SUD,OUD and MAT: Epidemiology, Stigma, Misconceptions, and Myths

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HRHCare

HOPE Conference

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DISCLOSURES

Dr. Ramsey has no relevant disclosures

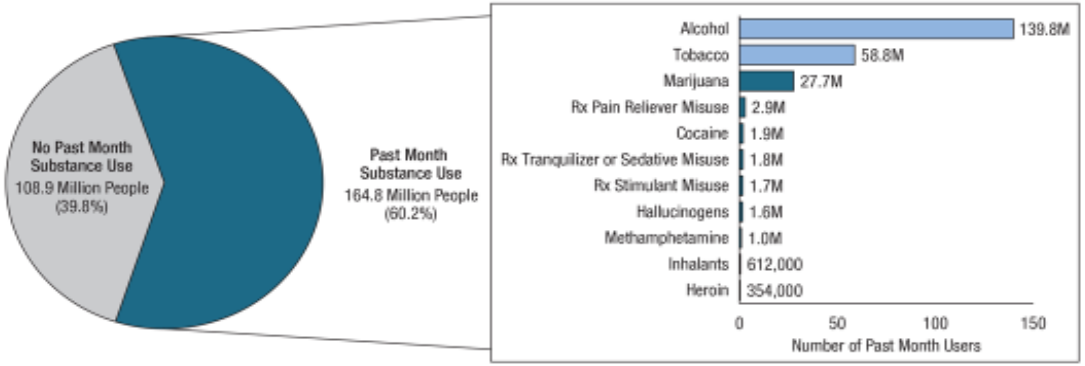
LEARNING OBJECTIVES

1. Discuss substance use disorder (SUD), the opioid epidemic and opioid use disorder (OUD)
2. Discuss stigma related to SUD/OUD/people who use drugs (PWUD)
3. Discuss medication assisted treatment (MAT) for OUD
4. Discuss the misconceptions and myths surrounding MAT

Epidemiology of SUD

FFR1.01

Past Month Substance Use among People Aged 12 or Older: 2018



Rx = prescription.

Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used more than one type of substance in the past month.

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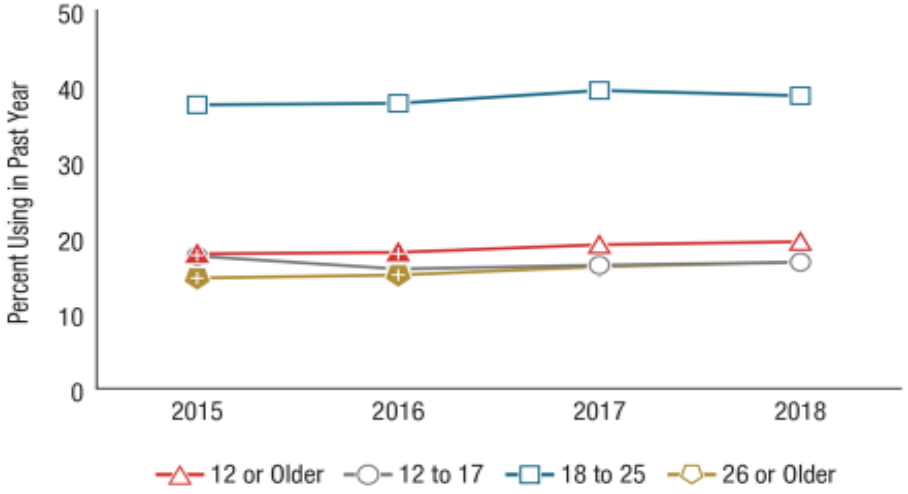
Epidemiology of SUD

FFR1.11

Past Year Illicit Drug Use among People Aged 12 or Older: 2015-2018



Age	2015	2016	2017	2018
12 or Older	17.8+	18.0+	19.0	19.4
12 to 17	17.5	15.8	16.3	16.7
18 to 25	37.5	37.7	39.4	38.7
26 or Older	14.6+	15.0+	16.1	16.7

+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

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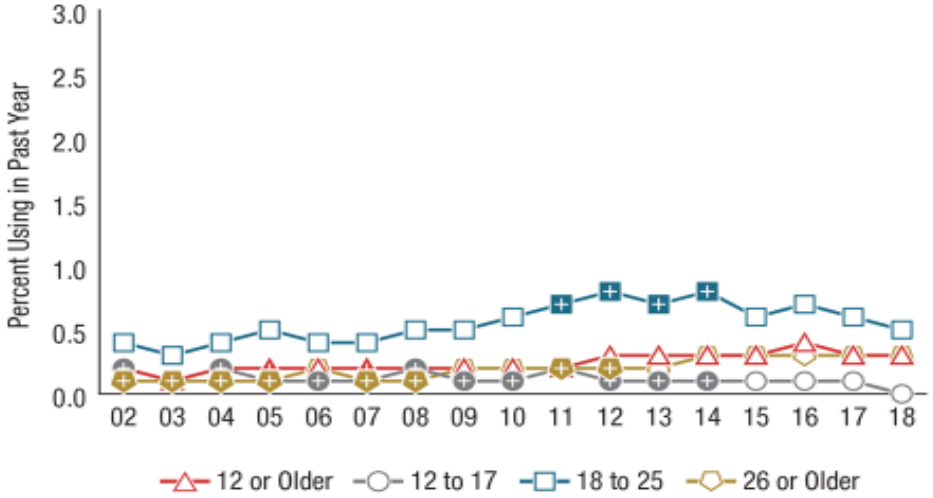
FFR1.14

Past Year Heroin Use among People Aged 12 or Older: 2002-2018



Age	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
12 or Older	0.2+	0.1+	0.2+	0.2+	0.2	0.2+	0.2+	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.3	0.3
12 to 17	0.2+	0.1+	0.2+	0.1+	0.1+	0.1	0.2+	0.1+	0.1+	0.2+	0.1+	0.1+	0.1+	0.1	0.1	0.1	0.0
18 to 25	0.4	0.3	0.4	0.5	0.4	0.4	0.5	0.5	0.6	0.7+	0.8+	0.7+	0.8+	0.6	0.7	0.6	0.5
26 or Older	0.1+	0.1+	0.1+	0.1+	0.2	0.1+	0.1+	0.2	0.2	0.2+	0.2+	0.2	0.3	0.3	0.3	0.3	0.3

Note: Estimates of less than 0.05 percent round to 0.0 percent when shown to the nearest tenth of a percent.

+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

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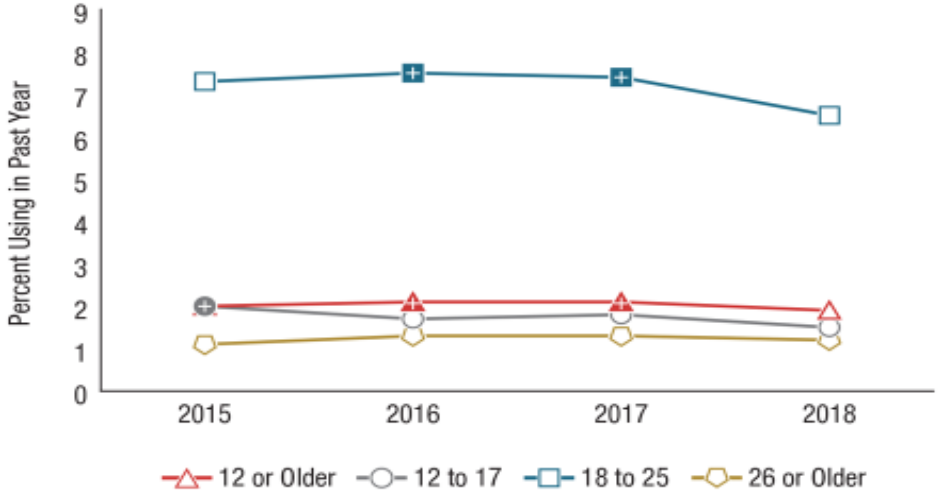
FFR1.18

Past Year Prescription Stimulant Misuse among People Aged 12 or Older: 2015-2018



Age	2015	2016	2017	2018
12 or Older	2.0	2.1+	2.1+	1.9
12 to 17	2.0+	1.7	1.8	1.5
18 to 25	7.3	7.5+	7.4+	6.5
26 or Older	1.1	1.3	1.3	1.2

+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

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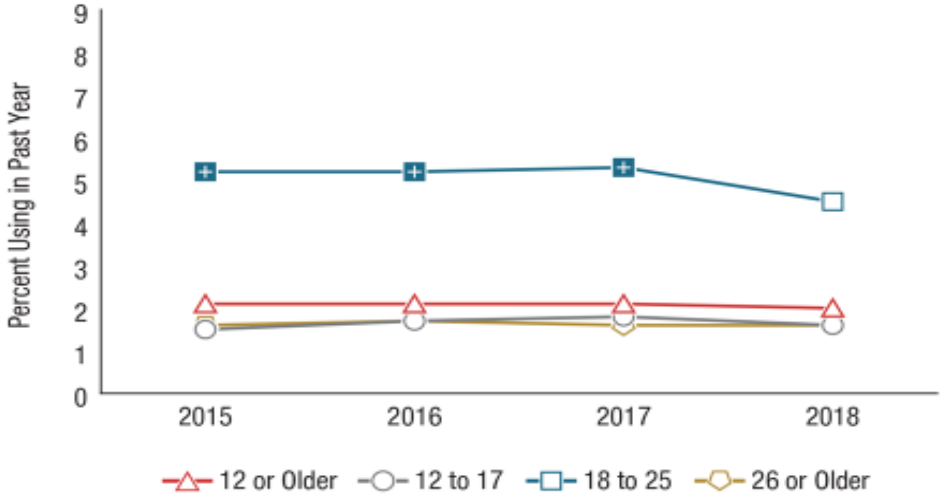
FFR1.20

Past Year Prescription Benzodiazepine Misuse among People Aged 12 or Older: 2015-2018



Age	2015	2016	2017	2018
12 or Older	2.1	2.1	2.1	2.0
12 to 17	1.5	1.7	1.8	1.6
18 to 25	5.2+	5.2+	5.3+	4.5
26 or Older	1.6	1.7	1.6	1.6

+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

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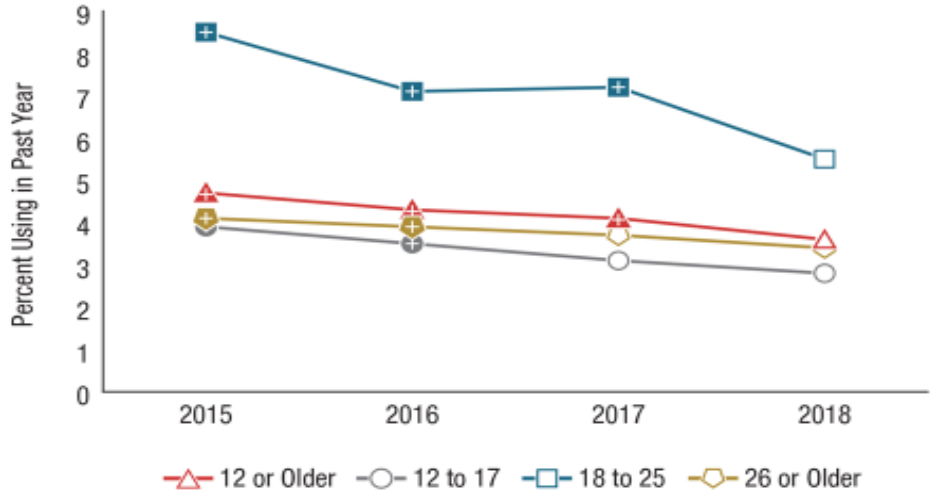
FFR1.21

Past Year Prescription Pain Reliever Misuse among People Aged 12 or Older: 2015-2018



Age	2015	2016	2017	2018
12 or Older	4.7+	4.3+	4.1+	3.6
12 to 17	3.9+	3.5+	3.1	2.8
18 to 25	8.5+	7.1+	7.2+	5.5
26 or Older	4.1+	3.9+	3.7	3.4

+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

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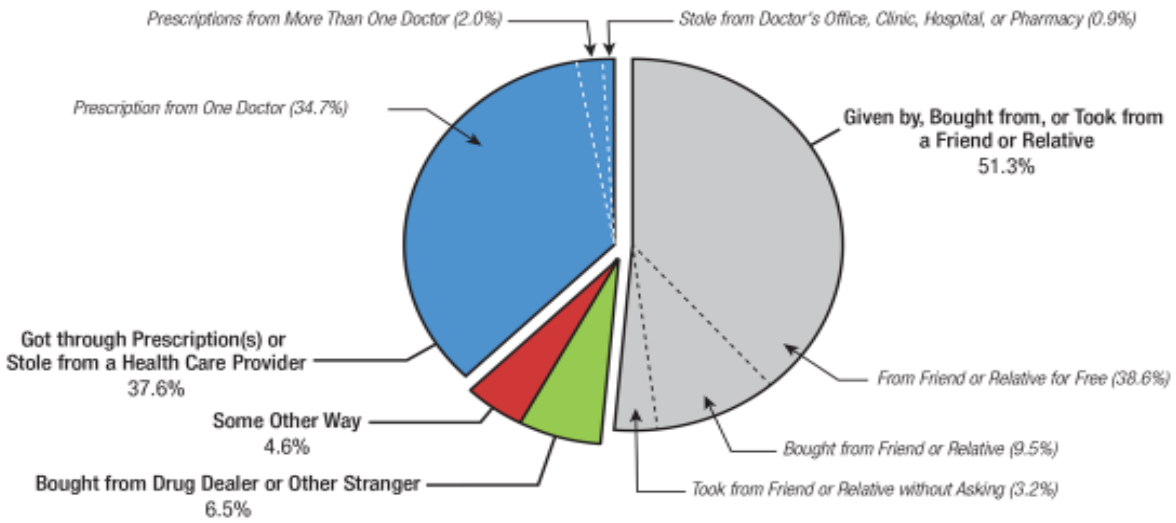
Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older Who Misused Pain Relievers in the Past Year: 2018



9.9 Million People Aged 12 or Older Who Misused Pain Relievers in the Past Year

Note: Respondents with unknown data for the Source for Most Recent Misuse or who reported Some Other Way but did not specify a valid way were excluded.

