ICAADA

LEADING INDIANA IN WORKFORCE DEVELOPEMENT AND CREDENTIALING FOR ADDICTION PROFESSIONALS

Our Mission

To advance the field of alcohol and other drug abuse and co-occurring disorders prevention and treatment through provision of addiction professional testing, credentialing and training programs and advocacy and membership services of the highest quality.

MHA Mental Health America of Indiana

ROSC and MAT Part I: Treatment Approaches

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GOALS

- Understand opioid addiction and its history
- Identify best practices for opioid addiction treatment
- Recognize medications approved for treatment of opioid addiction
- Understand medication assisted treatment and recovery issues
- Identify how recovery oriented systems of care interface with opioid addiction recovery

National Opioids Facts

- 681,000 Heroin users in 2013
- 11,000,000 Rx Opioid misusers in 2013
- SAMHSA

A BRIEF HISTORY OF OPIOID TREATMENT

- 1935: Federal Narcotic Treatment Program
- 1964: Methadone is approved
- 1974: Narcotic Treatment Act limits methadone treatment to specifically licensed Opioid Treatment Programs (OTP's)
- 1984: Naltrexone is approved, but has been rarely used until Vivitrol developed
- 1993: ORLAAM is approved (for non-pregnant patients only)

A BRIEF HISTORY OF OPIOID TREATMENT

- 2000: Drug Addiction Treatment Act of 2000 (DATA 2000) expands the clinical context of medication assisted opioid treatment.
- 2002: Tablet formulations of buprenorphine (Subutex) and buprenorphine/naloxone
- (Suboxone) were approved by FDA.
- 2004: Sale and distribution of ORLAAM is discontinued.
- 2006 and 2010: Vivitrol approved by FDA
- 2011: Suboxone film strips introduced.

Opiate/Opioid : What's the Difference?

Opiate

- A term that refers to drugs or medications that are derived from the opium poppy, such as heroin, morphine, codeine, and buprenorphine.

Opioid

- A more general term that includes opiates as well as the synthetic drugs or medications, such as methadone, meperidine (Demerol), fentanyl—that produce analgesia and other effects similar to morphine.

Basic Opioid Facts

Description: Opium-derived, or synthetics which relieve pain, produce morphine-like addiction, and relieve withdrawal from opioids

