in Conjunction With Medications for the Treatment of Opioid Addiction

Karen Dugosh, PhD, Amanda Abraham, PhD, Brittany Seymour, BA, Keli McLoyd, JD, Mady Chalk, PhD, and David Festinger, PhD

A Randomized Trial of Cognitive Behavioral Therapy in Primary Care-based Buprenorphine

David A. Fiellin, MD[a], Declan T. Barry, PhD[b], Lynn E. Sullivan, MD[a], Christopher J. Cutter, PhD[a], Brent A. Moore, PhD[b], Patrick G. O'Connor, MD, MPH[a], and Richard S. Schottenfeld, MD[b]

[a]Department of Internal Medicine, Yale University School of Medicine, New Haven, Conn

[b]Department of Psychiatry, Yale University School of Medicine, New Haven, Conn

PCP Management ONLY
PCP + CBT
=
No significant difference in decreasing opioid use, treatment retention, or cocaine abstinence (24 weeks)

Take Away Points…

- Many patients do NOT need psychosocial interventions to succeed in decreasing opioid use, move towards abstinence, and remain engaged in treatment.
- An area of limited research (only 8 studies focused on OBOT population)
- This does NOT include patients meeting criteria for active psychiatric diagnoses (i.e., major depressive disorder)
- We still have a lot to learn about what specific psychosocial interventions are effective for primary care patients receiving OBOT, ideal dosing and time, benefits limited by our assessment measures, and long-term effects.