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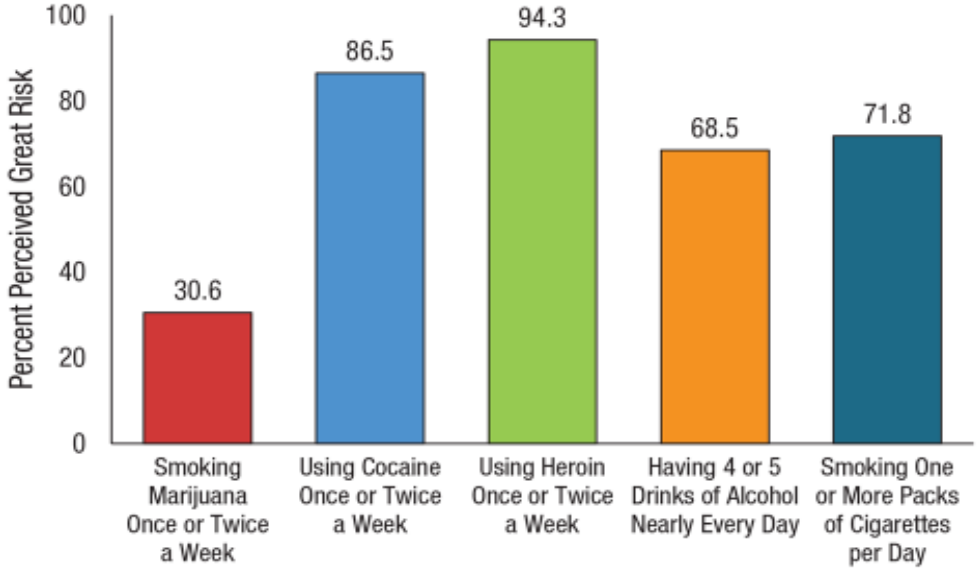
FFR1.32

Perceived Great Risk from Substance Use among People Aged 12 or Older: 2018



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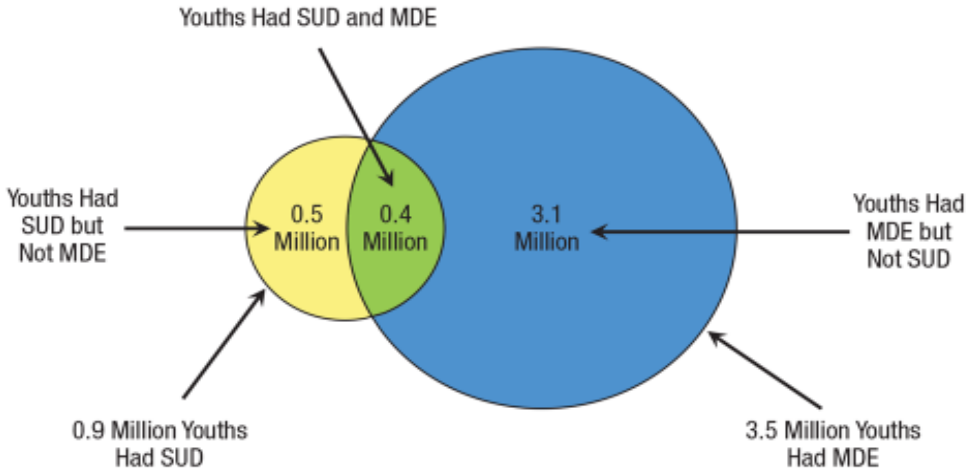
FFR1.51

Past Year Substance Use Disorder (SUD) and Major Depressive Episode (MDE) among Youths Aged 12 to 17: 2018



4.0 Million Youths Had Either SUD or MDE

Note: Youth respondents with unknown MDE data were excluded.

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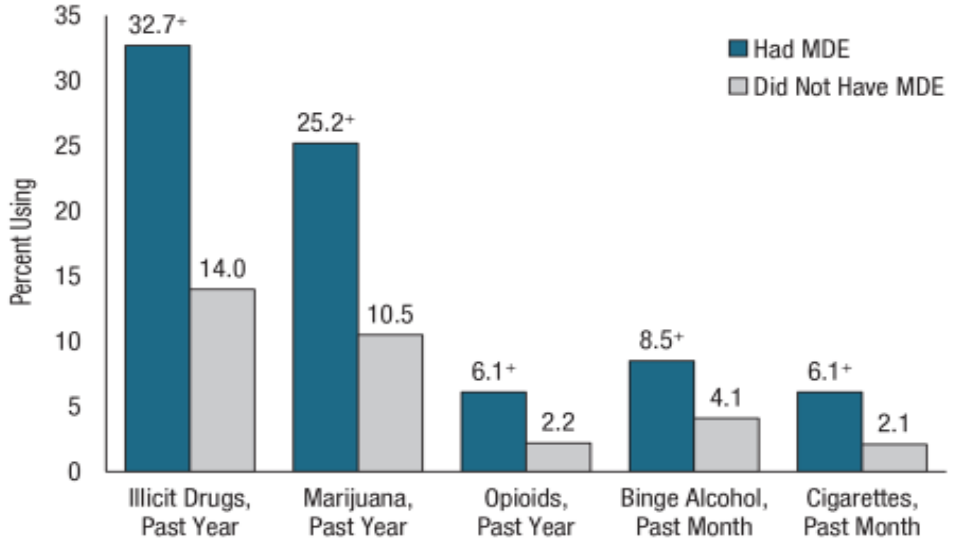
FFR1.52

Substance Use among Youths Aged 12 to 17, by Past Year Major Depressive Episode (MDE) Status: 2018



+ Difference between this estimate and the estimate for youths without MDE is statistically significant at the .05 level.
Note: Youth respondents with unknown MDE data were excluded.

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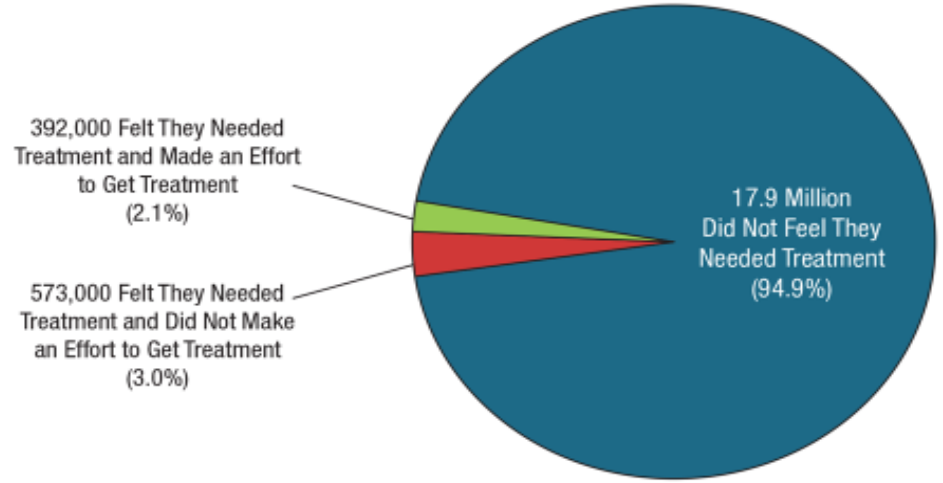
FFR1.66

Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed but Did Not Receive Specialty Substance Use Treatment in the Past Year: 2018



18.9 Million People Needed but Did Not Receive Specialty Substance Use Treatment

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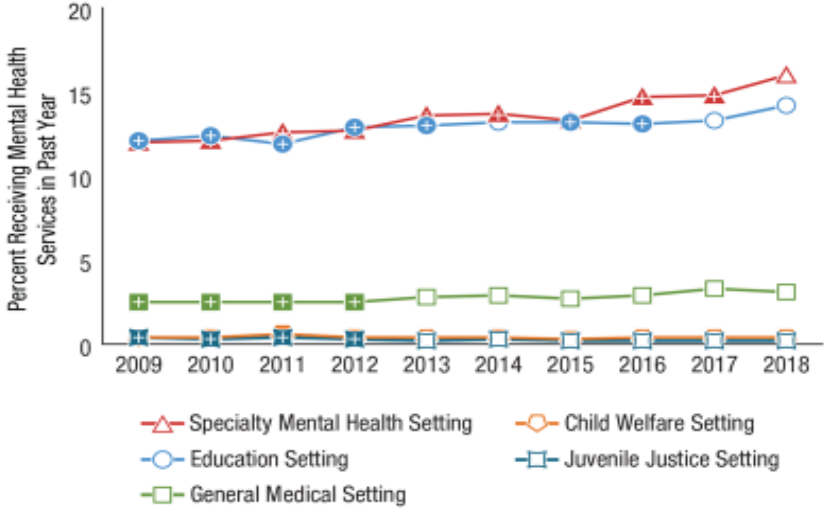
Epidemiology of SUD

FFR1.69

Sources of Mental Health Services in the Past Year among Youths Aged 12 to 17: 2009-2018



Source	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Specialty Mental Health Setting	12.0+	12.1+	12.6+	12.7+	13.6+	13.7+	13.3+	14.7+	14.8+	16.0
Education Setting	12.1+	12.4+	11.9+	12.9+	13.0+	13.2	13.2+	13.1+	13.3	14.2
General Medical Setting	2.5+	2.5+	2.5+	2.5+	2.8	2.9	2.7	2.9	3.3	3.1
Child Welfare Setting	0.4	0.4	0.6+	0.4	0.4	0.4	0.3	0.4	0.4	0.4
Juvenile Justice Setting	0.4+	0.3+	0.4+	0.3+	0.2	0.3	0.2	0.2	0.2	0.2

+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

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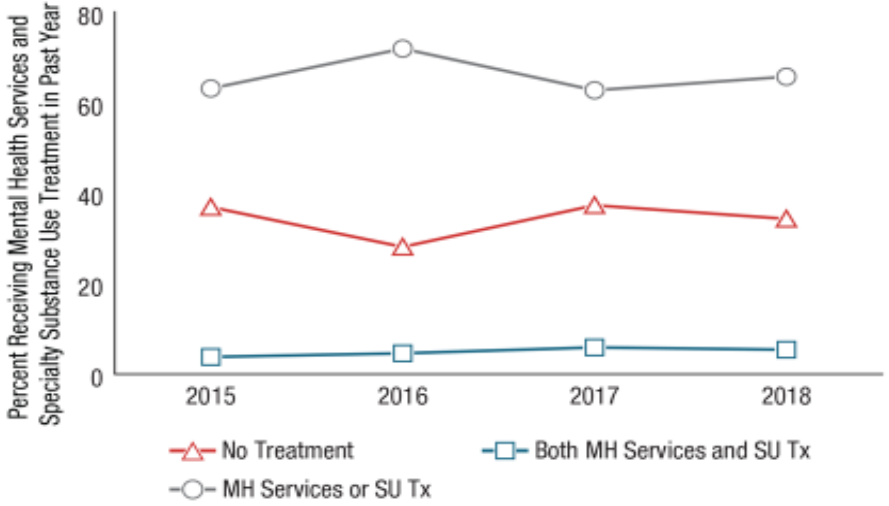
FFR1.75 **Receipt of Mental Health Services and Specialty Substance Use Treatment in the Past Year among Youths Aged 12 to 17 with Past Year Major Depressive Episode and Substance Use Disorder: 2015-2018**



Service Type	2015	2016	2017	2018
No Treatment	36.9	28.1	37.3	34.3
Mental Health Services or Specialty Substance Use Treatment	63.1	71.9	62.7	65.7
Both Mental Health Services and Specialty Substance Use Treatment	3.8	4.6	5.9	5.4

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Adverse Childhood Experiences

ABUSE

Physical

Emotional

Sexual

NEGLECT

Physical

Emotional

HOUSEHOLD DYSFUNCTION

Mental Illness

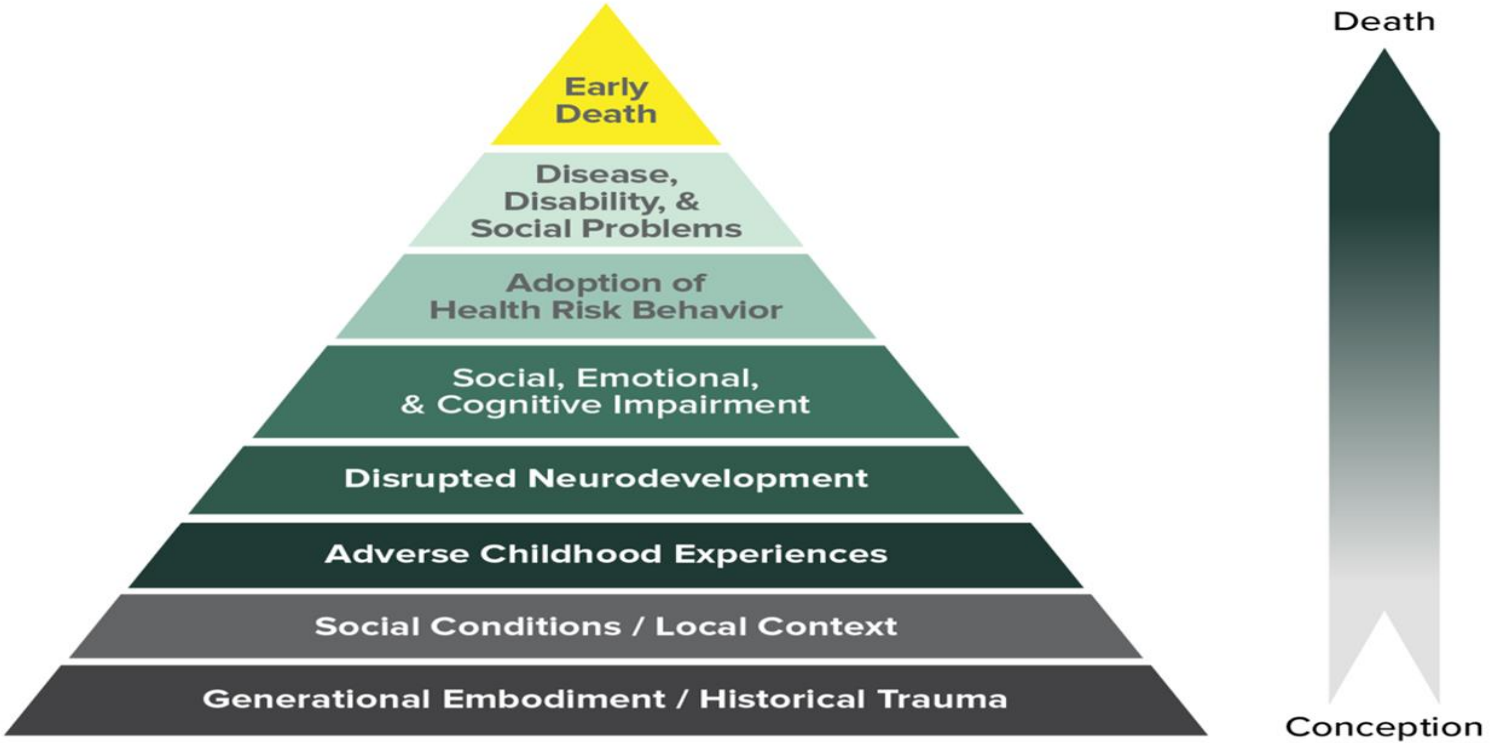
Incarcerated Relative

Mother treated violently

Substance Abuse

Divorce

Adverse Childhood Experiences and Outcomes



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Vulnerability Factors for SUD

- Genetic predisposition
- Concomitant mental health diagnoses: bipolar disorder, anxiety (GAD, PTSD, social anxiety), depression, ADD/ADHD, personality disorders (borderline, antisocial), antisocial conduct disorder (especially in adolescence); undiagnosed or undertreated or untreated or treated inappropriately
- History of trauma and/or abuse
- Poor coping mechanisms/escapism
- Impulsivity
- Sensation/novelty seeking (initially)
- Environmental triggers/cues
- Lack of homeostatic reward regulation; reward “deficiency”: orientation towards pleasurable rewards

Why Are We Here? Let's Discuss Opioids…

Opiate v. Opioid

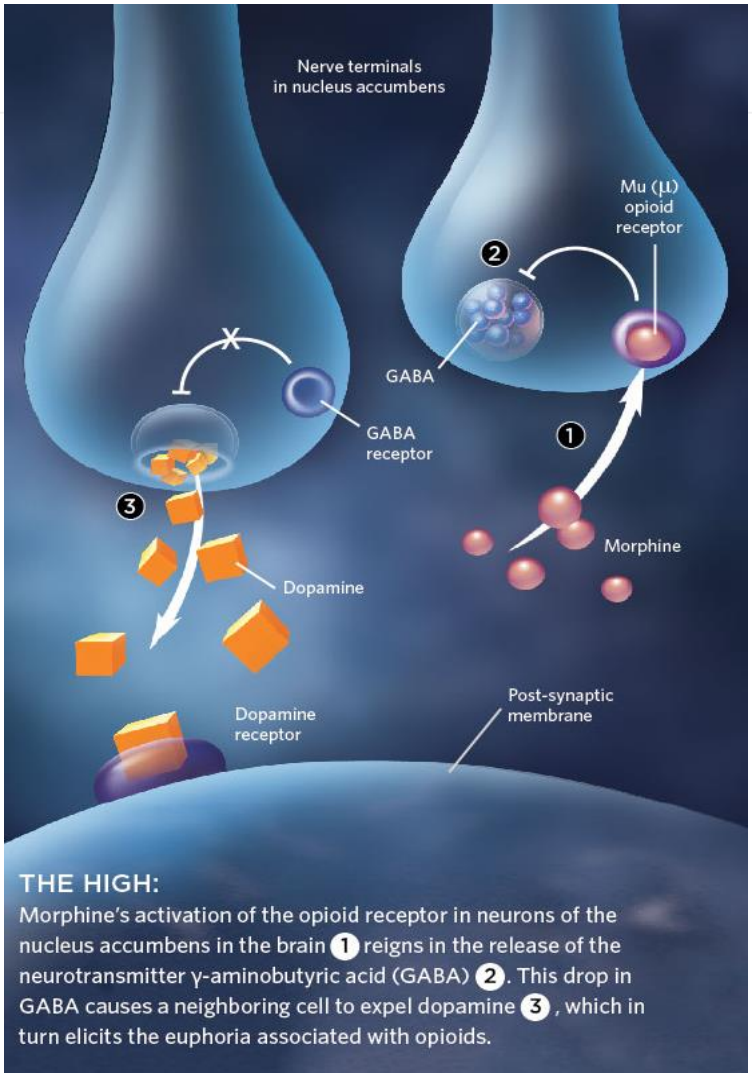
- ***Opiate*:** a term that refers to drugs or medications that are derived from the opium poppy, such as heroin, morphine, and codeine
- ***Opioid*:** a more general term that includes opiates, as well as the semi-synthetic or synthetic drugs or medications, such as buprenorphine, methadone, meperidine, fentanyl, that produce analgesia and other effects similar to morphine