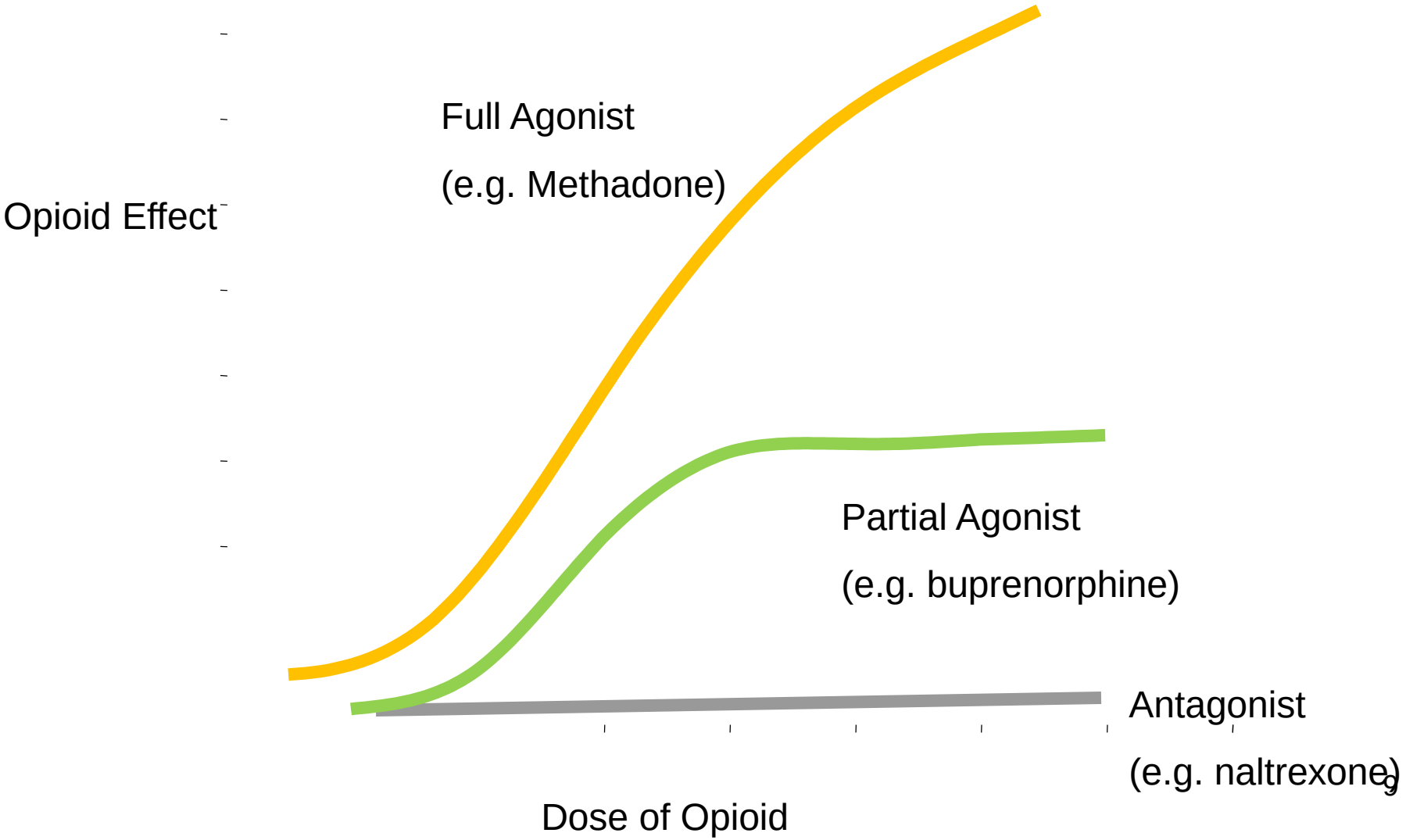
Medical Uses: Pain relief, cough suppression, diarrhea

Methods of Use: Intravenously injected, smoked, snorted, or orally administered

Types of Medications for Opioid Treatment

- Agonists
- Partial Agonists
- Antagonists

Partial vs Full Opioid Agonist and Angtagonist



Opioid Agonists

- Natural Derivatives
  - Opium
  - Morphine
  - Codeine

Opioid Agonists

- Semisynthetics: Derived from chemicals in opium

  - Diacetylmorphine – Heroin
  - Hydromorphone – Dilaudid
  - Oxycodone – Oxycontin, Percocet
  - Hydrocodone – Vicodin
  - Oxymorphone -- Opana

Opioid Agonists

- Synthetics

  - Propoxyphene – Darvon, Darvocet
  - Meperidine – Demerol
  - Fentanyl citrate – Fentanyl
  - Methadone – Dolophine
  - Levo-alpha-acetylmethadol – Orlamm

Opioid Partial Agonists

- Buprenorphine– Suboxone, Subutex
- Pentazocine-- Talwin

Opioid Antagonists

- Naltrexone– Vivatrol, ReVia, Trexan
- Naloxone-- Narcan

Terminology
Dependence versus Addiction

- Addiction may occur with or without the presence of physical dependence.
- Physical dependence results from the body's adaptation to a drug or medication and is defined by the presence of
  - Tolerance and/or
  - Withdrawal

Terminology
Dependence versus Addiction

Tolerance:

The loss of or reduction in the normal response to a drug or other agent, following use or exposure over a prolonged period

Terminology
Dependence versus Addiction

Withdrawal:

A period during which somebody dependent to a drug or other addictive substance stops taking it, causing the person to experience painful or uncomfortable symptoms

OR

a person takes a similar substance in order to avoid experiencing the effects described above.

Terminology Dependence verses Addiction Summary

- To avoid confusion, in this training, "Addiction" will be the term used to refer to the pattern of continued use of opioids despite pathological behaviors and other negative outcomes.
- "Dependence" will only be used to refer to physical dependence on the substance as indicated by tolerance and withdrawal as described above.

