Medication-Assisted Treatment of Opioid Use Disorders: Why Community Behavioral Health Organizations (CBHOs) Need to Lead this Effort

Hilary Connery, MD, PhD
Clinical Director
Division of Alcohol and Drug Abuse
McLean Hospital/Harvard Medical School
Disclosures

- No conflicts of interest
- Small royalties from a behavioral treatment manual published by Guilford Press
Opioid Use Disorder: Why MAT?
MOR: site of addiction, site of treatment

7 transmembrane G-protein coupled receptor

Agonist: binds, activates, reduces withdrawal and craving

Antagonist: binds and competitively blocks, psychological reduction of craving

MAT for OUD has Significant Impact
In a Nutshell…

In *treatment-seeking patients*:

1. MAT for OUD doubles opioid abstinence rates in controlled RCTs
2. MAT for OUD reduces opioid overdose while patients remain in treatment
3. MAT for injection OUD reduces use and thereby transmission of HCV, HIV
4. Providing confidential options for MAT for pregnant women with OUD supports prenatal care engagement and postnatal adjustment, and is better for fetal outcomes than untreated OUD

Connery 2015 Harv Rev Psychiatry. 23(2):63-75
MAT for OUD

Agonist treatment: easy to get on, hard to get off
- **Methadone** (full agonist)
- **Buprenorphine** (partial agonist)
- Diversion value, overdose potential
- Good patient engagement/retention

Antagonist treatment: hard to get on, easy to get off
- **Extended-release naltrexone** injection
- No diversion value or overdose potential
- Difficult patient engagement/retention
Optimal antagonist candidates

- Committed to opioid abstinence
- Lower risk for accidental or intentional opioid overdose
- Contingency or clear monitoring for monthly adherence
- No foreseeable need for opioid analgesia
- Not pregnant or planning pregnancy
OUD and Mental Illness: Interactive Burden
Severity of MI Predicts Probability of SUD

![Bar chart](chart.png)

- **Serious Mental Illness (SMI)**: 27.3%
- **Moderate Mental Illness**: 18.9%
- **Low (Mild) Mental Illness**: 15.9%
- **No Mental Illness**: 6.4%

NSDUH, 2013
Men Abstaining from Heroin Use

<table>
<thead>
<tr>
<th></th>
<th>DAY 3</th>
<th>DAY 10</th>
<th>DAY 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>severe</td>
<td>moderate</td>
<td>mild</td>
</tr>
<tr>
<td>Depression</td>
<td>moderate</td>
<td>subclinical</td>
<td>mild</td>
</tr>
<tr>
<td>Craving</td>
<td>high</td>
<td>moderate</td>
<td>mild</td>
</tr>
<tr>
<td>Nasal discharge</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Vomiting</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

OUD and Suicide: Persistent Risk
### Table 1
Attempted suicide histories and current suicidal ideation of heroin users at 11-year follow-up.

<table>
<thead>
<tr>
<th></th>
<th>Male (n=276)</th>
<th>Female (n=155)</th>
<th>All (n=431)</th>
<th>Comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever attempted suicide</td>
<td>36.2%</td>
<td>52.9%</td>
<td>42.2%</td>
<td>OR 1.98 (CI 1.33–2.95)</td>
</tr>
<tr>
<td>Multiple attempts (lifetime)</td>
<td>15.6%</td>
<td>23.9%</td>
<td>18.6%</td>
<td>OR 1.70 (CI 1.04–2.78)</td>
</tr>
<tr>
<td><strong>No. of lifetime attempts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>20.7%</td>
<td>29.0%</td>
<td>23.7%</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>4.3%</td>
<td>5.8%</td>
<td>4.9%</td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td>5.1%</td>
<td>6.5%</td>
<td>5.6%</td>
<td></td>
</tr>
<tr>
<td>Four or more</td>
<td>6.2%</td>
<td>11.6%</td>
<td>8.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male (n=276)</td>
<td>Female (n=155)</td>
<td>All (n=431)</td>
<td>Comparisons</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------</td>
<td>----------------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Recent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within previous 12 months</td>
<td>1.4%</td>
<td>1.9%</td>
<td>1.6%</td>
<td>OR 1.34 (CI 0.30–6.06)</td>
</tr>
<tr>
<td>Within previous 24 months</td>
<td>2.5%</td>
<td>3.9%</td>
<td>3.0%</td>
<td>OR 1.55 (CI 0.51–4.69)</td>
</tr>
<tr>
<td>Within previous 36 months</td>
<td>4.0%</td>
<td>6.5%</td>
<td>4.9%</td>
<td>OR 1.66 (CI 0.69–4.00)</td>
</tr>
<tr>
<td>Current ideation</td>
<td>9.1%</td>
<td>12.9%</td>
<td>10.4%</td>
<td>OR 1.49 (CI 0.80–2.78)</td>
</tr>
<tr>
<td>Current plan</td>
<td>4.0%</td>
<td>4.5%</td>
<td>4.2%</td>
<td>OR 1.14 (CI 0.43–3.00)</td>
</tr>
</tbody>
</table>
MAT, Residential Treatment Improves Long-Term MH
MDD Predicts Poorer Long-Term Outcomes
SF-12 measured changes in physical and mental health