Illicit Fentanyl: Potency of Analogs

Opioid Receptors: Full Agonists

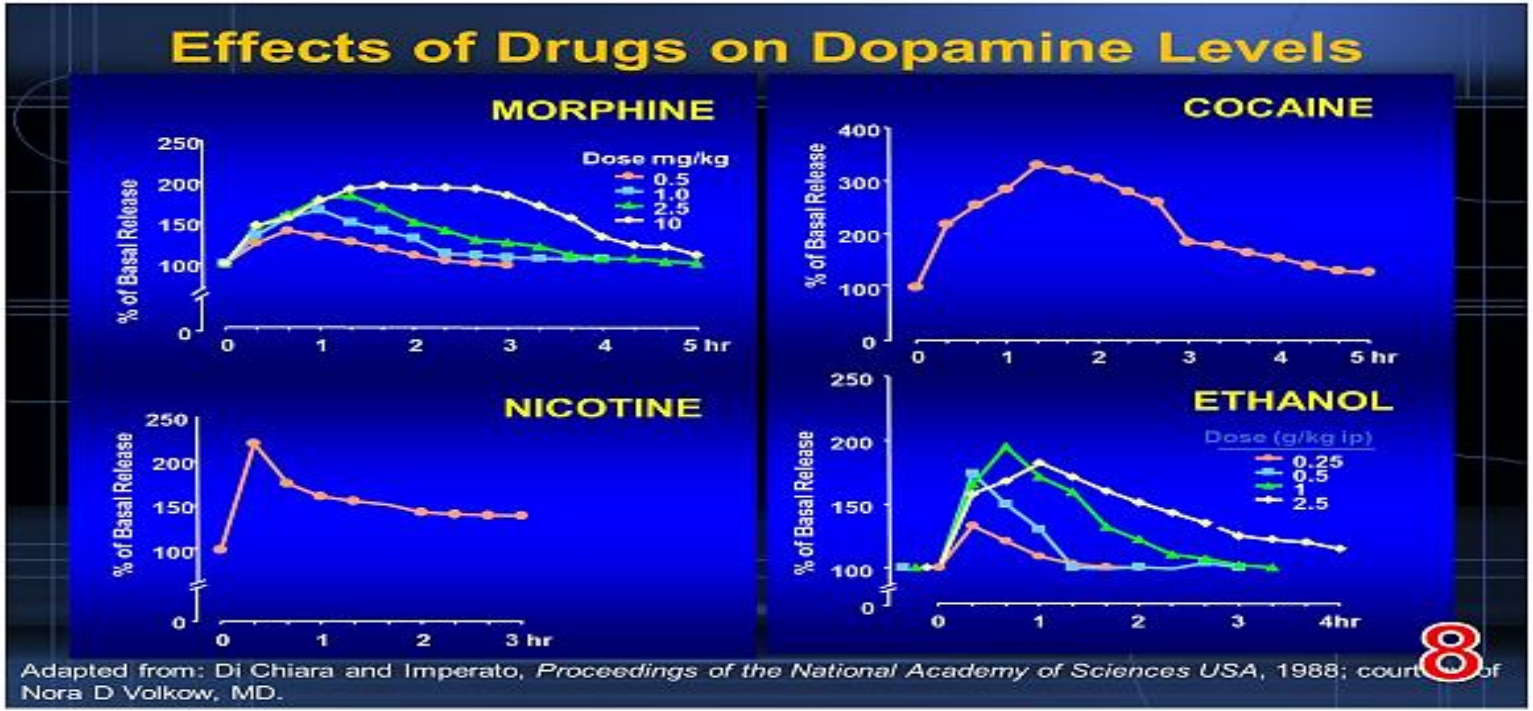
- Full agonists activate the mu receptor
- This is highly reinforcing
- This is the most misused opioid type
- Full agonists include: heroin, methadone, and oxycodone
- What determines opioid effects?
  - Receptor affinity
  - Dissociation
  - Intrinsic activity

Opioids in the Brain



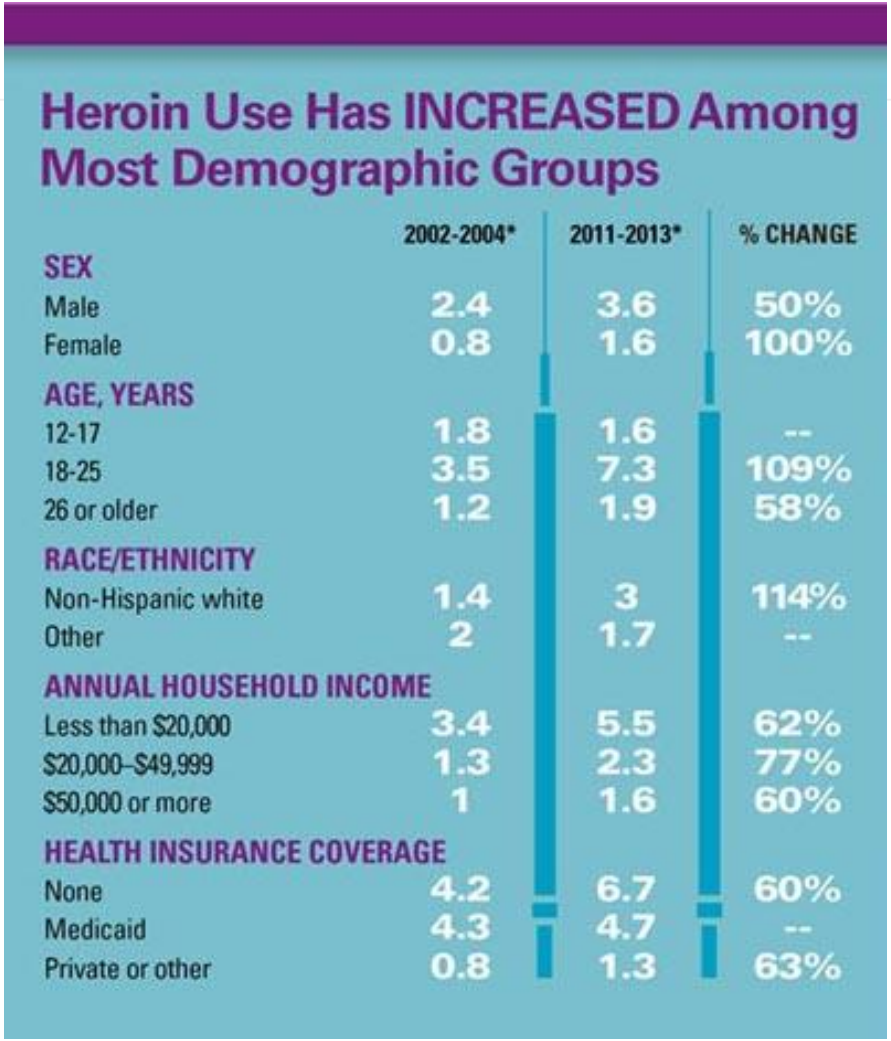
Similar Effects of Pleasurable Substances in the Brain…

Substance Use Disorder is a Brain Disease



Adapted from: Di Chiara and Imperato, *Proceedings of the National Academy of Sciences USA*, 1988; courtesy of Nora D Volkow, MD.

The Current Opioid Epidemic



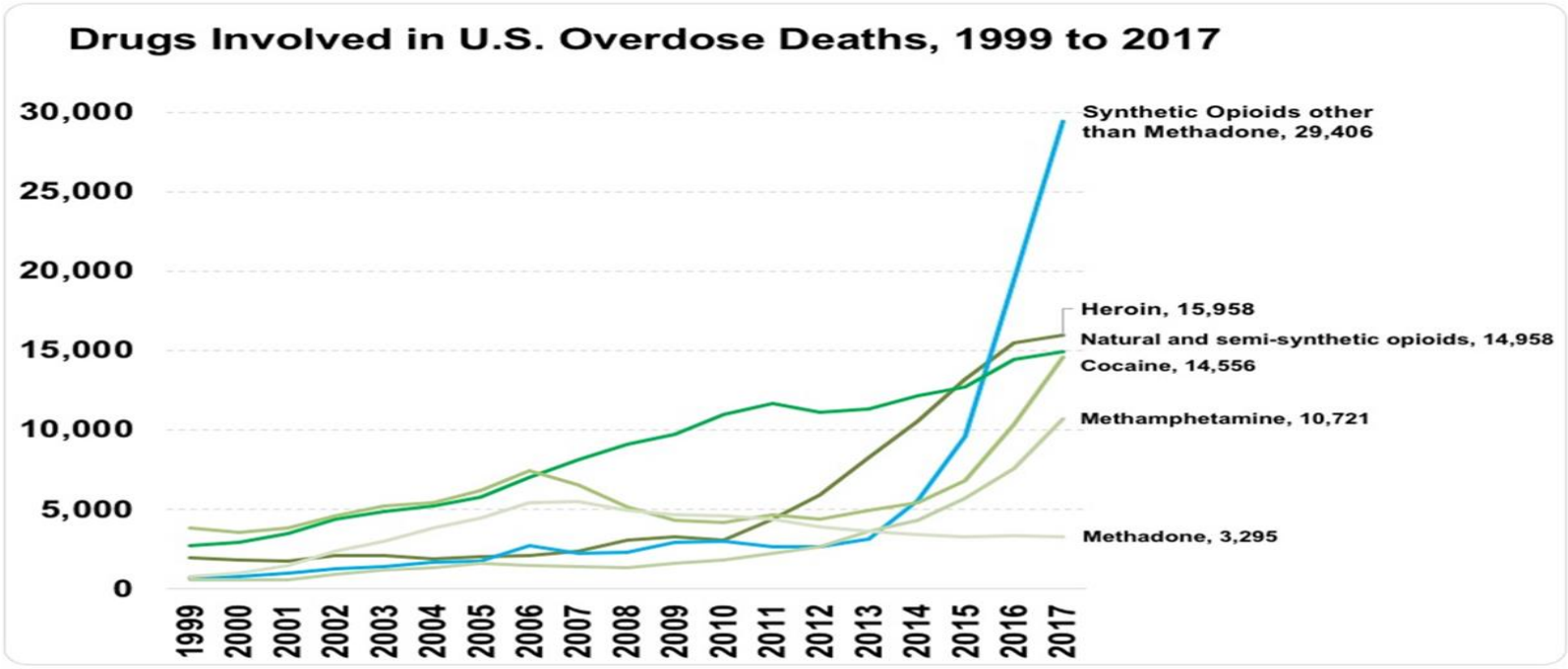
The Current Opioid Epidemic

- Drug overdose is the leading cause of accidental death in the US; in 2017: 70,237 drug overdose deaths occurred

- Opioid use disorder is driving this epidemic; the rate of drug overdose deaths due to synthetic opioids, other than methadone (fentanyl, fentanyl analogs), increased by 45% from 2016 to 2017. 49,068 persons died due to opioid overdose in 2017.