Opioid Agonists: Pharmacology

- Stimulate opioid receptors in central nervous system & gastrointestinal tract
- Analgesia – pain relief (somatic & psychological)
- Antitussive action – cough suppression
- Euphoria, stuperousness, “nodding”
- Respiratory depression

Opioid Agonists: Pharmacology

- Pupillary constriction
- Constipation
- Histamine release (itching, bronchial constriction)
- Reduced libido
- Tolerance, cross-tolerance
- Withdrawal: acute & protracted

Possible Acute Effects of Opioid Use

- Surge of pleasurable sensation = “rush”
- Warm flushing of skin
- Dry mouth
- Heavy feeling in extremities
- Drowsiness
- Clouding of mental function
- Slowing of heart rate and breathing
- Nausea, vomiting, and severe itching

Consequences of Opioid Use

- Addiction
- Overdose
- Death
- Use related (e.g., HIV infection, malnutrition)
- Negative consequences from injection:
  - Infectious diseases (e.g., HIV/AIDS, Hepatitis B and C)
  - Collapsed veins
  - Bacterial infections
  - Abscesses
  - Infection of heart lining and valves
  - Arthritis and other rheumatologic problems

Heroin Withdrawal Syndrome

- Intensity varies with level & chronicity of use
- Cessation of opioids causes a rebound in function altered by chronic use
- First signs occur shortly before next scheduled dose
- Duration of withdrawal is dependent upon the half-life of the drug used:
  - Peak of withdrawal occurs 36 to 72 hours after last dose
  - Acute symptoms subside over 3 to 7 days
  - Protracted symptoms may linger for weeks or months

Opioid Withdrawal Syndrome
Acute Symptoms

- Pupillary dilation
- Lacrimation (watery eyes)
- Rhinorrhea (runny nose)
- Muscle spasms (“kicking”)
- Yawning, sweating, chills, gooseflesh
- Stomach cramps, diarrhea, vomiting
- Restlessness, anxiety, irritability

Opioid Withdrawal Syndrome Protracted Symptoms

- Deep muscle aches and pains
- Insomnia, disturbed sleep
- Poor appetite
- Reduced libido, impotence, anorgasmia
- Depressed mood, anhedonia
- Drug craving and obsession

Treatment Options for Opioid-Addicted Individuals

- Behavioral treatments educate patients about the conditioning process and teach relapse prevention strategies.
- Medications such as methadone, buprenorphine and naltrexone operate on the opioid receptors to relieve craving and/or block opiod effects.
- ***Combining the two types of treatment enables patients to stop using opioids and return to more stable and productive lives.***

How Can You Treat Opioid Addiction?

Medically-Assisted Withdrawal

- Relieves withdrawal symptoms while patients adjust to a drug-free state
- Can occur in an inpatient or outpatient setting
- Typically occurs under the care of a physician or medical provider
- Serves as a precursor to behavioral treatment, because it is designed to treat the acute physiological effects of stopping drug use

How Can You Treat Opioid Addiction?

Long-Term Residential Treatment

- Provides care 24 hours per day
- Planned lengths of stay of 6 to 12 months
- Models of treatment include Therapeutic Community (TC), Cognitive Behavioral Therapy.

Outpatient Psychosocial Treatment

- Less costly than residential treatment
- Varies in types and intensity of services offered
- Group counseling is emphasized
- Medically-assisted withdrawal is offered generally done with clonidine and other non-narcotic medications.

National Institute on Drug Abuse , (2009)

How Can You Treat Opioid Addiction?

Behavioral Therapies

- Contingency management
  - Based on principles of operant conditioning
  - Uses reinforcement (e.g., vouchers) of positive behaviors in order to facilitate change
- Cognitive-behavioral interventions
  - Modify patient's thinking, expectancies, and behaviors
  - Increase skills in coping with various life stressors

National Institute on Drug Abuse, (2009)

How Can You Treat Opioid Addiction?

