MAT Roundtable: Lessons Learned from CBHOs Implementing MAT for Opioid Dependence

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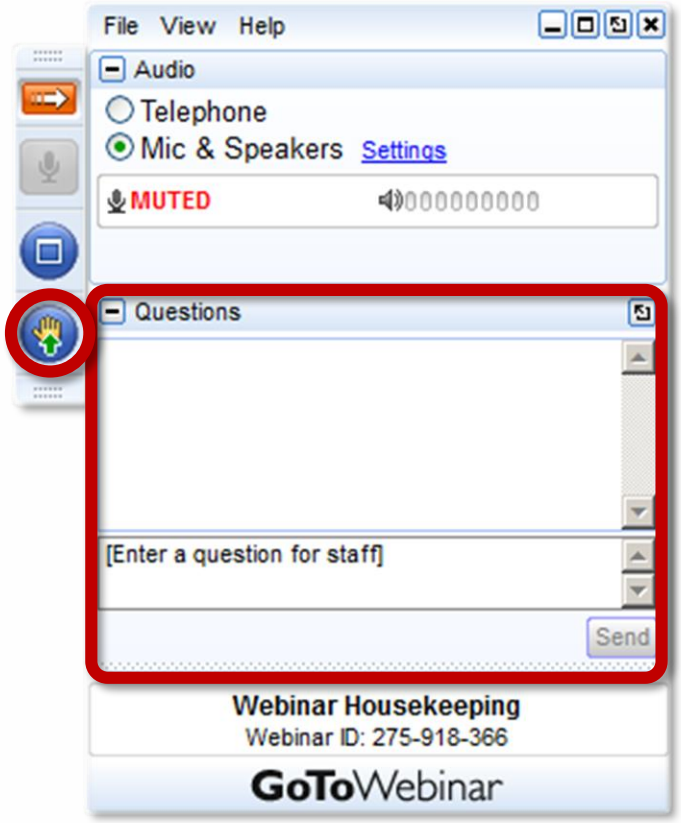
Comments & Questions?



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MAT Roundtable Lessons Learned

Lynn M. Fahey, PhD.
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B C C S
Brandywine Counseling & Community Services
Change is good.

I have no relevant conflicts of interest to disclose

How did we get to MAT Integration

* Addiction is a disease
* Historical link between addiction and the legal system
* Resources dedicated to research for addiction
* Current Cost of addiction

Research

"Treatment can alter the natural history of opiate dependence, most commonly by prolonging periods of abstinence from illicit opiate abuses. Of the various treatment s available, Methadone Maintenance Treatment (MMT), COMBINED with attention to medical, psychiatric, and socioeconomic issues, as well as drug counseling, has the highest probability of being effective." NIH Consensus Panel 1997

Treatment Works!
MAT Works!

* Reduction in the use of illicit substances
* Reduction in criminal activity
* Reduction in needle sharing
* Reduction in HIV infection
* Cost-effectiveness
* Reduction in commercial sex work

MAT Works

* Reduction in number reports of multiple sex partners
* Improvements in social health productivity
* Improvements in health conditions
* Retention in addiction treatment
* Reduction in suicide
* Reduction in lethal overdose

Provider Structure

* Organizational specialties
  * By level of care
  * By population
* Continuum of Care
  * Multiple levels of care
  * Multiple population specialties

How BCCS Got Started

* Part of a Hospital System- Methadone Maintenance Program
* Incorporated 1986
* Expanded into early intervention service offerings during HIV Epidemic
* Through the years added:
  * Prevention Programming
  * Community Based Services
  * Criminal Justice Programs
  * Health Screening
  * Syringe Exchange

BCCS

* Current Treatment Programs
  * 5 outpatient treatment programs all offer IOP level of care and peer support services, medical screenings and physicals, psychiatric evaluations and ongoing treatment
  * 3 Locations provide access to Vivitrol and Suboxone
  * 2 locations provide access to Methadone and Infectious Disease Clinic

BCCS Experience

* Vivitrol- minimal
* Suboxone- Office Based and Through the Opioid Treatment Program – extensive
* Methadone- the Opioid Treatment Program- extensive

Why Suboxone or Methadone?

Typical client Presenting for care: Caucasian male between the ages of 18 and 29. He has been actively addicted to opioids for over two years. He has physical signs of his use – track marks, abscess. Utilizes the Emergency Room for his primary care. He is most often unemployed or underemployed, has a criminal history related to his drug use, has co-occurring disorder, as well as limited positive social support systems. He reports previous treatment episodes (residential treatment facility and had at least one outpatient treatment). May or may not have tried suboxone.

Administrative Challenges

* Qualified Medical Staff
* Not in my back yard (NIMBY)
* Numerous Regulatory Bodies – DEA, State Authority, SAMSHA
* Philosophical values and beliefs of those in the behavioral health field.