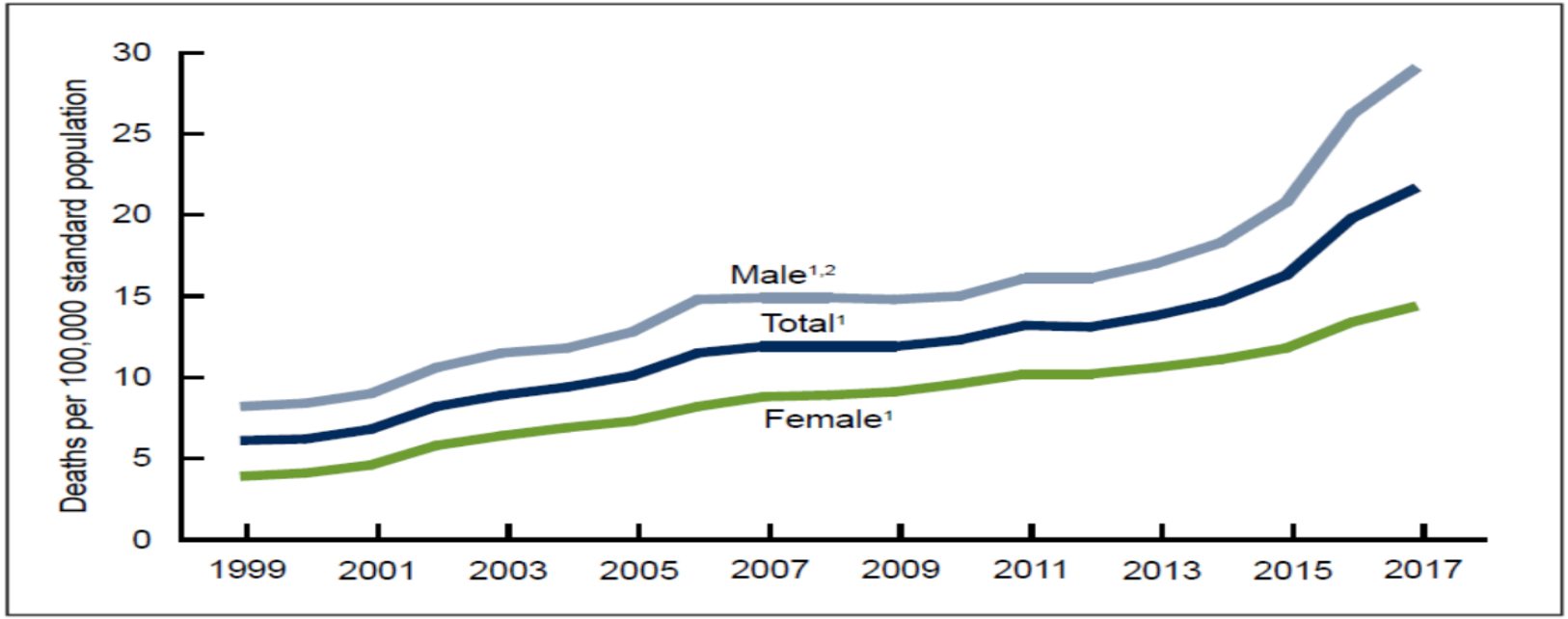
- Source: CDC

The Current Opioid Epidemic



The Current Opioid Epidemic

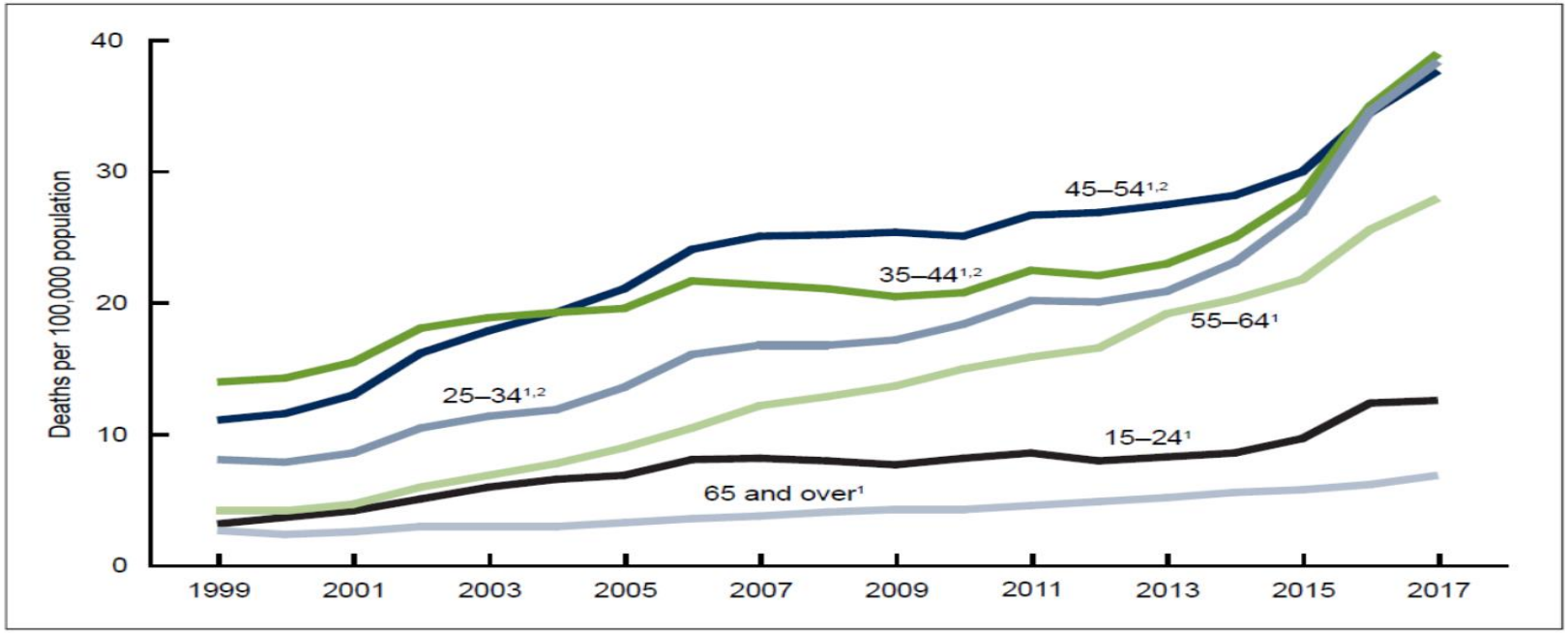
Figure 1. Age-adjusted drug overdose death rates: United States, 1999–2017



[1]Significant increasing trend from 1999 through 2017 with different rates of change over time, $p < 0.05$.
[2]Male rates were significantly higher than female rates for all years, $p < 0.05$.
NOTES: Deaths are classified using the *International Classification of Diseases, 10th Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. The number of drug overdose deaths in 2017 was 70,237. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf#1.
SOURCE: NCHS, National Vital Statistics System, Mortality.

The Current Opioid Epidemic

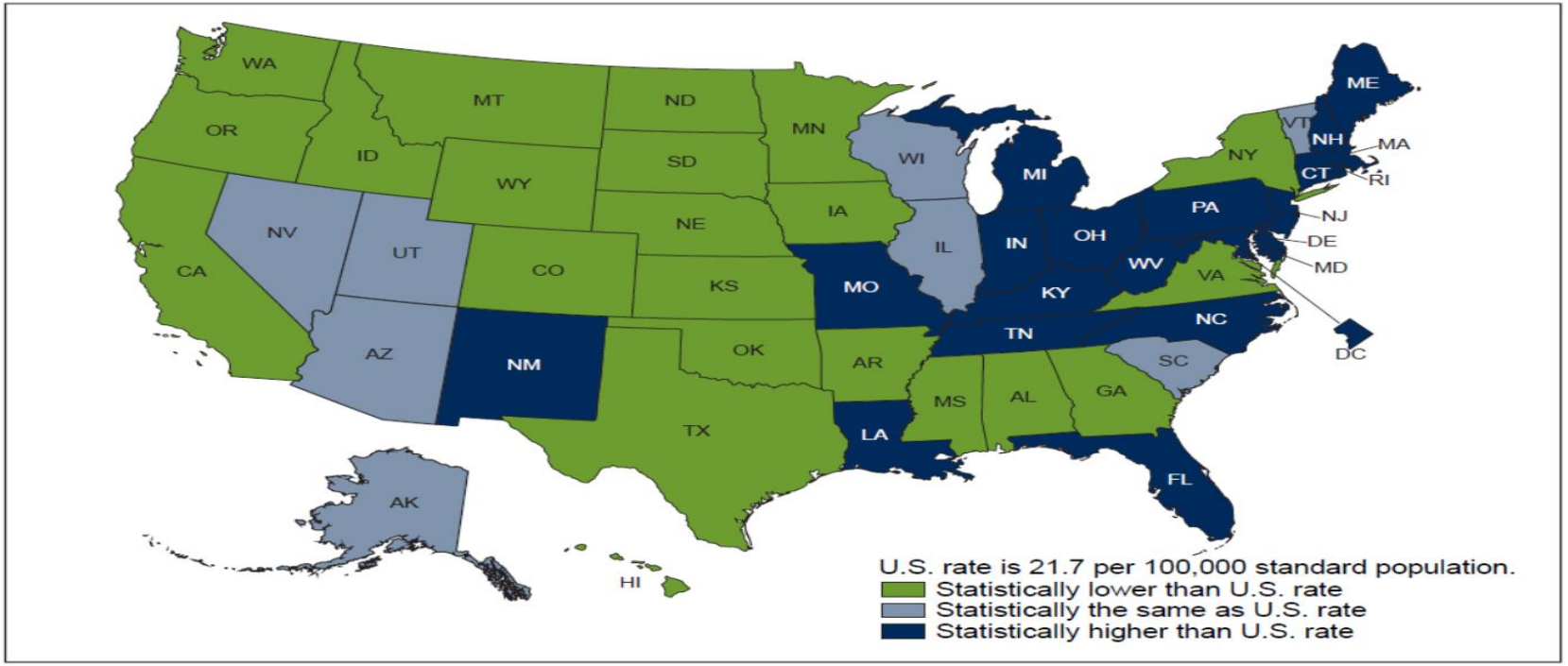
Figure 2. Drug overdose death rates, by selected age group: United States, 1999–2017



[1]Significant increasing trend from 1999 through 2017 with different rates of change over time, $p < 0.005$.
[2]2017 rates were significantly higher for age groups 25–34, 35–44, and 45–54 than for age groups 15–24, 55–64, and 65 and over, $p < 0.05$. The rate for age group 35–44 was significantly higher than the rate for age group 45–54 and statistically the same as the rate for age group 25–34.
NOTES: Deaths are classified using the *International Classification of Diseases, 10th Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Access data table for Figure 2 at:
https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf#2.
SOURCE: NCHS, National Vital Statistics System, Mortality.

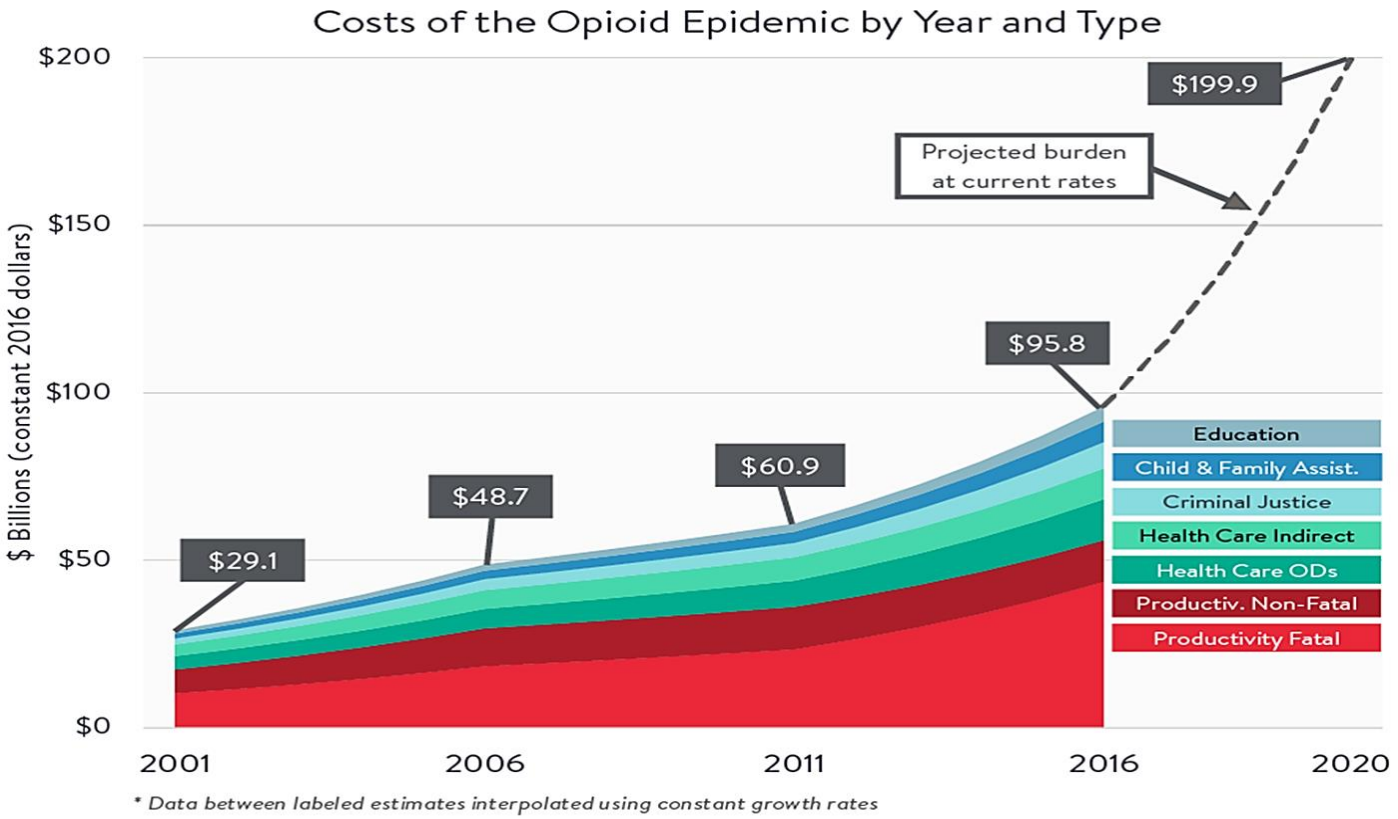
The Current Opioid Epidemic

Figure 3. Age-adjusted drug overdose death rates, by state: United States, 2017

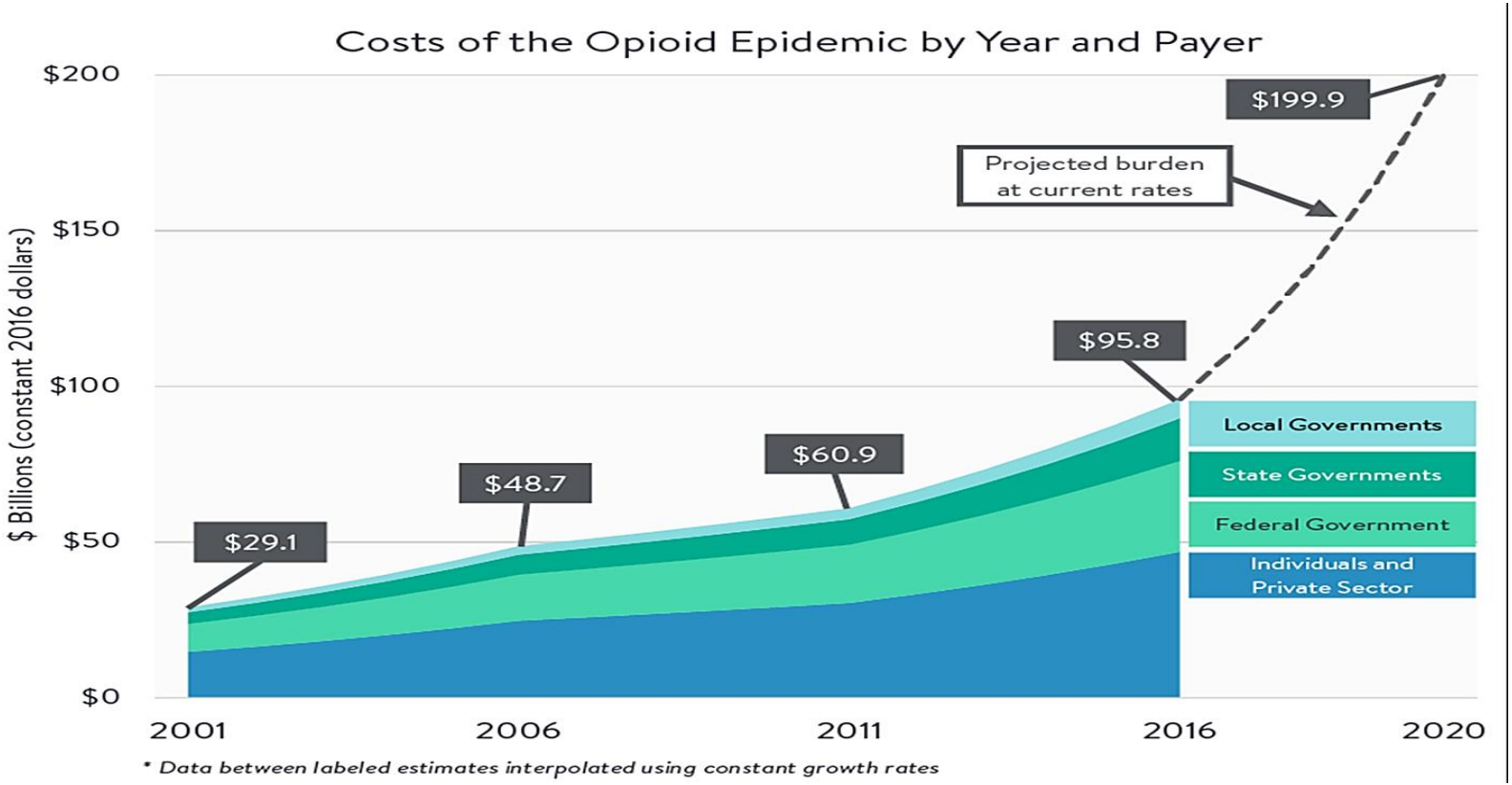


NOTES: Deaths are classified using the *International Classification of Diseases, 10th Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Access data table for Figure 3 at:
https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf#3.
SOURCE: NCHS, National Vital Statistics System, Mortality.