Talking with patients about potential benefits of counseling…

Elicit past experiences

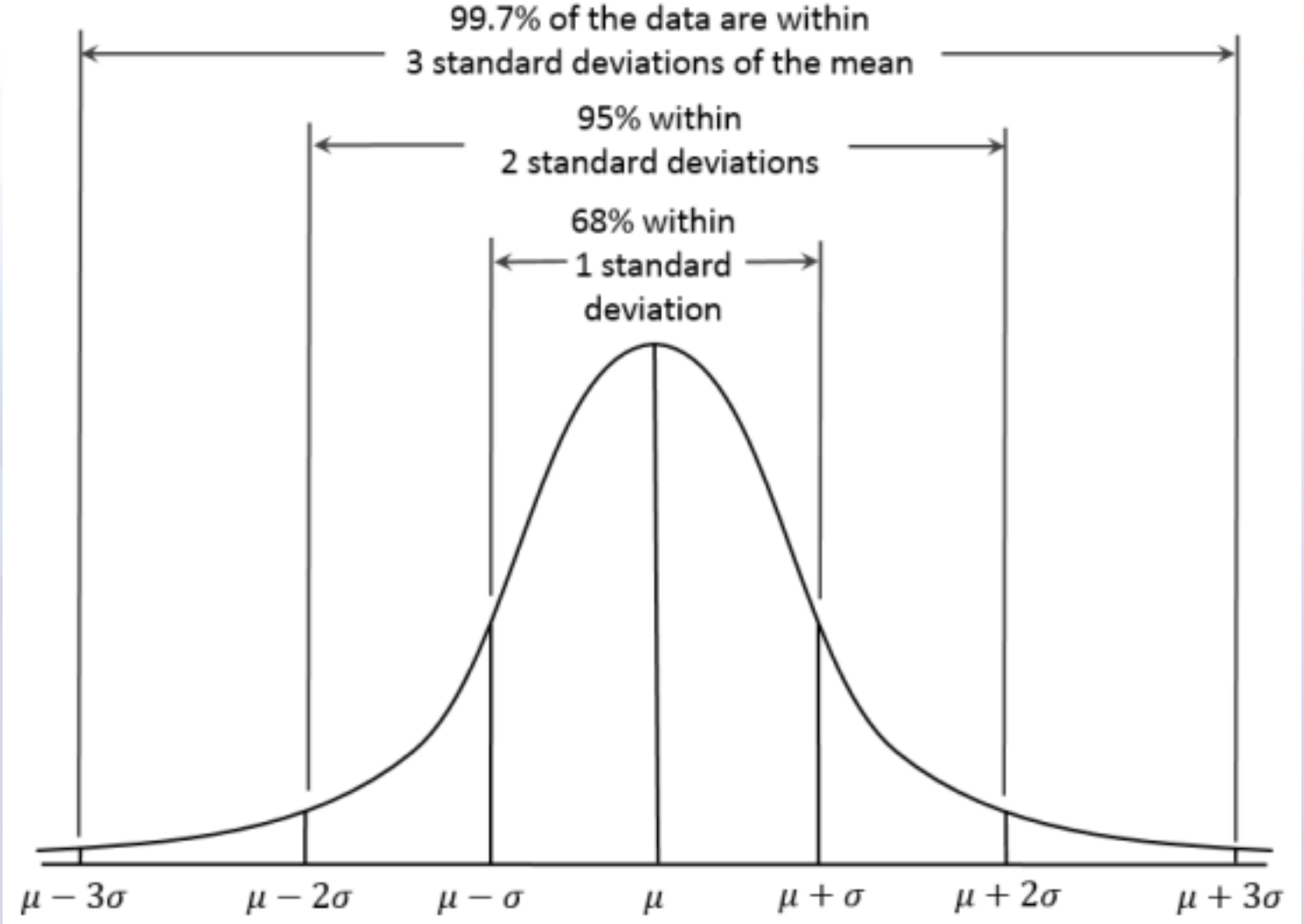
Clarify potential misconceptions

Provide a clear, specific overview of what to expect and how engagement in counseling could help the patient reach their goals

Normalize stress and other psychological symptoms

Avoid coercion and contingency

Medication-Assisted Treatment


99.7% of the data are within
3 standard deviations of the mean
95% within
2 standard deviations
68% within
1 standard
deviation
$\mu - 3\sigma$
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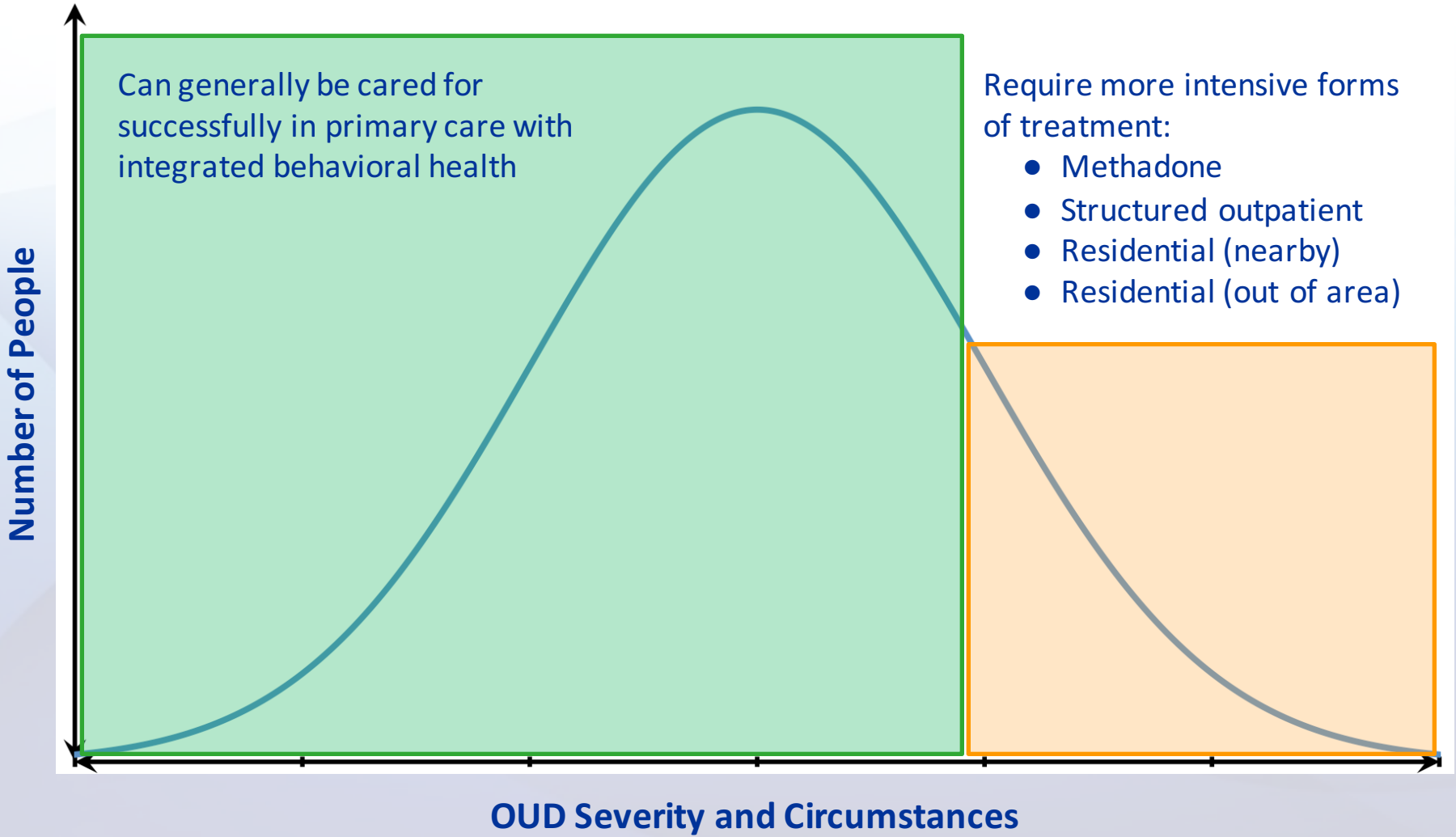
μ
$\mu + \sigma$
$\mu + 2\sigma$
$\mu + 3\sigma$