Agonist Maintenance Treatment

- Usually conducted in outpatient settings
- Treatment provided in opioid treatment programs traditionally using methadone or buprenorphine, with buprenorphine also in office-based settings
- Patients stabilized on adequate, sustained dosages of these medications can function normally.
- Can engage more readily in counseling and other behavioral interventions essential to recovery and rehabilitation
- The best, most effective opioid agonist maintenance programs include individual and/or group counseling, as well as provision of, or referral to other needed medical, psychological, and social services.

National Institute on Drug Abuse, (2009)

Benefits of Methadone Maintenance Therapy

- Used effectively and safely for over 30 years
- Not intoxicating or sedating, if prescribed properly
- Effects do not interfere with ordinary activities
- Suppresses opioid withdrawal for 24-36 hours

Benefits of Buprenorphine Maintenance Therapy

- “Ceiling Effect” reduces OD and over medication
- “High Receptor Affinity” blocks other Opioids
- Dosing possible on less-than-daily basis
- Patients report minimal sedation
- Buprenorphine/Naloxone discourages IV use
- Buprenorphine less likely to be diverted

How Can You Treat Opioid Addiction?

Antagonist Maintenance Treatment

- Usually conducted in outpatient setting
- Initiation of naltrexone often begins after medical detoxification in a residential setting
- Vivitrol injections effective for up to a month
- Repeated lack of desired opioid effects will gradually over time result in breaking the habit of opioid addiction.
- Patient noncompliance can be a common problem. A favorable treatment outcome requires a positive therapeutic relationship, effective counseling or therapy, and careful monitoring of medication compliance.

Adopted from National Institute on Drug Abuse,

Best Predictors for Addiction Recovery

- Long term involvement in treatment and recovery
- Viable occupation
- Intact positive support system

Myths About Use of Medication in Recovery

- Patients are still addicted
- Medication is simply a substitute for opioids
- Providing Medication alone is sufficient treatment
- Patients still getting high

Patients in Opioid Maintenance Treatment

- 75% have Positive UDS in 1st 6 mo.
- 30% have Positive UDS in 6 mo.-4.5 years
- 10% positive UDS after 5 years

SAMHSA

POATS 42 Month Follow-up

- 31.7% Abstinent
- 29.4% in MATS
- 7.5% in MATS and using illicit opioids
- 31.4 % using illicit opioids w/o MATS

- CSAT Study 2013

Issues in Recovery

- 12 Step meetings and medication
- Drug cessation and early recovery skills
  - Disposing of drugs and paraphernalia
  - Dealing with triggers and cravings
- Treatment should be delivered in formal structure
- Relapse Prevention is not a matter of will power

Patient Management: Treatment Monitoring

Goals for treatment should include:

- No illicit opioid drug use
- No other drug use
- Absence of adverse medical effects
- Absence of adverse behavioral effects
- Responsible handling of medication
- Adherence to treatment plan

Patient Management: Treatment Monitoring

Weekly visits (or more frequent) are important to:

1. Provide ongoing counseling to address barriers to treatment, such as travel distance, childcare, work obligations, etc
2. Provide ongoing counseling regarding recovery issues
3. Assess adherence to dosing regimen
4. Assess ability to safely store medication
5. Evaluate treatment progress

Special Populations

- Patients with co-occurring psychiatric disorders
- Pregnant women
- Adolescents and young adults

Co-Occurring Psychiatric Disorders

- Opioid users frequently have concurrent psychiatric diagnoses.
- Sometimes the effects of drug use and/or withdrawal can mimic psychiatric symptoms.
- Clinicians must consider the duration, recentness, and amount of drug use when selecting appropriate patients.
- Signs of anxiety, depression, thought disorders or unusual emotions, cognitions, or behaviors should be reported to physician and discussed with the treatment team.

Pregnancy-Related Considerations

Methadone Maintenance is the treatment of choice for pregnant opioid-addicted women.

Opioid withdrawal should be avoided during pregnancy.

Burenorphine may be eventually used in pregnancy, but is currently not approved.

