

Medication Treatment for Opioid Use Disorder

February 19th, 2019

12:00pm – 1:00pm

Presenters: Thomas E. Freese, PhD, Gloria Miele, PhD, and Daniel Dickerson,
DO, MPH, and Larissa Mooney, MD



Disclosures

The speakers do not have relevant financial relationships with commercial interests.

Objectives

- Specify three FDA approved medications to treat patients with opioid use disorders.
- Describe at least three (3) benefits for using medication assisted treatment in tribal health clinic settings.
- Identify at least three (3) strategies to prevent opioid overdose.
- Demonstrate two (2) lessons learned from the clinical case presentation.

Opioid epidemic



- ▶ An opioid crisis exists within AI/AN communities.
- ▶ AI/ANs had the highest drug overdose death rates in 2015 (CDC)
- ▶ AI/ANs had the largest percentage increase in the number of deaths over time from 1999-2015 compared to other racial and ethnic groups (CDC).
- ▶ From 1999-2015, deaths rose more than 500 percent among AI/ANs (CDC).
- ▶ In March 2017, the Indian Health Service (IHS) chartered the National Committee on Heroin, Opioids, and Pain Efforts (also known as the HOPE Committee).

Medications for Opioid Use Disorder

- ▶ Buprenorphine (sublingual, implantable, injectable)
- ▶ Naltrexone (oral and extended release injectable)
- ▶ Methadone

“Detox” has no long-term effect on outcomes; it is medication maintenance that saves lives and reduces relapse

Pharmacotherapy for Opioid Addiction: **Methadone**

- Most effective
 -  survival, treatment retention, employment
 -  illicit opioid use, hepatitis and HIV infections, criminal activity
- Highly regulated, dispensed at Opioid Treatment Programs (OTP)
 - Supervised daily dosing with take-home doses if stable
 - Counseling, urine testing
 - Psychiatric, medical services often not provided
 - **Illegal** to prescribe methadone for addiction in general practice
- Cost-effective
 - Every dollar invested generates \$4-5 in savings

Pharmacotherapy for Opioid Addiction: Methadone

Daily, observed dosing

- ▶ Full opioid agonist
- ▶ Onset within 30-60 minutes
- ▶ Long-acting: Daily dosing effective for addiction
- ▶ Dose 20-40 mg for acute withdrawal
- ▶ >80 mg for craving and “blockade”
- ▶ To evaluate stability, ask about take-home doses
- ▶ **Multiple** medication interactions

Advise staying in treatment until social, medical, psychiatric, legal, and family issues are stable.

- ▶ “Detox” therapy has no long-term effect on outcomes
- ▶ Longer duration, higher dose treatment most effective
- ▶ For some patients methadone therapy should be lifelong, as risk of relapse is high after cessation

Pharmacotherapy for Opioid Addiction: **Buprenorphine**

- 2000 Federal Drug Addiction Treatment Act (“DATA-2000”):
 - Made office-based addiction treatment by physicians legal
 - Must complete 8-hour training and obtain federal waiver
- 2002: Suboxone (buprenorphine/naloxone) FDA approved
 - Outcomes much superior to psychosocial treatment alone
 - Longer treatment duration is more effective
- Compared to methadone:
 - Similar abstinence from illicit opioids and decreased craving
 - Lower retention in treatment
 - Can be prescribed in general practice, lowering barriers to treatment

Pharmacotherapy for Opioid Addiction: **Buprenorphine**

- Partial opioid agonist, so safer than methadone
- High mu receptor affinity, so blocks other opioids
- Formulated with naloxone - abuse deterrent
- Sublingual dosing and newer implant (Probuphine)
- Can precipitate withdrawal in tolerant patients
- Requires induction after patient enters mild-moderate withdrawal
- Home induction appears to be safe and effective, widely adopted
- Induction from methadone more difficult (taper to ~30 mg)
- Implant approved for stable patients on ≤ 8 mg buprenorphine