Can generally be cared for successfully in primary care with integrated behavioral health
Require more intensive forms of treatment:
Methadone
Structured outpatient
Residential (nearby)
Residential (out of area)
Number of People
OUD Severity and Circumstances

ADDICTION SCIENCE & CLINICAL PRACTICE

COMMENTARY Open Access

Just call it "treatment"

Peter D Friedmann[1*] and Robert P Schwartz[2]

Abstract

Although many in the addiction treatment field use the term "medication-assisted treatment" to describe a combination of pharmacotherapy and counseling to address substance dependence, research has demonstrated that opioid agonist treatment alone is effective in patients with opioid dependence, regardless of whether they receive counseling. The time has come to call pharmacotherapy for such patients just "treatment". An explicit acknowledgment that medication is an essential first-line component in the successful management of opioid dependence.

Keywords: Buprenorphine, Behavioral counseling, Methadone, Opioid dependence, Substance abuse counseling, Substance abuse treatment.

The recently published National Institute on Drug Abuse Clinical Trials Network's Prescription Opiate Treatment Study (POATS) [1] found that only 6.6% of prescription-opioid dependent participants had minimal or no opioid use following brief treatment with buprenorphine/naloxone (BUP/NX). Patients enrolled in that trial who returned to opioid use on discontinuation of BUP/NX resumed BUP/NX for an extended period. Although 49.2 % of those patients who resumed BUP/NX had a successful outcome at the final week of the extended BUP/NX treatment, the success rate dropped to 8.6% at eight weeks after a two-week dose taper. In neither case did individual opioid dependence counseling (45–60 minute weekly sessions with a trained mental health or substance abuse professional) provide additional benefit over standard medical management (15–20 minute visits with a physician certified to prescribe BUP/NX).

Increasingly, practitioners, administrators, and policy-makers in the addiction treatment field have taken to using the terms "medication-assisted treatment" or "medication-assisted recovery" to describe the combination of pharmacotherapy with counseling and/or recovery work. Recovery-movement traditionalists have maintained that addiction remission is not genuine if produced through use of medication alone, because the person has not undergone the interpersonal and spiritual changes deemed necessary for lasting recovery. The terms medication-assisted treatment and medication-assisted recovery manifest this perspective. Such terms bespeak an implicit judgment that medication is only an adjunct to the "truly effective components" of counseling and recovery work.

Terminology is meaningful in a field because it both reflects and influences the beliefs of practitioners. The view that pharmacotherapy-induced remission is less valuable than "real" recovery stigmatizes patients, providers, and the therapy itself. The view of medication as a temporary adjunct opens the door for rejection of patients on medication at some self-help meetings, time limits on insurance coverage for addiction medication, and preference for medication tapering on the part of patients, practitioners and criminal justice professionals, despite evidence that this approach leads to inferior and sometimes adverse outcomes, including death [2]. Such views are contrary to the modern perspective on opioid dependence, that many patients should be treated as having a chronic neurobehavioral brain disorder.

Although one earlier clinical trial conducted among veterans suggested that adding counseling to methadone increased opioid agonist treatment (OAT) efficacy [3], much research prior to the POATS has demonstrated that pharmacotherapy alone is effective treatment for opioid dependence with minimal to no drug-abuse counseling. A recent Cochrane systematic review of the literature found that OAT without counseling is more effective than being waitlisted for treatment or receiving psychosocial treatment with or without placebo [4]. In addition, randomized clinical trials have provided strong evidence for the effectiveness of directly administered methadone without drug abuse counseling for one month [5], four months [6], and six months [7].

Throughout the world, OAT is commonly delivered with minimal or no counseling beyond standard medication management, with rates of treatment retention and improvement in illicit drug use comparable to OAT with counseling [8-12]. In the United States, a study on office-based buprenorphine treatment also found that intensive counseling with OAT was no more effective than opioid agonist pharmacotherapy with standard medication management [13].

The POATS findings and other rigorous studies demonstrate that OAT is effective in suppressing opioid use as long as it is maintained, and that a tapering detoxification strategy, regardless of duration, fails the great majority of opioid-dependent patients [14-16]. As with the treatment of hypertension or diabetes, as long as the patient takes the medication, the disorder's manifestations are mitigated; when the medication is stopped, those manifestations recur [17]. For many patients seeking treatment for opioid dependence, drug abuse counseling does not appear to add any measurable improvement in outcome beyond prescribed buprenorphine with standard medication management delivered in an office-based setting [1], or direct administration of methadone without counseling in an opiate treatment program [7,18].