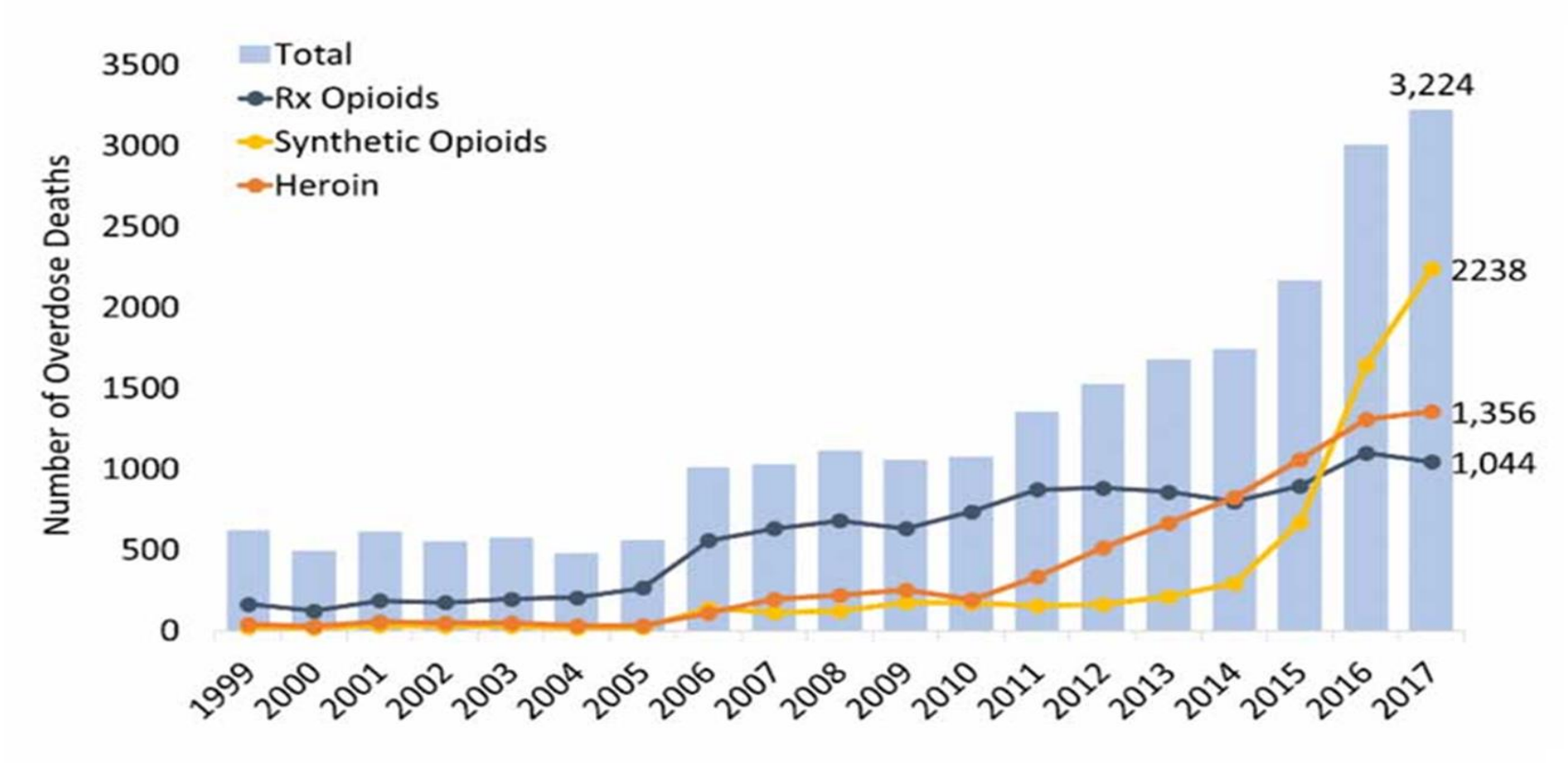
The Current Opioid Epidemic



The Current Opioid Epidemic

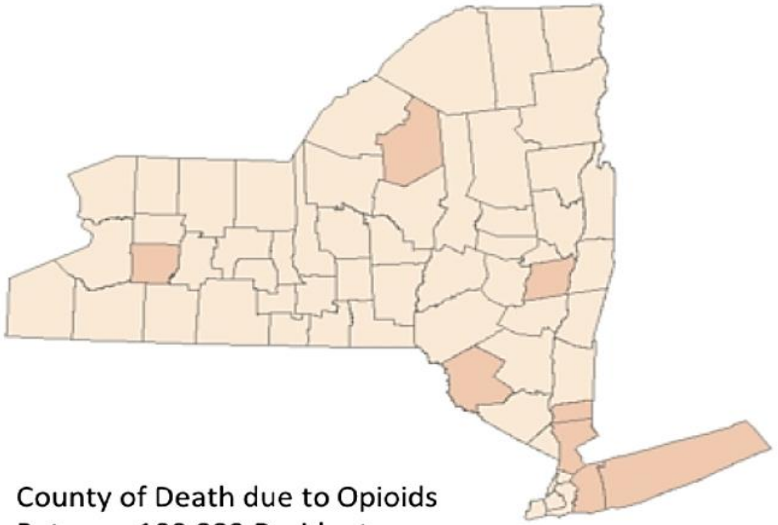


The Current Opioid Epidemic in NYS

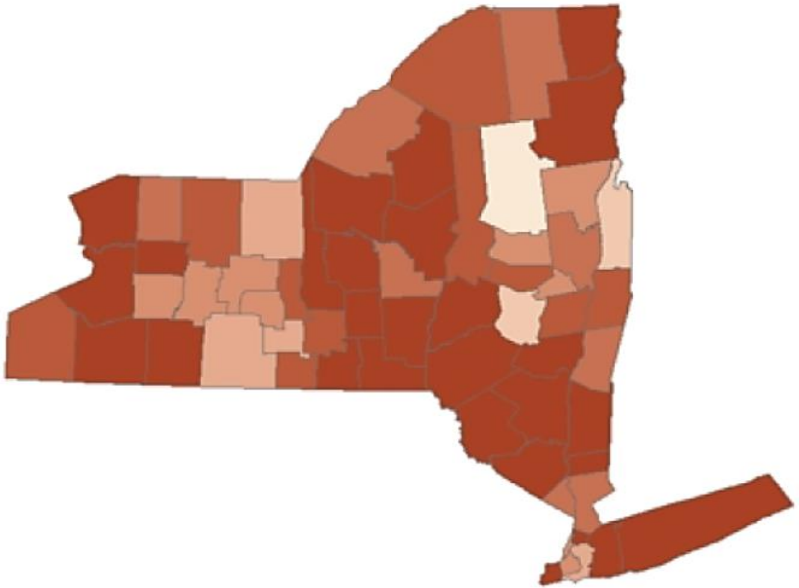


The Current Opioid Epidemic in NYS

1999



2015

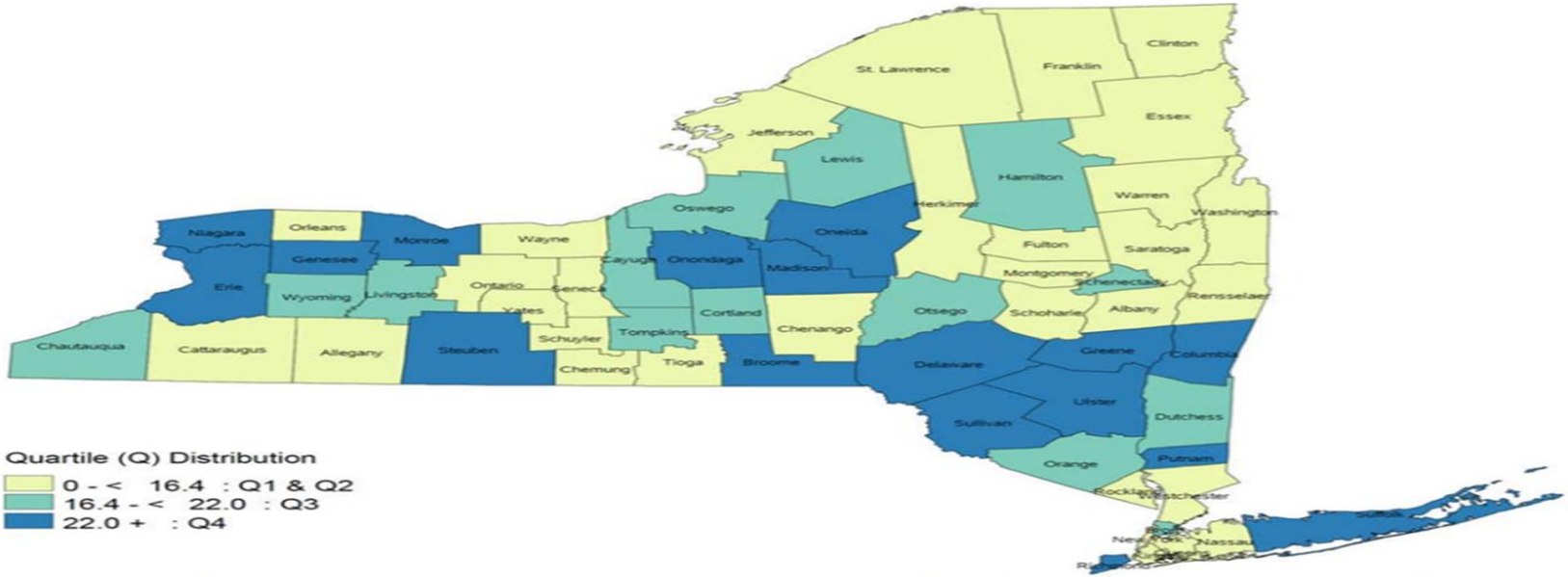


County of Death due to Opioids
Rate per 100,000 Residents

The Current Opioid Epidemic in NYS

New York State Opioid Annual Report 2018

Figure 1.2 Overdose deaths involving any opioid, age-adjusted rate per 100,000 population, by county, New York State, 2016



Data source: New York State Department of Health, Bureau of Vital Statistics; Data as of May 2018
For county data on overdose deaths involving any opioid, see Appendix: Data Table 1.2.

Treatment Goals for OUD

Treatment Goals

- Range of treatment goals

Minimization of harms from ongoing use ⟷ Sustained recovery with abstinence from all substances

- Treatment Options; Federations of State Medical Boards 2013
  - Partial Agonist (Buprenorphine) at the mu-receptor – OBOT/OTP
  - Agonist (Methadone) at the mu-receptor - OTP
  - Antagonists (Naltrexone) at the mu-receptor
  - Simple detoxification and no other treatment
  - Counseling and/or peer support without MAT
  - Referral to short or long term residential treatment

Recovery is Individualized

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

- ***Health***: **overcoming or managing one's disease(s) or symptoms;**
- ***Home:*** **a stable and safe place to live;**
- ***Purpose:*** **meaningful daily activities and the independence, income, and resources to participate in society; and**
- ***Community***: **relationships and social networks that provide support, friendship, love, and hope.**

- **Source: Abridged from SAMHSA**

What is Harm Reduction?

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. It is based on a strong commitment to public health and human rights.

Harm Reduction: Principles

- *A set of practical strategies by which harm related to illicit drug use is reduced*:

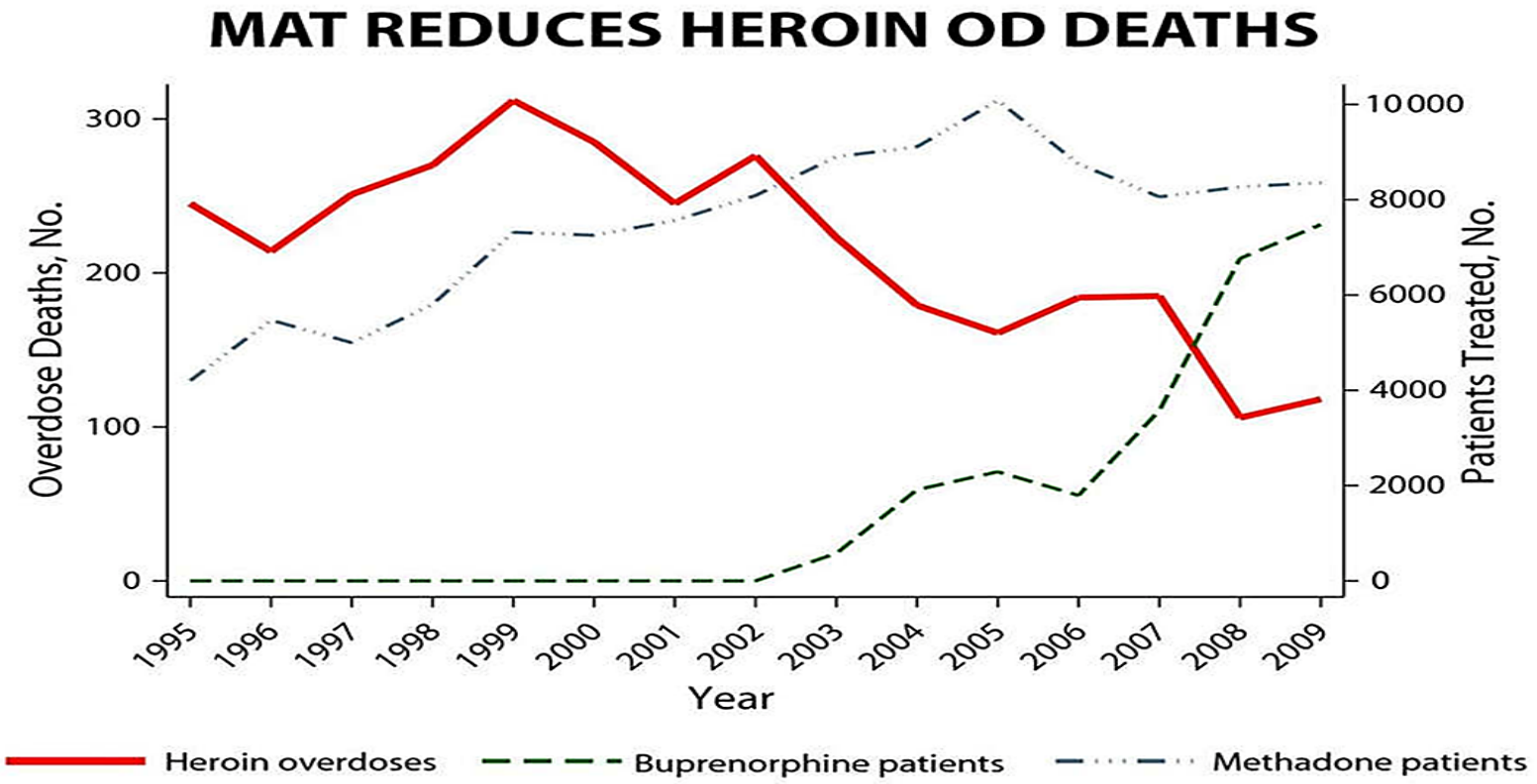
- Recognizes that drug use is common
- Includes a "spectrum" of strategies from safer use to abstinence
- Is low threshold: entry requirements appropriate to the targeted group
- Ensures that PWUD have a real voice in the creation of programs and policies

- Source: www.harmreduction.org

Drug Treatment Isn't for Everyone

- Some occasional alcohol and/or other drug use may not present a health risk; though any use is worthy of discussion
- Not all people who use want to stop
- Not all have time for treatment due to work and other obligations
- Fear of stigma

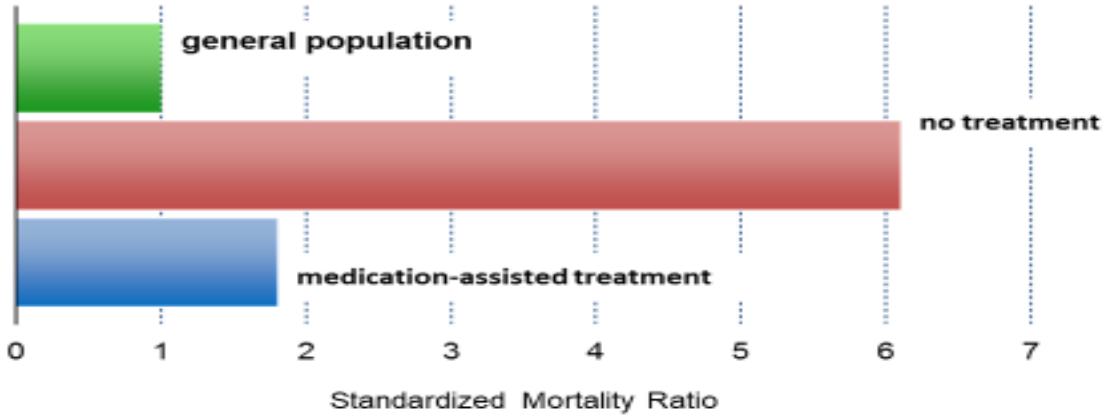
Why MAT?