Clinical Challenges

* Limited knowledge of MAT – educational curriculums
* High burn out
* Balance between meeting a client where they are and enabling
* Lack of resources for client referrals

Challenges

* Definition of Recovery
* Multiple Substance Use
* Severity of disease

Methadone Myths

The Myth	Fact
Methadone is addicting	Methadone is addicting but NO evidence that it induces addiction Definition of addiction: 1) Tolerance; 2) Withdrawal and 3) Compulsive use in spite of negative consequences- Since widespread use of methadone has begun there has not been a significant population compulsively seeking methadone as a drug of choice.
Methadone is harder to "kick" than heroin	Withdrawal from methadone takes longer than acute withdrawal from heroin

Methadone Myths

Myth	Fact
Methadone is nothing more than another way to get high	Optimal dose of methadone does not produce intoxication; it produces physiological stabilization without heroin's brief cycles of withdrawal distress and impairment related to acute intoxication
Methadone Rots your teeth and bones.	After 50 years of use, methadone remains a safe medication. There are side effects from taking methadone and other opioids, such as constipation and increased sweating. These are usually easily manageable. If patients engage in good dental hygiene, they should not have any dental problems.

Conclusion

Methadone blocks opiate withdrawal symptoms and craving. It does not find a person a job, deal with past trauma or guilt from past actions, and teach a person how to deal with painful emotions or how to relate well to others. These things are only learned in living life free of active addiction. Great methadone programs offer medical and psychiatric care, individual and group counseling and referrals to needed community supports they do not directly provide.

Contact Information

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Gosnold
ON CAPE COD

Implementing Medication Assisted Treatment for Opiate Dependence

SUCCESSES AND CHALLENGES

Raymond V. Tamasi

President/CEO

I have no relevant conflicts of interest to disclose

WHO IS GOSNOLD ON CAPE COD?

- Addiction & Mental Health Provider
  - 175 Beds (Four different Levels of Care)
  - Seven Ambulatory Clinics
    - Outpatient Detoxification
    - Mental Health Treatment (Clinic Based & Tele-psychiatry)
    - Intensive Outpatient Addiction
  - Community Based Services
    - School Based Counseling
    - Recovery Management
    - Overdose Intervention Services
    - Primary Care Integration
  - Prevention

OPIATE DEPENDENCE TREATMENT

- Detoxification
  - Opiate (Suboxone) & Non-Opiate (Clonidine) Protocols
  - 5- 7 Day Protocols
  - 85% “completion” rate
- Post-Detoxification Care Challenges
  - Cravings
  - High Rates of Recurrence
  - Poor Level of Care Transition Rates

RECOVERY MANAGEMENT

- High Recurrence Rates even for Motivated Patients
- Need for Comprehensive Post-Hospitalization Management (Chronic Care Management)
- Recovery Coaches, Technology, Family Engagement and **MEDICATION**

MEDICATION OPTIONS

- Methadone--No, we're not a Methadone Provider
- Suboxone--Yes, but there are problems & more patients requesting withdrawal from the medication
- Injectable Naltrexone (Vivitrol)--Yes, with growing frequency.

FUNCTION AT RECEPTORS—FULL AGONIST

METHADONE

Mu receptor

Full agonist binding …

❶ activates the mu receptor

❷ is highly reinforcing

❸ has the most abuse potential

Function at Receptors: Partial Agonists

SUBOXONE

Mu receptor

Partial agonist binding …

❶ activates the receptor at lower levels

❷ is relatively less reinforcing

❸ has less abuse potential than full agonist

Function at Receptors: Antagonists

NALTREXONE

❶ occupies without activating

❷ is not reinforcing

❸ blocks abused agonists

GOSNOLD AND MAT

- Began Suboxone Management in 2005
- Patient Capacity Limit at Time was 30; we still have 20+ patients on Suboxone
- We began migrating to Vivitrol in 2011
- Have had nearly 1,000 patients on Vivitrol; currently about 150

WHY WE PREFER VIVITROL

- Medication Compliance is not an Issue
- It's not Addictive; not an Opiate
- It's a once a month administration
- Patients report that it reduces cravings
- Not Mood Altering
- No Withdrawal upon Cessation
- Insurance Covers; No "Cash" business as with Suboxone

CHALLENGES WITH VIVITROL

- Patients bypass counseling requirement
- Patient must be free of opiates prior to administration (the “7-10 day gap”)
- Drop Out Rate is Concerning (3-4 Month)
- Possibility of Patient Resuming Opiate Use, Overriding Vivitrol and Overdosing (We know of no overrides with our patients)

ADMINISTRATIVE CHALLENGES

- Pre-Authorization Requirements
- Dealing with Specialty Pharmacy
- Coverage as a Pharmacy or Medical Benefit
- Complicated ordering process

- All of this is going away in Massachusetts

CLINICAL CHALLENGES WITH MAT

- Some clinicians remain opposed to MAT
- Clinicians lack of education about Vivitrol's mechanism of action
- Only 60% MAT adoption rate among addiction treatment providers

HOW LONG TO STAY ON VIVITROL

- Average time on Vivitrol is between 6 months and 2 years
- Some may require it for an indefinite period of time
- Depends on the presence or absence of cravings
- Pace and quality of Recovery Skill Development

End the "…ists" of Medication Assisted

I'm a Harm ReductionIST

I'm an AbstinenceIST

End use of the term "Medication Assisted Treatment"

- It's MEDICATION

Contact Information

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Q & A

Thank you!

Please fill out the post webinar survey.

If you have questions, please send an email to policy@thenationalcouncil.org