It should not be construed that drug abuse counseling is without value. Such counseling should be offered to patients, but patient resistance to counseling should not be a barrier to receiving highly effective medication, such as methadone or buprenorphine, any more than insulin should be withheld from diabetic patients who refuse dietary counseling. Perhaps for this reason, the World Health Organization has called effective treatment for opioid dependence *psychosocially-assisted pharmacotherapy* [19].

Counseling-assisted pharmacotherapy has also been suggested as a term that reflects the true relative effectiveness of these treatment modalities [20]. However, other medical disciplines do not use the modifer "-assisted" to describe multimodal treatment. Type-2 diabetics take medication and get counseling about weight loss, diet and exercise; all are important, and none is viewed as "assisting." The time has come to call medication therapy for addiction just "treatment"—an explicit acknowledgment that pharmacotherapy is an essential component and common first-line treatment for opioid dependence.

Competing interests
Dr. Friedmann declares that Alkermes has donated medication for a NIDA/National Institutes of Health (NIH) funded study for which he is principal investigator. Dr. Schwartz declares that Reckitt-Benckiser has donated medication for a NIDA/NIH funded study for which he is a co-investigator.

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OUR VIEW

State rightly sues over addiction-drug price

Drug companies should not keep generics off the market by making insignificant changes.

"Product hopping" is a tactic used by some drugmakers to keep generic alternatives off the market by making superficial changes to the formulas of their medications. It's a way to extend patent protections and preserve a monopoly that forestalls price competition.

It's also against the law.

We all have to pay when drug prices are too high, either at the cash register or through our taxes and insurance premiums. But when we are talking about artificially inflated prices for drugs that can combat addiction, some people pay with their lives.

So, we are happy to see Maine join the lawsuit against Indivior, the manufacturer of Suboxone, alleging that the company made an insignificant change to the delivery system of the opioid addiction medication to keep a generic version off the market in the middle of a public health crisis.

Just as with the makers of the allergic-reaction antidote EpiPen, which has increased in cost fivefold in the last seven years, the government should not allow companies to abuse the patent laws to enrich themselves at the expense of people's suffering.

Medication-assisted treatment is the gold standard for treating dependence on heroin and prescription opioids. People receiving it as part of their treatment are 75 percent less likely to die of an overdose than people who are not, according to a study by the National Institute on Drug Abuse.

Suboxone reduces cravings for opioids in addicts, allowing them to work, seek therapy and live normal lives. Unlike methadone, another addiction maintenance drug, it can be prescribed by a physician and distributed by a pharmacy instead of a clinic.

Indivior, a British company, had a monopoly on Suboxone for seven years, making $1 billion on sales in the United States.