MAT REDUCES HEROIN OD DEATHS
Overdose Deaths, No.
300
200
100
0
Patients Treated, No.
10000
8000
6000
4000
2000
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
Year
Heroin overdoses
Buprenorphine patients
Methadone patients

Why MAT?

Benefits of MAT: Decreased Mortality

Death rates:



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

Goals for MAT

- Decrease risk for fatal and nonfatal overdose (methadone and buprenorphine)
- Alleviate physical withdrawal symptoms
- Create a “narcotic blockade” (saturate the opioid mu receptors)
- Alleviate drug cravings
- Normalize brain changes: anatomy
- Normalize brain physiology: neurotransmitters
- Increase functionality for the patient: goals are individualized
- Decrease harm (incidence of infectious disease: HIV/HCV/HBV, incidence of infections: endocarditis/abscesses, etc.)

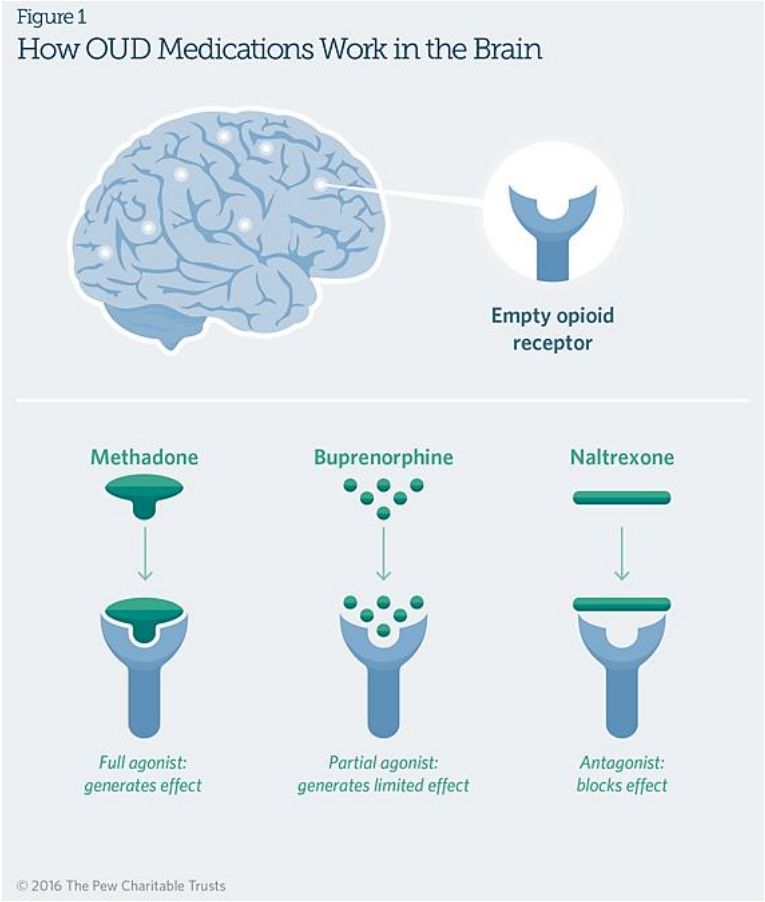
Options for MAT

FDA approved medications

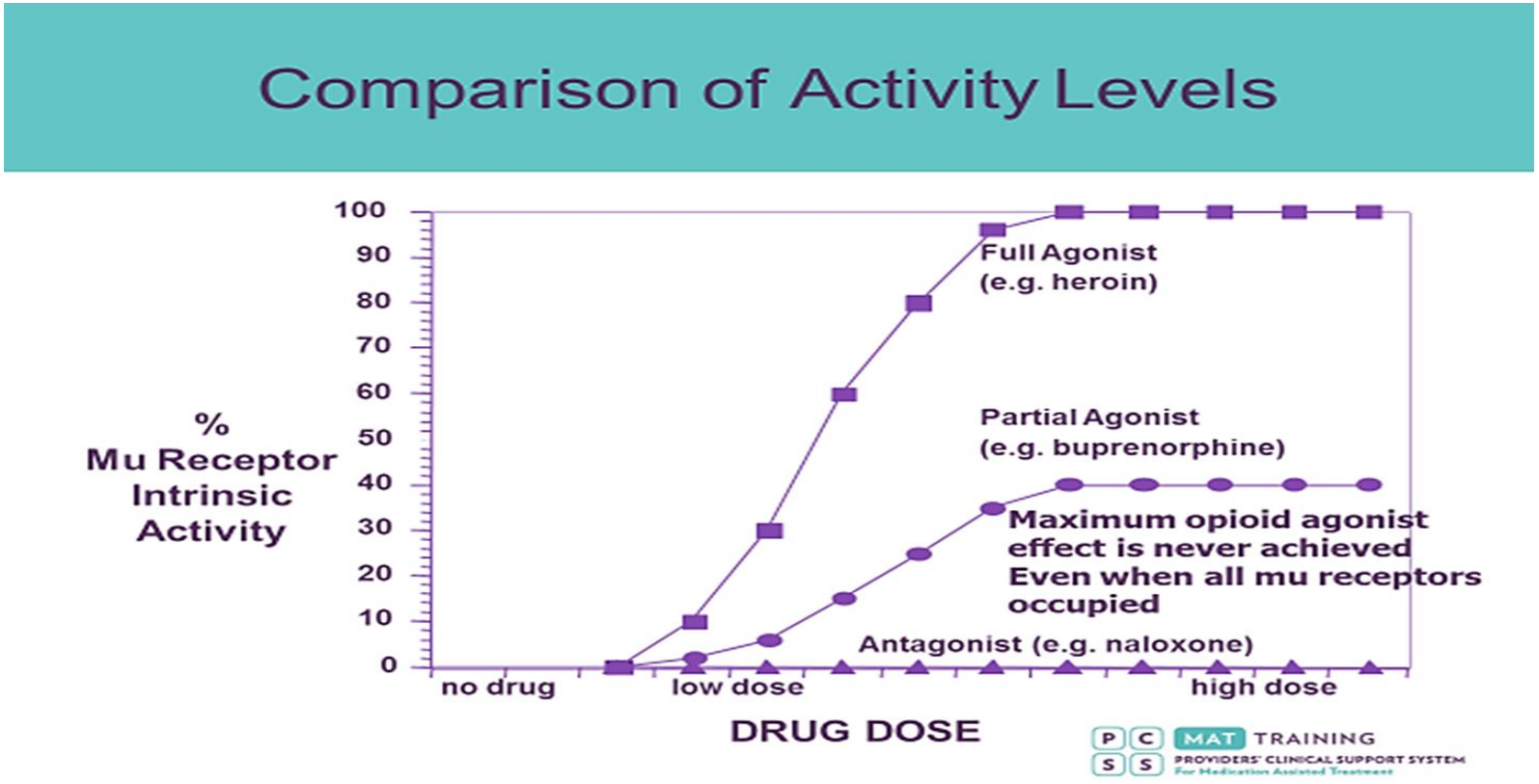
Medication	Euphoria	Overdose Risk	Effectiveness	Other
Methadone	Some	Low	↓ mortality ↓ illicit opioids ↓ criminality	Good data Structured Inexpensive
Buprenorphine	Minimal	Minimal	↓ mortality ↓ illicit opioids ↓ HIV risk	Good data Convenient Feasible
Long-acting naltrexone	None	None	↓ illicit opioids	Minimal data Expensive

Sharma *Substance Abuse & Rehabilitation* 2016

How MAT Works in the Brain



% Mu Receptor Intrinsic Activity



Options for MAT: Methadone

Major Features of Methadone

***Full Agonist* at mu receptor**

Long acting

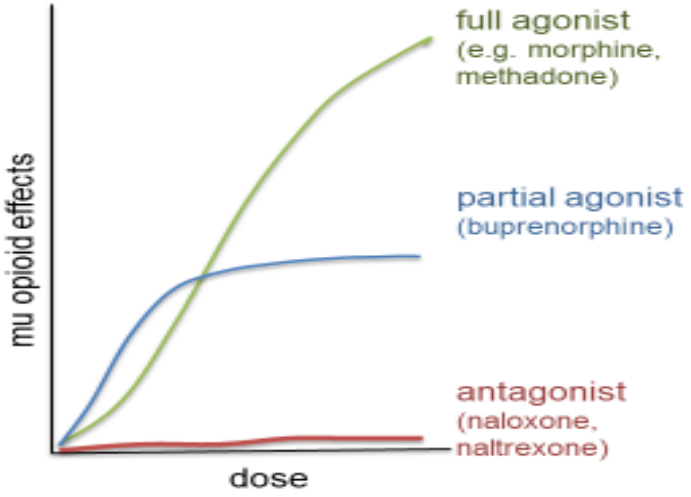
- Half-life ~ 15-60 Hours

Weak affinity for mu receptor

- *Can be displaced by partial agonists (e,g. burprenorphine) and antagonists (e.g.naloxone, naltrexone),* which can both precipitate withdrawal

Monitoring

- Significant respiratory suppression and potential respiratory arrest in overdose
- QT prolongation



CSAT, 2005

Options for MAT: Naltrexone

Major Features of Naltrexone

Full Antagonist at mu receptor

- Competitive binding at mu receptor

Long acting

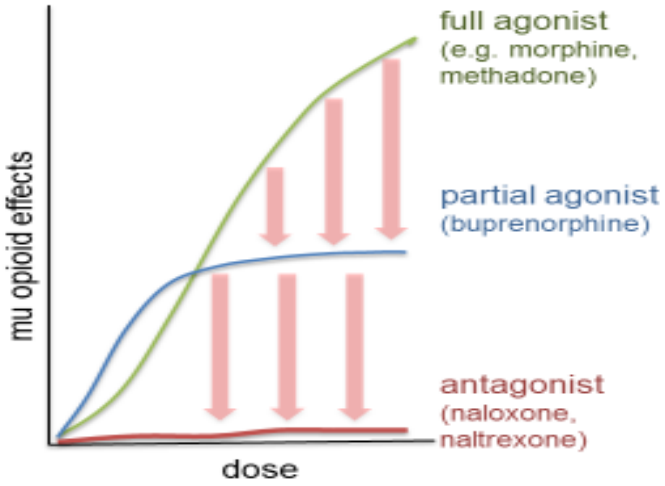
- Half-life:
  - Oral ~ 4 Hours
  - IM ~ 5-10 days

High affinity for mu receptor

- *Blocks* other opioids
- *Displaces* other opioids
  - Can precipitate withdrawal

Formulations

- *Tablets: Revia®: FDA approved in 1984*
- *Extended-Release intramuscular injection: Vivitrol®: FDA approved in 2010*



SAMHSA, 2018

PCSS Providers Clinical Support System

Options for MAT: Buprenorphine

Major Features of Buprenorphine

Partial agonist at mu receptor

- Comparatively minimal respiratory suppression and no respiratory arrest when used as prescribed

Long acting

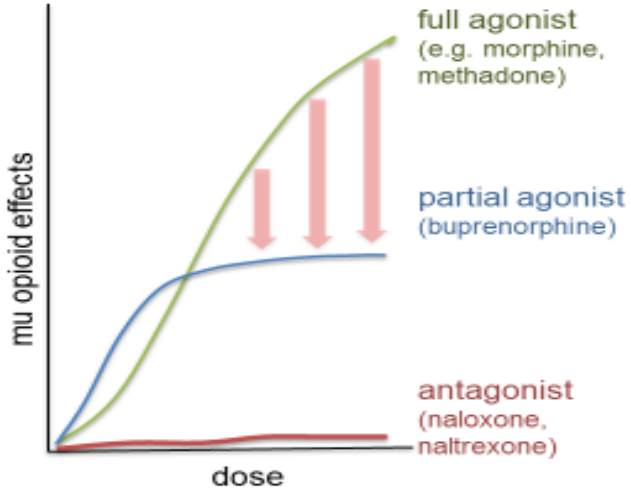
- Half-life ~ 24-36 Hours

High affinity for mu receptor

- *Blocks* other opioids
- *Displaces* other opioids
  - Can precipitate withdrawal

Slow dissociation from mu receptor

- *Stays on receptor for a long time*



SAMHSA, 2018
Orman & Keating, 2009

PCSS Providers Clinical Support System

Duration of MAT

- LONG ENOUGH...!!!
- It is different for every patient, but...recidivism rates and mortality are higher for shorter courses of treatment and for no treatment
- At a minimum, patients should remain on MAT for six months-1 year; but, in reality, MAT is often much longer, and, often chronic
- Average duration on buprenorphine treatment: 8-9 years
- OUD is a CHRONIC disease, and, like other chronic diseases, may require medication CHRONICALLY (think long term versus lifetime)

Buprenorphine Treatment: Crux of the Problem

- Less than 10% of persons with SUD successfully access treatment
- Only 25% of providers with a buprenorphine waiver actually have ever written a prescription for buprenorphine
- Of those that have written prescriptions, they often have less than 10 buprenorphine patients on their panel
- Buprenorphine providers are often not located in communities where persons with OUD can access them
- Many buprenorphine providers do not prescribe buprenorphine in a harm reduction context, but rather use an abstinence-based recovery model and punitive measures with patients with OUD who "fail"
- Many buprenorphine prescribers have a high threshold for entry, meaning no polysubstance use, no comorbid mental health conditions, etc.
- Some buprenorphine providers do not accept insurance* and accept cash payments only, preying on desperate patients and families, and discharging patients when they cannot pay

*this is partially due to low insurance reimbursement rates for visits

Buprenorphine Treatment: Misconceptions or Perceived Challenges

- "I don't want *those patients* in my waiting room (or pharmacy…)"
- "The floodgates will open"
- "I don't want to be a social worker (and don't we need to provide psychosocial counseling in our office setting?)"
- "Buprenorphine induction is too challenging"
- "I don't know what to do with polysubstance use"
- "I don't know how to order and interpret urine drug screens"
- "What about buprenorphine diversion? Are people on the street going to get high from my buprenorphine prescriptions?" (pharmacists think this too…)
- "There are too many insurance and prior authorization issues"
- "I need support; *those patients* are too needy and too difficult"
- "*Those patients* will disrupt the clinic (or pharmacy…) and patient flow"
- "I am not confident in treating OUD and I don't feel that I received adequate training"

Stigma

- “An attribute that is deeply discrediting” (Goffman, 1963)
- “Mark” of a deviant condition, flawed, spoiled (Jones, et al, 1984)
- Stigma: a process consisting of labeling, stereotyping, cognitive separation, emotional reactions, status loss and discrimination- often institutional (Link and Phelan, 2001)

Stigma and Substance Use

Substance Use Disorders are more highly stigmatized than other health conditions

Stigmatizing attitudes towards certain behaviors and groups are widely accepted, culturally endorsed, and enshrined in policy

Substance Use Disorders are often treated as a moral and/or criminal issue rather than a chronic health problem

Health care providers may hold negative beliefs about people with substance use disorders (i.e. they overuse system resources, are not invested in their health, “abuse” the system)

Stigma and Substance Use

Research indicates that stigma contributes to a host of adverse outcomes for people with substance use disorders, including:

- Poor mental and physical health
- Non-completion of substance use treatment
- Delayed recovery and reintegration processes
- Increased involvement in risky behavior (i.e. needle sharing)

Stigma Towards People Who Use Drugs (PWUD)

- Healthcare providers have high levels of stigma and bad feelings towards people who use drugs, in part from derogatory or dehumanizing language that is commonplace
- Studies indicate that the language used corresponds with providing poorer treatment

Stigma Towards PWUD

Stigma: a barrier to help-seeking behavior

Stigma in the moment of health care seeking discourages people from seeking additional help

Stigma does not discourage substance use, rather it fosters feelings of worthlessness/hopelessness, and is triggering for ongoing use