Trial of Buprenorphine

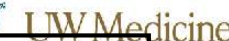
40 people addicted to heroin

Buprenorphine 16 mg/day vs taper + placebo

All received indiv counseling + therapy groups

Followed for 1 year

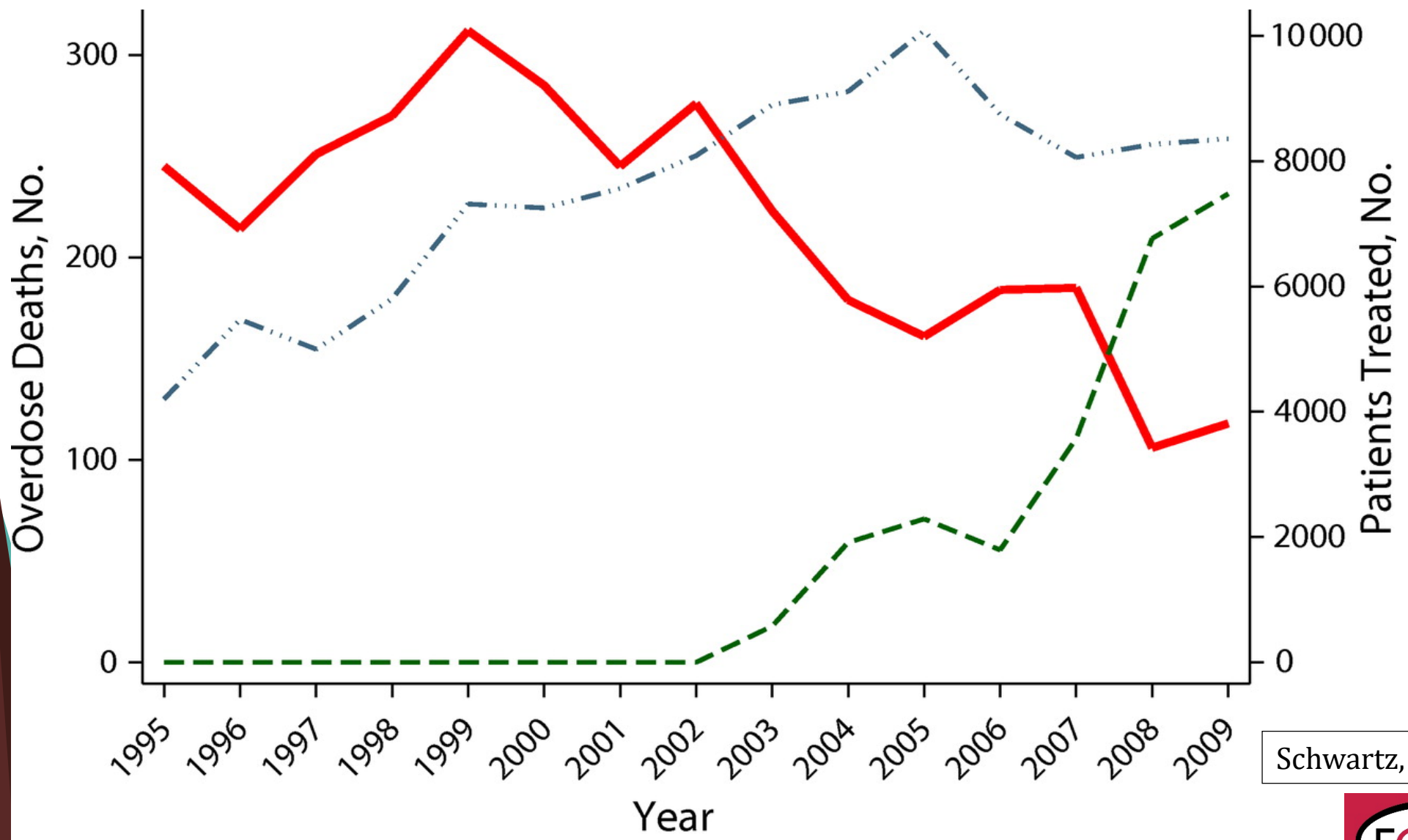
	Buprenorphine 16 mg per day	Placebo
Retained at 1 yr	75%	0
% died	0	20%



Kakko et al, Lancet 2003



L.A. Care
HEALTH PLAN



Schwartz, AJPH, 2012

— Heroin overdoses
 - - - Buprenorphine patients
 - · - · - Methadone patients



Buprenorphine in Primary Care

- ▶ Not widely used in primary care
- ▶ Most prescribers treat few patients, so poor access
- ▶ Barriers in primary care include:
 - ▶ Urgency of scheduling
 - ▶ Induction visit and frequent early follow up (consider home induction)
 - ▶ Urine testing and prescription logistics
 - ▶ Linkages to psychosocial services
 - ▶ Difficult decisions about when to stop or refer
- ▶ Some physicians restrict prescribing to patients who were already in their own practice

Buprenorphine in Primary Care

- Advantages of buprenorphine in primary care:
 - Setting built for chronic disease management
 - Reduces the stigma of addiction treatment
 - Reduced contact with active drug users
 - Facilitates management of mental health and medical co-morbidities and preventive care
 - Important tool when problems arise during chronic opioid therapy
 - Public health benefit: increases local access to lifesaving care
- Highly gratifying form of treatment!

Naltrexone

- ▶ Opioid antagonist that blocks other opioids
- ▶ Does not lead to physical dependence, or to withdrawal when stopped
- ▶ Causes acute withdrawal in opioid-dependent patients
- ▶ Can be used in office-based settings without added training
- ▶ Effective in alcohol use disorder treatment
- ▶ Two formulations available:
 - ▶ Oral ReVia 50 mg PO daily
 - ▶ Injectable Vivitrol 360 mg IM monthly

Naltrexone for Opioid Use Disorder

- Requires opioid abstinence prior to initiation, a major barrier since most treatment-seeking patients are actively using opioids
- Difficult to compare with methadone or buprenorphine (trial underway)
- Russian studies show benefit in population where opioid substitution therapy is not available
- Mixed results in US populations (Cochrane reviews)
- Recent study (Lee, NEJM) in criminal justice population showed short term reduction in opioid relapse compared with “usual care” (not buprenorphine or methadone), and reduction in overdose compared with no medication

Overdose Prevention

- Naloxone (“Narcan”) reverses opioid overdose
- Overdose education and naloxone is an effective harm reduction strategy
- For those at high risk of overdose and their friends or family
- Populations: syringe exchange, exit from jail, in drug treatment, high risk prescribed opioids
- [Prescribe to Prevent educational modules](#)

Need for comprehensive approaches to addiction treatment for AI/ANs

- ▶ Use of evidence-based psychosocial interventions (e.g., motivational interviewing, cognitive behavior therapy)
- ▶ Use of traditional practices (e.g., drumming, beading, attending AI/AN cultural events)
- ▶ Use of community based support networks and groups (A.A., White Bison)
- ▶ AND...
- ▶ Use of FDA-approved medications for alcohol and opioid disorders!

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Thank you for attending!