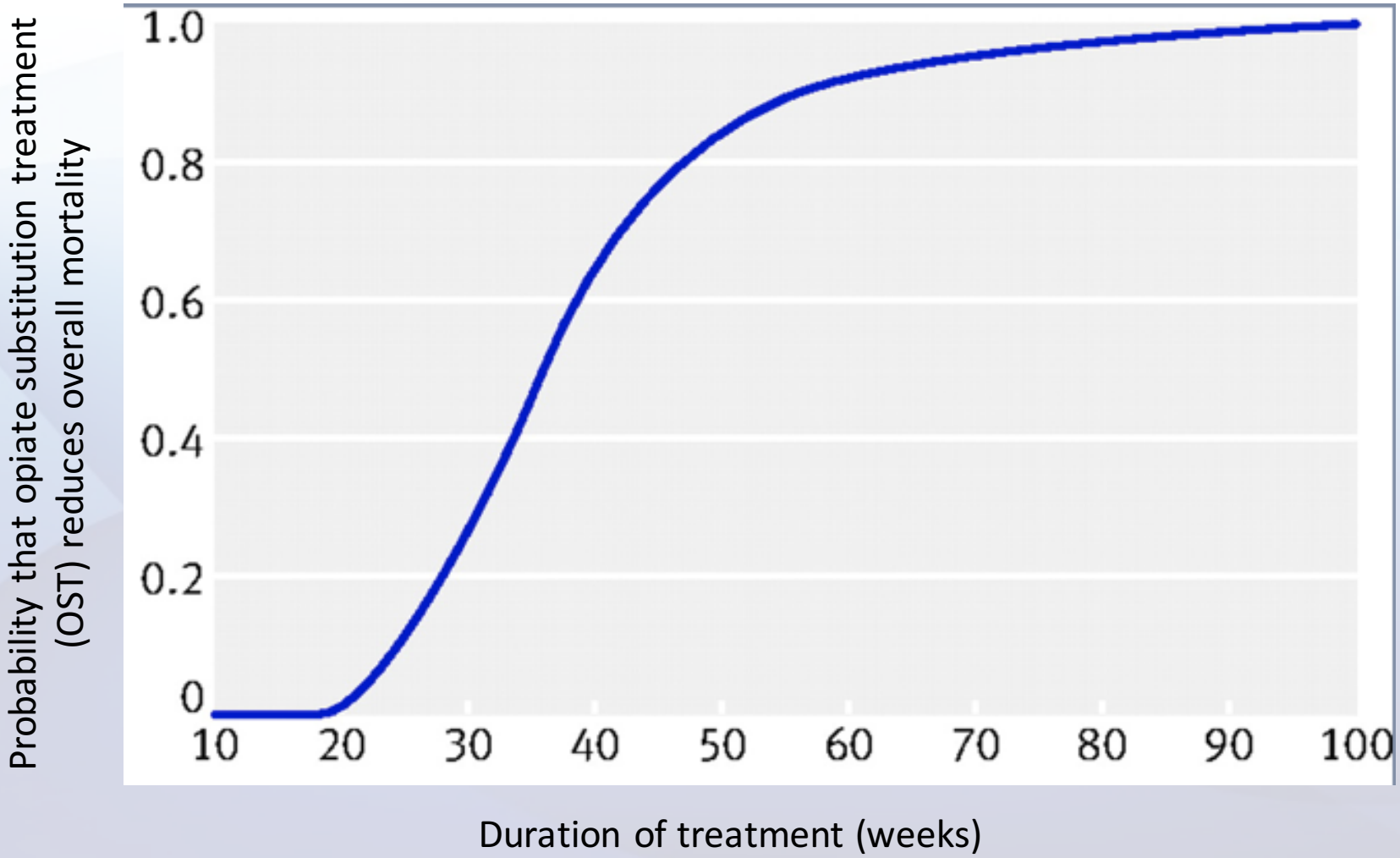
Just before the exclusive period was up and a generic version of the drug was hitting the market, Indivior changed the way the drug is delivered from a pill to a dissolving film. Since there was no generic version of the drug in film form, consumers had to pay the full sticker price for the brand-name version.

Price is not the only hurdle that keeps addicts away from medication-assisted treatment – it's not even the highest one.

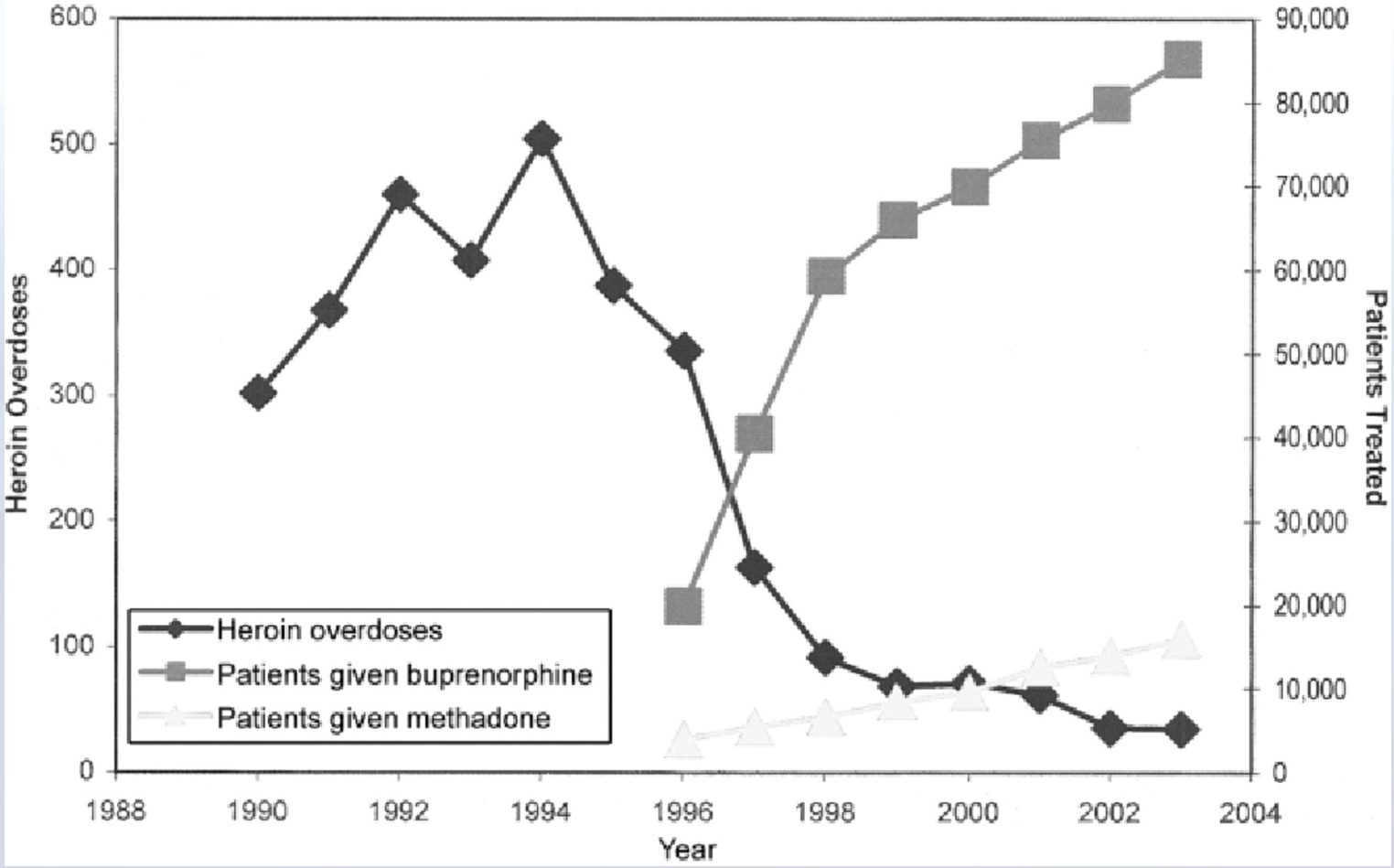
There are too few doctors who can write prescriptions for Suboxone, and those who can have artificial caps on the number of patients they can treat. And some policymakers have an abstinence-only bias when it comes to drug treatment that pushes public funds to other, less effective treatment methods.