Source: Lancaster, et al, Drug Policy Modeling Program, 2018

Stigma Towards PWUD

- People internalize/reject/react to external stigma
- Experiences of dehumanization are common
- This results in delayed presentations to healthcare, not disclosing substance use, downplaying pain, and seeking care elsewhere

Source: Biancarelli, et al, Drug Alcohol Dependence, May 2019

Access to OBOT in Areas with High Rates of Opioid-Related Mortality: Cash-Paying Patients Favored Over Medicaid Recipients

Setting: 6 US jurisdictions with a high burden of opioid-related mortality: MA, MD, NH, WV, OH, and Washington DC

Design: Audit survey (“secret shopper” study)

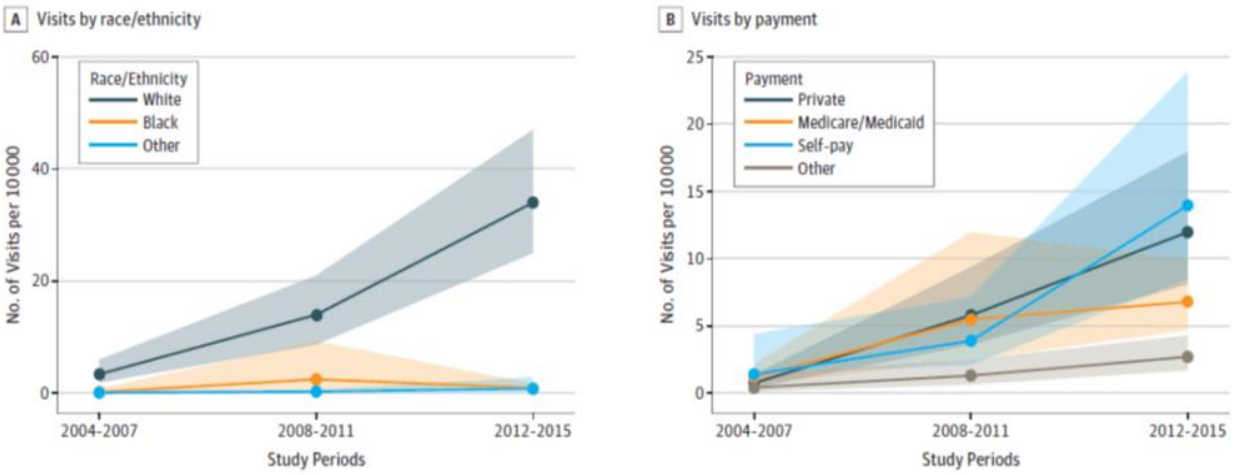
Participants: From July to November 2018, callers contacted 546 publicly listed buprenorphine prescribers twice, posing as uninsured or Medicaid-covered patients seeking buprenorphine treatment

Results: New appointments were offered to 54% of Medicaid contacts and 62% of uninsured self-pay contacts, whereas 27% of Medicaid and 41% of uninsured self-pay contacts were offered an appointment with the possibility of a buprenorphine prescription on the first visit

Conclusions: Many buprenorphine prescribers did not offer new appointments or rapid buprenorphine access to callers reporting active heroin use, particularly those with Medicaid coverage

Buprenorphine Treatment Divide by Race/Ethnicity and Payment

Figure. Buprenorphine Visits by Race/Ethnicity and Payment Type, 2004-2015



Buprenorphine visits (n = 1369) and 95% CIs per 10 000 visits (shaded areas), grouped by year and stratified by race/ethnicity and payment type. Estimates account for complex survey design elements and are nationally representative.

Buprenorphine Treatment: Addressing STIGMA

Making the Change to Person-Centered Language

Instead of this…	Say this…
Addiction	Substance Use Disorder/Opioid Use Disorder
Drug Addict, Abuser	A **person who** uses drugs
"Clean" or "Dirty" toxicology	Test was "Negative" or "Positive"; test was "unexpected" or "expected"
Got clean	A **person who** formerly used drugs
Junkie, Crackhead, Tweaker, etc.	A **person who** uses… (specify drug/s)

*2017. *Talking about drug use: A glossary for elected officials*. Drug Policy Alliance, New York, NY.

NEW YORK STATE | Department of Health

Buprenorphine Treatment: Addressing STIGMA

NYS DOH AIDS Institute Recommendations for Improving Language and Establishing Stigma-Free, Supportive, Service Delivery Environments

- Use person-first language: examples: “person who uses drugs”, “woman who uses drugs”; NOT “drug addict” or “drug abuser” or “dope fiend”
- Use Identity-affirming language: encourage positive talk instead of negative talk
- Establish a welcoming environment: create a “safe space”
- Recognize the value of staff being representative of the communities served
- Build staff skills to dialogue with clients/patients about language
- Be on the alert for judgmental language: examples: “clean”, “dirty”, “infectious”
- Use quality improvement to dismantle stigma
- Promote ongoing discussions regarding stigma
- Document agency policies, practices, and progress toward eliminating stigma

Buprenorphine Treatment: Psychosocial Counseling

Lack of effect of additional psychosocial treatment with buprenorphine treatment

- 4 negative RCTs
  - RCT of telephonic support vs standard of care
    - "Care coach" called participants, provided OUD education, assistance with treatment challenges, encouragement
    - No change in retention
  - 3 RCTs of standard vs. enhanced medical management
    - MDs & RNs; HIV+/- patients; primary care setting
    - Standard (15-20 min): counseling about drug use, drug abstinence/reduction, self-help groups, utox results
    - Enhanced (45 min): similar content
    - No change in abstinence, retention, adherence

Fiellin 2006; Weiss 2011; Tetrault 2012; Brigham 2014; Ruetsch 2012;

Buprenorphine Treatment: Induction

Buprenorphine induction strategies

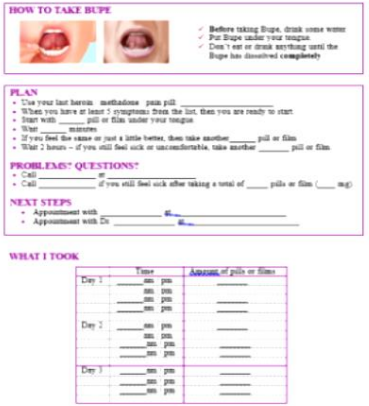
- National guidelines provide induction options
  - Home- and office-based inductions
- In 2005, nearly half of MA providers used home-based inductions
- Induction "tool kit"
  - Buprenorphine
  - Ancillary medications
  - Instruction sheet
  - Teach self-management of chronic disease


STARTING BUPRENORPHINE ("Bupe" or "Suboxone")
Congratulations on starting treatment!

WHAT TO START WITH?

WHEN AM I READY TO START BUPE?

THINGS NOT TO DO WITH BUPE


HOW TO TAKE BUPE

PLAN

PROBLEMS? QUESTIONS?

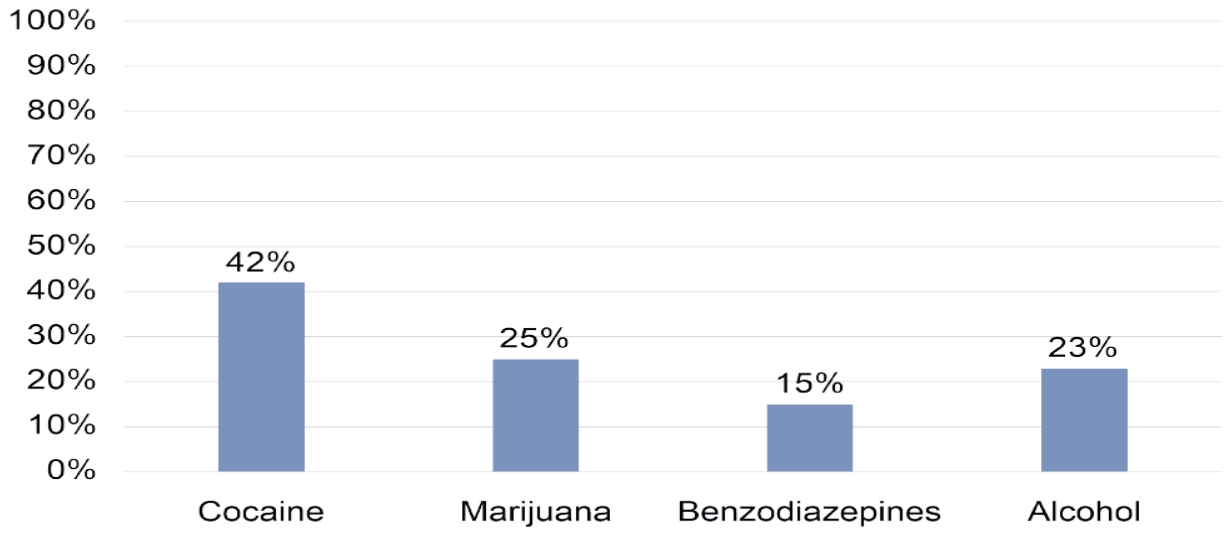
NEXT STEPS

WHAT I TOOK

ASAM National Practice Guideline 2015; Walley 2008; Sohler 2009; Cunningham 2011

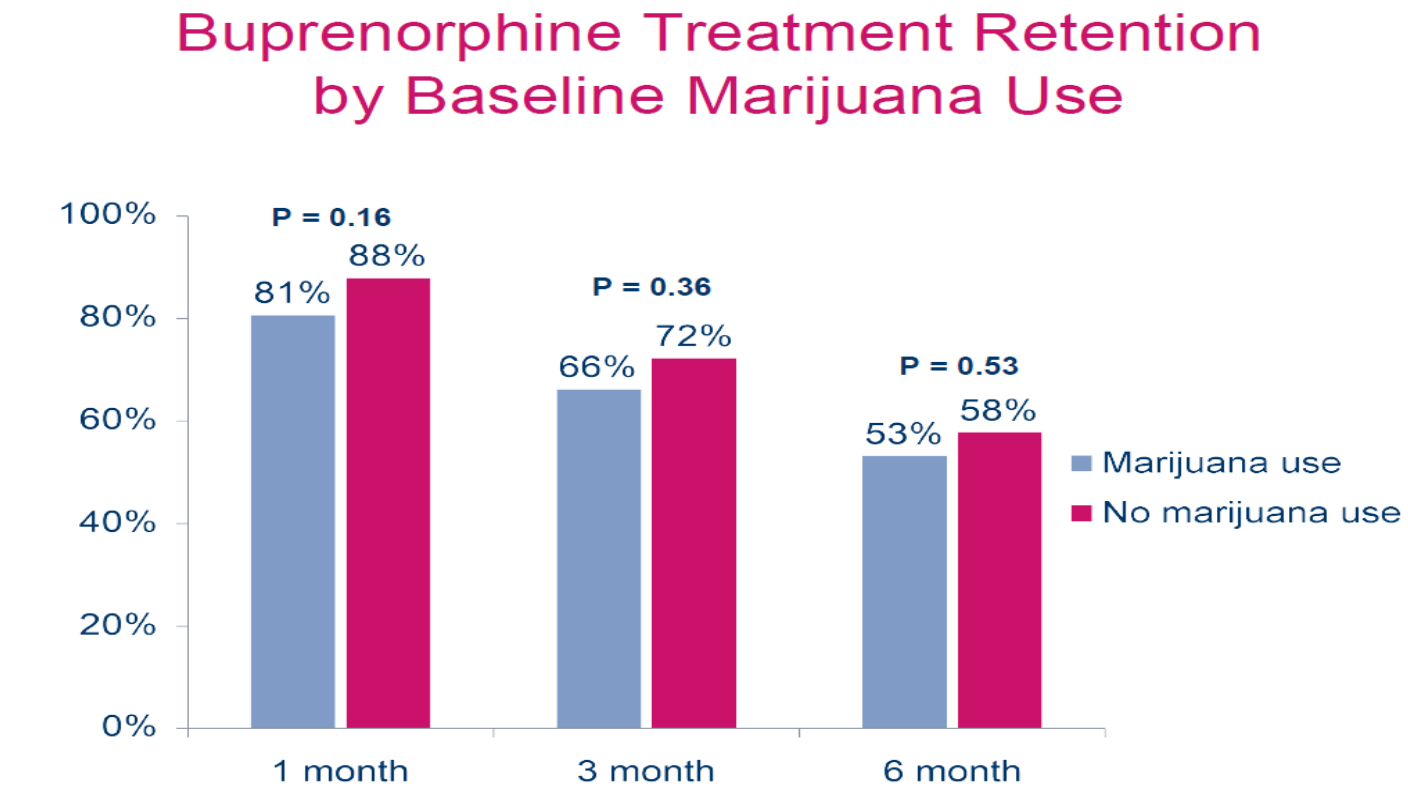
Buprenorphine Treatment: Polysubstance Use

Polysubstance use among patients initiating buprenorphine treatment in the Bronx



Cunningham 2008, 2013; Lu 2017

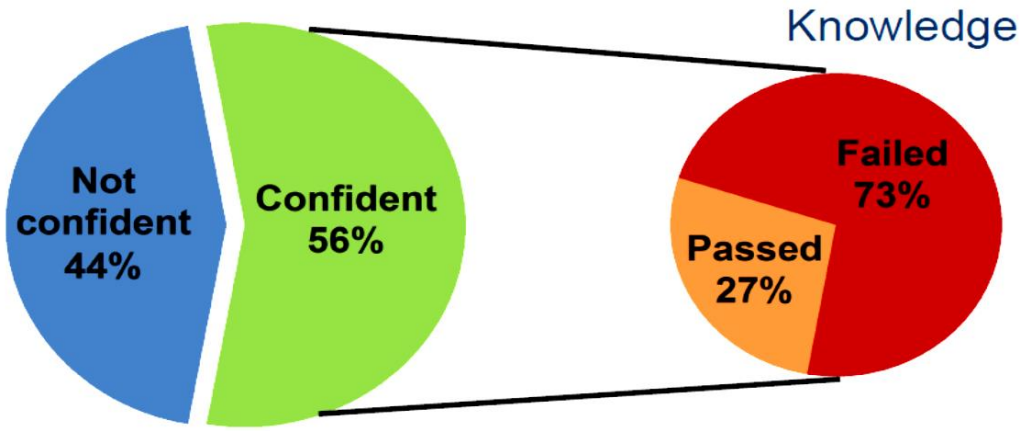
Buprenorphine Treatment: Polysubstance Use



Lu T, AMERSA, 2017

Buprenorphine Treatment: UDS Interpretation

Urine drug test interpretation



Starrels JL et al. JGIM 2012

Buprenorphine Treatment: Diversion

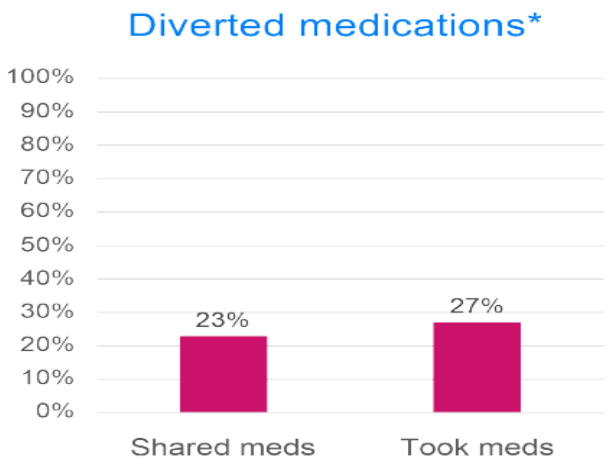
Diversion

- It happens
- With many meds
- Buprenorphine <<< other opioids

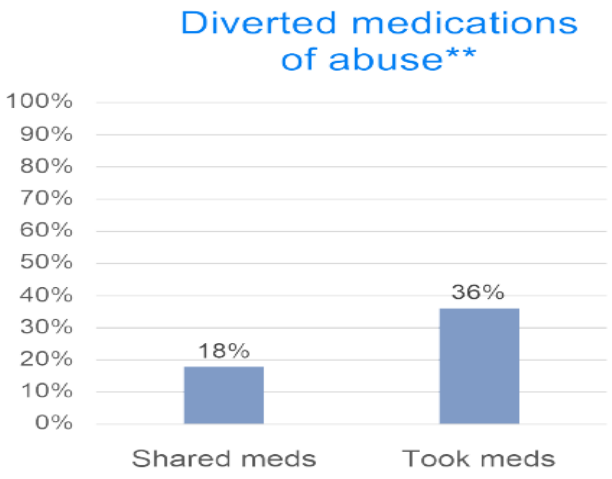
Buprenorphine Treatment: Diversion

Diversion in general and OUD populations

General population



OUD patients



*Medications = antibiotics; birth control pills; meds for allergies, pain, mood, acne
**Medications of abuse = sedatives; buprenorphine; meds for ADHD, sleep, pain