Opioid-Addicted Adolescents and Young Adults

- Current treatments for opioid-addicted adolescents and young adults are often unavailable and when found, clinicians report that the outcome leaves much to be desired.
- States have different requirement for admitting clients under age 18 to addictions treatment. It is important to know the local requirements.

Opioid-Addicted Adolescents and Young Adults

- Buprenorphine is approved for use with opioid dependent persons age 16 and older
- Research conducted through the NIDA Clinical Trials Network (CTN 010) demonstrated that it can be safely and effectively used with young adults.
- This research also indicated that medical treatment likely needs to be longer than current standard treatment indicates.

Counseling Opioid Patients

- Address issues of the necessity of counseling with medication for recovery.

Recovery and Pharmacotherapy:

  - Patients may have ambivalence regarding medication.
  - The recovery community may ostracize patients taking medication.
  - Counselors need to have accurate information.

Counseling Opioid Patients

Recovery and Pharmacotherapy:

- Focus on “getting off” buprenorphine or methadone may convey taking medicine is “bad.”
- Suggesting recovery requires cessation of medication is inaccurate and potentially harmful.
- Support patient’s medication compliance
- “Medication,” not “drug”

Counseling Opioid Patients

Dealing with Ambivalence:

- Impatience, confrontation, “you’re not ready for treatment”

  or,

- Deal with patients at their stage of acceptance and readiness

Counseling Opioid Patients

Counselor Responses:

- Be flexible
- Don’t impose high expectations
- Don’t confront
- Be non-judgmental
- Use a motivational interviewing approach
- Provide reinforcement

Counseling Opioid Patients

Encouraging Participation in 12-Step Meetings:

- What is the 12-Step Program?
- Benefits
- Meetings: speaker, discussion, Step study, Big Book readings
- Support groups vs. treatment

Counseling Opioid Patients

Issues in 12-Step Meetings:

- Medication and the 12-Step program
  - Program policy
    - "The AA Member: Medications and Other Drugs"
    - NA: "The ultimate responsibility for making medical decisions rests with each individual"
  - Some meetings are more accepting of medications than others

Counseling Opioid Patients

A Motivational Interviewing Approach:

- Dealing with other drugs and alcohol
- Doing more than not-using

MIA-STEP

- Developed through the Blending Initiative
- Empirically supported mentoring products to enhance the MI skills of treatment providers
- Provides tools to help supervisors offer structured, focused, and effective supervision.
- The blending products are available at www.drugabuse.gov/Blending/ www.attcnetwork.org

Using Motivational Incentives

- NIDA CTN research shows that treatment retention and drug abstinence are improved by providing low-cost reinforcement (prizes, vouchers, clinic privileges, etc.), for drug negative urine tests.
- The Blending Product Promoting Awareness of Motivational Incentives (PAMI) provides information on this effective technique.
- The blending products are available at:
  www.drugabuse.gov/Blending/
  www.attcnetwork.org

Counseling Opioid Patients

Relapse Prevention:

- Patients need to develop new behaviors.
- Learn to monitor signs of vulnerability to relapse
- Recovery is more than not using illicit opioids.
- Recovery is more than not using drugs and alcohol.

ROSC

- Recovery-Oriented Systems of Care
  - Coordinated service/support network
  - person-centered infrastructure
  - Builds on strengths and resiliencies
  - Abstinence/wellness/life quality focused
  - Prevention, intervention, treatment and recovery community services

Recovery-Oriented Activities

- Prevention: early screening, collaboration, stigma reduction
- Intervention: pre-treatment outreach, screening, recovery support
- Treatment: menu of holistic services, alternative therapies, family inclusion
- Recovery; support services, check-ups, self-monitoring

MAT/ROSC Interface

- Is MAT stigma reduction part of your ROSC
- Is MAT part of a coordinated network?
- Are recovery supports part of MAT?
- Are families and family serving agencies part of MAT?
- Is the community MAT aware?
- Are health, wellness and quality of life resources part of MAT?

MAT and ROSC Interface

- Develop on-going collaboration strategies
- Cross-training for MATS and ROSC
- MAT stigma reduction activities
  - patients, families, community
- Organization development plans
- On-going feedback

Questions

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