But when we are experiencing a record number of fatal overdoses, there is no barrier to medication-assisted treatment that is too low to be considered a serious problem, and there should be no tolerance for profiteering.

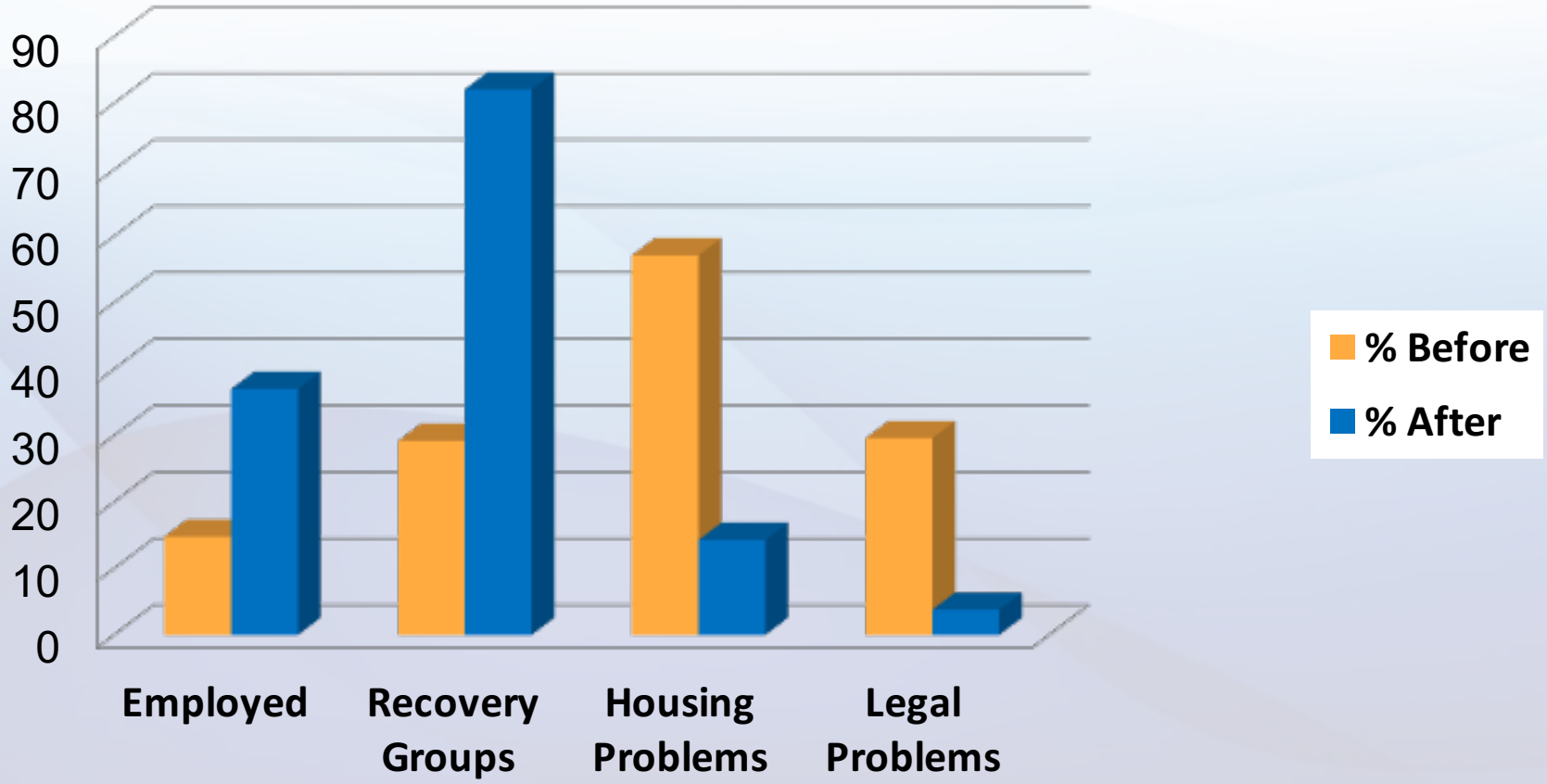
The states are right to sue, if for no other reason than the message it sends to drugmakers looking to product hop. This practice should end.