Caviness 2013; Lowfall 2013; Goldsworthy 2008

Understanding the Use of Diverted Buprenorphine

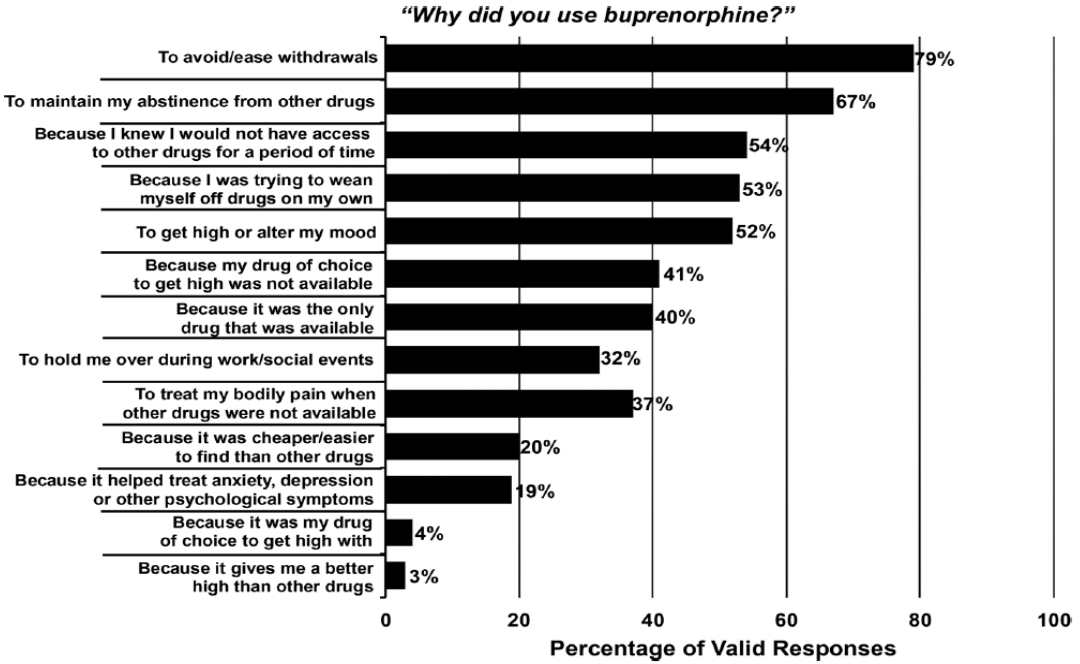
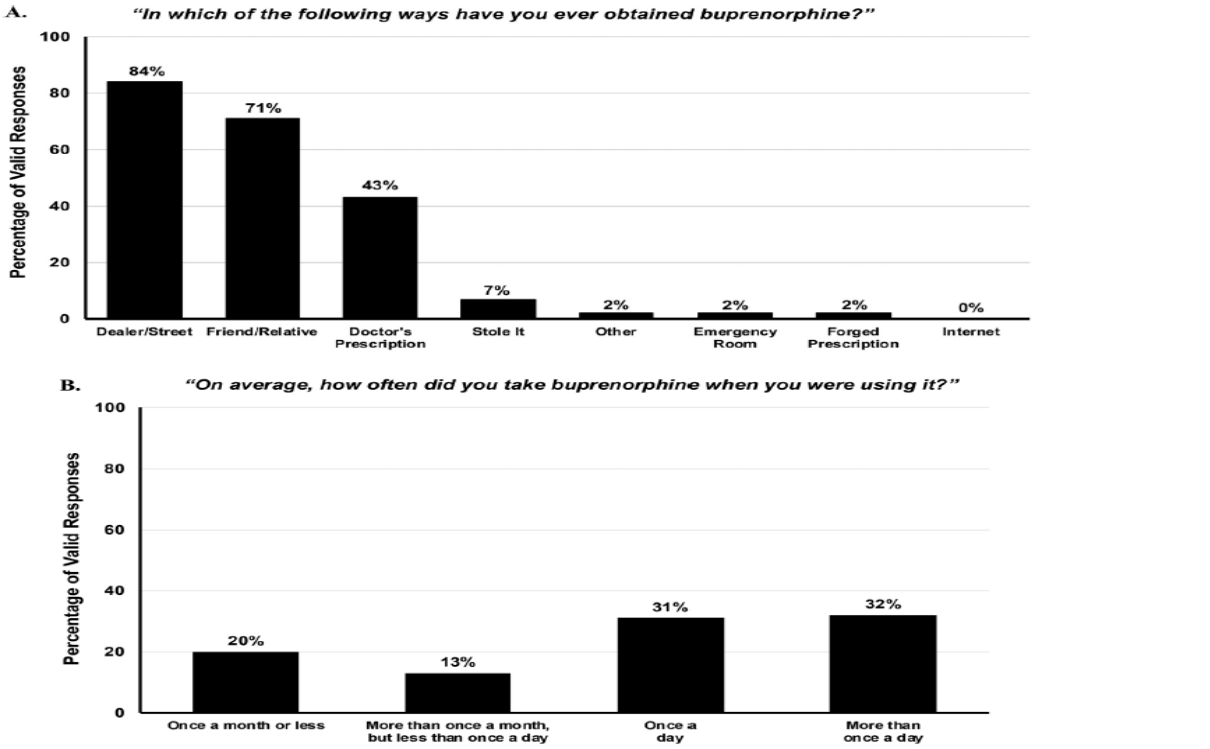


Fig. 3. Motivations for use among those who used diverted buprenorphine.

Understanding the Use of Diverted Buprenorphine

Drug and Alcohol Dependence 193 (2018) 117–123



Understanding the Use of Diverted Buprenorphine

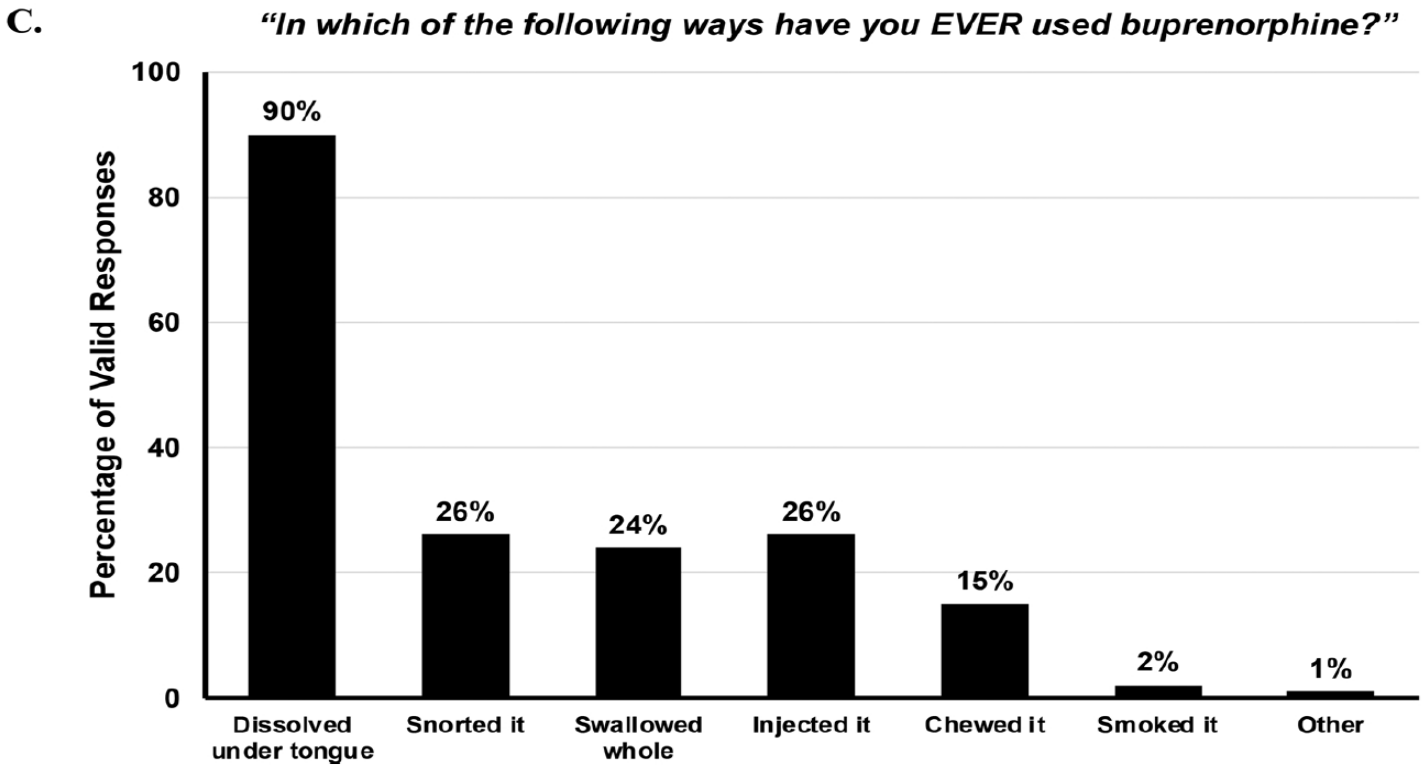


Fig. 4. Patterns of diverted buprenorphine use.

Challenging the Myths About MAT for OUD

- ***Myth:*** *"MAT just trades one addiction for another"*
- ***Fact:*** Both buprenorphine and methadone do cause physical dependence to an opioid; however, physical dependence does not equal addiction or a use disorder; OUD is characterized by a compulsion to use opioids with associated behaviors which lead to dysfunction in the PWUD's life; buprenorphine and methadone allow people to stabilize, by occupying the mu opioid receptors to keep opioid withdrawal symptoms at bay and control opioid cravings, allowing a person to regain functionality in his/her life

- ***Myth:*** *"MAT is only for the short term"*
- ***Fact:*** Research has consistently shown that people maintained on MAT for longer durations have better long-term outcomes than those who are taken off MAT; there is no evidence to support benefits from stopping MAT

Challenging the Myths About MAT for OUD

- ***Myth**: "My patent's condition is not severe enough to require MAT"*
- ***Fact:*** Given the lethality of the current opioid epidemic, preventing unintentional opioid overdose among opioid users is a key goal of MAT; MAT is now recommended for all opioid users, including adolescents, and all pregnant women, even if they do not meet DSM-5 criteria for OUD; the three MAT options allow tailoring of treatment to meet each person's needs

- ***Myth**: "MAT increases the risk for overdose in patients"*
- ***Fact:*** Research has shown clearly that both methadone and buprenorphine use are associated with decreased risk for mortality due to opioid overdose; occupancy of the mu opioid receptors by either methadone or buprenorphine protects a PWUD from an unintentional overdose if he/she relapses with opioids

Challenging the Myths About MAT for OUD

- ***Myth:*** *"Providing MAT will only disrupt and hinder a patient's recovery process"*
- ***Fact:*** MAT has been shown to assist PWUD in recovery by improving quality of life, level of functioning, and the ability to handle stress; most importantly, MAT reduces mortality while PWUD begin their recovery process; PWUD are often more open to other supports for their recovery once stable on MAT

- ***Myth:*** *"There isn't any proof that MAT is better than abstinence"*
- ***Fact:*** MAT is evidence-based and is the recommended course of treatment for OUD; AAAP, AMA, NIDA, SAMHSA, NIAAA, CDC, WHO, and many other professional organizations emphasize MAT as **first-line treatment for OUD**

- ***Myth:*** *"Most insurance plans don't cover MAT"*
- ***Fact:*** This is no longer true; most Medicaid, Medicare, and private insurance plans cover MAT; a prior authorization (PA) may be required

Best Practices for Engaging PWUD

1. *Engaging* with PWUD is the most important activity: *demonstrate empathy*

2. *Utilizing* harm reduction principles in counseling and employing harm reduction interventions with PWUD is vital (make referrals as needed: MAT, MH; link with local services: SEP, MMTP)

3. *Utilizing* motivational interviewing to engage PWUD *in whatever stage of change they are currently in*

4. *Giving* a naloxone kit to anyone at risk of opioid overdose (either experiencing it or witnessing it)

5. *True integration* (not just coordination of care or co-location) of behavioral health, primary care, and SUD services is *key* to *effecting* change

6. *Think outside the box!*

7. *Support one another*

OUD and MAT Conclusions

- OUD is prevalent; OUD is a chronic disease/medical condition
- MAT is efficacious for OUD; chronic medication is often needed
- MAT is only effective if the person with OUD is READY for treatment
- Do harm reduction education and give naloxone kits
- Be non-judgmental with persons with OUD; it is not a moral issue or a character defect, it is a medical condition
- Incorporating MAT into general medical practice is the ideal forum in which to deliver care; it is a rewarding part of practice
- Dispel stigma!
- Dispel myths and misconceptions about MAT

Resources

- www.harmreduction.org
- www.samhsa.gov
- https://www.confidentialrecovery.com/services/mat-medication-assisted-treatment/
- https://www2.palomar.edu/users/warmstrong/wwstaff.htm
- http://www.penington.org.au/community-overdose-prevention-and-education-cope/
- Special thanks to: Petros Levounis, MD, Chinazo Cunningham, MD, Ross Sullivan, MD, Kimberly Sue, MD, PhD, and Crystal Marr, LCSW for use of their slides
- www.cdc.gov
- www.nytimes.com
- https://www.cdc.gov/nchs/about/index.htm
- https://www.ahrq.gov/data/hcup/index.html
- https://www.vox.com/
- https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis
- https://www.hhs.gov/opioids/about-the-epidemic/index.html
- https://www.health.ny.gov/
- https://pcssnow.org/
- https://www.naabt.org/
- https://www.ncbi.nlm.nih.gov/pubmed/12606177
- https://www.asam.org/
- https://www.health.ny.gov/diseases/aids/consumers/prevention/

Resources

1) http://www.shatterproof.org/blog/entry/medication-assisted-treatment-for-addiction
2) https://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication assisted treatment 9-21-20121.pdf
3) http://www.overdosefreepa.pitt.edu/education-toolbox/medication-assisted-treatment-mat-2/#clarifying
4) http://www.asam.org/docs/default-source/advocacy/aaam implications-for-opioid-addiction-treatment final
5) http://store.samhsa.gov/shin/content/SMA14-4854/SMA14-4854.pdf
6) http://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines#DATA-2000
7) http://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone
8) http://www.samhsa.gov/medication-assisted-treatment/training-resources/support-organizations
9) https://www.federalregister.gov/articles/2016/03/30/2016-07128/medication-assisted-treatment-for-opioid-use-disorders
10) http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview
11) https://www.congress.gov/bill/114th-congress/senate-bill/524/text
12) http://pcssmat.org/waiver-eligibility-training/
13) "MAT Maintenance Treatment and Superior Outcomes" PowerPoint, Dr. Arthur Williams
14) https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-long-does-drug-addiction-treatment
15) Challenging the Myths About Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) information sheet by Nick Szubiak, Director, Clinical Excellence in Addictions, at NICKS@thenationalcouncil.org
16) https://altarum.org
17) Theodore J. Cicero, et al. *Understanding the Use of Diverted Buprenorphine*, Drug and Alcohol Dependence, 193 (2018), 117-123.

QUESTIONS?

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