Probability that opiate substitution treatment (OST) reduces overall mortality
1.0
0.8
0.6
0.4
0.2
0
10
20
30
40
50
60
70
80
90
100
Duration of treatment (weeks)

Impact of Buprenorphine in France



Social Outcomes of Treatment



Data courtesy of David Roll, M.D., Cambridge Health Alliance

Break

Basics of Buprenorphine Pharmacology

Basics of Buprenorphine Pharmacology

It is very difficult to cause harm from prescribing buprenorphine

Concern for Overdose from Buprenorphine

- Buprenorphine has been available from any French GP since 2006 and has not been associated with overdose
- In studies of Massachusetts, NYC, San Francisco, and other geographies, buprenorphine has been found in < 1% of overdose deaths
- Buprenorphine's respiratory ceiling effect that makes overdose highly unlikely from oral use

Basics of Buprenorphine Pharmacology

It is very difficult to cause harm from prescribing buprenorphine

Concern for Precipitated Withdrawal from Buprenorphine

- As long as a patient is experiencing some level of withdrawal, buprenorphine use is not associated with significant worsened withdrawal
- The exception is a very long-acting opioid such as methadone; this risk can be mitigated in planned transfers from methadone treatment or candid discussions with other patients
- Withdrawal and side effect risk can be further mitigated by having patients take 2 to 4mg every 2 hours as needed to improve withdrawals; this can be done to a total of 16mg per day to start

Basics of Buprenorphine Pharmacology

It is very difficult to cause harm from prescribing buprenorphine

Harms Can Potentially Occur If:

— A patient diverts buprenorphine. However, the most common reason for diversion is lack of access to formal buprenorphine treatment and scarcity.

— A patient diverts buprenorphine in order to keep using opioid drug of choice. This is a very unusual situation.

— Buprenorphine is dosed too low or for too short a treatment period. Both are strongly associated with relapse.

— A patient relapses repeatedly on buprenorphine at indicated doses with no improvement; a higher level of care, including methadone, may be needed to avoid harm.

Responding to Relapse

How we talk about relapse is key…

Moving towards sustained abstinence from opioids looks more like this…

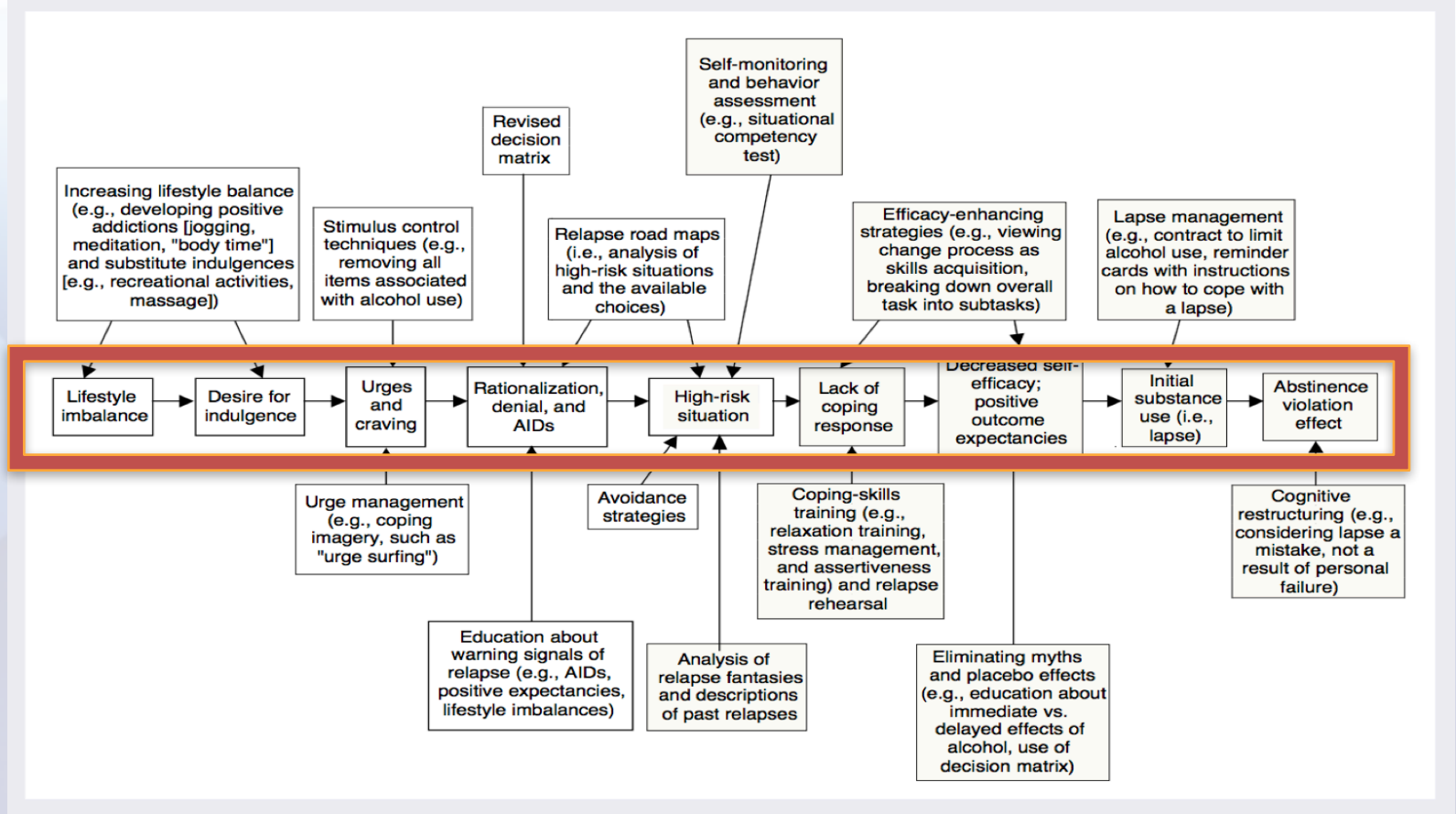
Harmful Opioid Use

Sustained Abstinence

Starting the Conversation

- What have you learned works best for you to help decrease the chances of relapse?
- From your perspective, what would be a helpful conversation for you and I to have if you relapse in the future?
- This has been a long road for you… What specific skills have your learned along the way to decrease your use?
- What's typically happening when you have an easier time manaing cravings or not using?
- What's typically going on right before you use, internally, or perhaps in your relationships?
- What would be a sign to you that your substance use is becoming overwhelming and you could benefit from additional, more frequent treatment?

If you aren't convinced yet that relapse is a complex process with a complex set of possible interventions, this should do the trick…



Larimer, Palmer, & Marlatt, 1999

Responding to Relapse: What's Practical as a PCP?

Relapse = Opportunity

1. Elicit triggers, precipitating variables (What was going on in the days, hours, minutes before you used? Where were you?)
2. Elicit the function/purpose of the use in that particular moment (What changed immediately following the use?)
3. Elicit the point of least control
4. What did you learn about your addiction in this situation that you want to remember going forward? Is there something you wish you would have done differently?
5. What ideas or solutions have you come up with for similar situations in the future?
6. Would you like advice on other options?

Defining “Success” and Asking the Right Questions

- The harm reduction model directs attention to the changes and successes, not limited to abstinence from the substance.
- If you are having success with taking buprenorphine, how will you know? What changes in your life/relationships will you see? Are there certain thoughts/emotions you fight daily that might change?
- Noticing the smaller, nuances of change can boost self-efficacy, motivation. Focusing on the larger, overarching, long-term goal → triggers fear, anxiety, a sense of being overwhelmed.
- Following a relapse → Was there anything different about this time, versus use in the past? Did you notice any change in your thoughts/emotions before or after this use?
- Bring in family members – typically see positive changes the patient cannot

Trauma-informed care

PTSD: Lifetime Prevalence 5.4%
46.4% met criteria for SUD

Patients seeking treatment for SUD =
lifetime PTSD rates 30% - 60%

Brady, Back, & Coffey, 2004; 2010 National Epidemiologic Survey on Alcohol and Related Conditions

versus

Thank You!

Questions and Next Steps

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