<table>
<thead>
<tr>
<th>Physical health</th>
<th>Mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regression coefficient (β)</strong></td>
<td><strong>95% CI</strong></td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Change over time</td>
<td></td>
</tr>
<tr>
<td>Baseline to 36 months</td>
<td>4.66</td>
</tr>
<tr>
<td>36 months to 11 years</td>
<td>-3.43</td>
</tr>
<tr>
<td>Baseline to 11 years</td>
<td>1.23</td>
</tr>
<tr>
<td>Age</td>
<td>-0.21</td>
</tr>
<tr>
<td>Sex</td>
<td>2.10</td>
</tr>
<tr>
<td>Major depression</td>
<td>-2.58</td>
</tr>
<tr>
<td>ASPD</td>
<td>-1.15</td>
</tr>
<tr>
<td>BPD</td>
<td>-0.74</td>
</tr>
<tr>
<td>PTSD</td>
<td>-1.30</td>
</tr>
<tr>
<td>Maintenance therapy</td>
<td>-0.65</td>
</tr>
<tr>
<td>Detoxification</td>
<td>0.02</td>
</tr>
<tr>
<td>Residential rehabilitation</td>
<td>1.39</td>
</tr>
<tr>
<td>Treatment episodes</td>
<td>0.11</td>
</tr>
</tbody>
</table>
Community Behavioral Health Organizations: a group therapy model of integrated care
Buprenorphine/Naloxone Group

- 80% co-occurring mental illness
- 20% prior suicide attempt
- Similar outcomes in suburban, academic hospital and in FQHCs with predominantly poor, African American and Hispanic patients

Julie Volpe, MD of Community Health Services in Hartford, CT will present poster session at IPS this week
Buprenorphine/Naloxone Group

**Table 1. Structure of Integrated Group Therapy Program**

- Abstinence-based philosophy of treatment
- Admission criteria selects for patients with readiness for abstinence as a long-term goal
  - Attend 4 weeks of BN readiness group + submit weekly urine tox screens positive only for opioids
  - OR complete dual diagnosis residential program
- Patients who fail to meet selection criteria are referred to substance abuse counseling for motivational enhancement, may be offered alternative treatments (methadone or naltrexone)
- Psychiatrist led group and supervised urine tox screens weekly for first 6 mo
  - > 6 months clean – biweekly groups and urine screens;
  - > 1 year clean - monthly groups and urine tox screens
- Adherence to program policies, including submission of supervised urine, is required for receipt of BN
- Weekly group includes check-in procedure on both substance use and symptoms of mental illness that may be affecting recovery
- Leaders actively encourage 12-step and other self help supports + individual therapy as needed
- Patients with repeated relapses are referred to higher levels of care (dual dx residential or IOP/PHP) with option to re-enter BN outpatient program once stabilized.
N= 202 with 28% drop out by 3 months

Significant improvement even if missing urine imputed as opioid +
Discussion
Comments & Questions?
What is PCSS-MAT?

The Providers’ Clinical Support System for Medication Assisted Treatment is a three-year grant funded by SAMSHA in response to the opioid overdose epidemic.

PCSS-MAT is a national training and mentoring program developed to educate healthcare professionals on the use and availability of the latest pharmacotherapies.
The overarching goal of PCSS-MAT is to make available educational and training resources on the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
PCSS-MAT Training Modalities

PCSS-MAT offers no-cost training activities with CME to health professionals through the use of:

- Webinars (Live and Archived)
- Online Modules
- Case Vignettes
- Buprenorphine Waiver Trainings
- One-on-one and Small Group Discussions—coaching for clinical cases

In addition, PCSS-MAT offers a comprehensive library of resources:

- Clinical Guidances and other educational tools
- Community Resources
- Listserv - Provides a “Mentor on Call” to answer questions about content presented through PCSS-MAT. To join email: pcssmat@aaap.org
PCSS-MAT Mentoring Program

- Designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- A national network of trained providers with expertise in medication-assisted treatment, addictions and clinical education.
- 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and designed to the specific needs of both parties.
- The mentoring program is available at no cost to providers.

For more information to request or become a mentor visit: pcsssmat.org/mentoring
PCSS-MAT Program Highlights

- 98 webinars and online modules with 22,399 training participants
- 175 Buprenorphine waiver trainings with 2,768 training participants
- 54 clinicians have participated in Small Group Discussions within mentoring program (new initiative starting 2015)
- 59 mentors and 123 mentees and growing

Mentee Feedback
“I wanted to compliment my Mentor. I sent an email to him with a question…and within four hours I had not only his response but the input of four of his peers. This is a great service for those of us who are stretching the edges of what we would otherwise consider ‘comfortable.’

– William Roberts, MD, Medical Director, Northwestern Medical Center Comprehensive Pain Management

All figures as of 8/20/2015
PCSS-MAT is a collaborative effort led by American Academy of Addiction Psychiatry in partnership with: American Osteopathic Academy of Addiction Medicine, American Psychiatric Association, American Society of Addiction Medicine and Association for Medical Education and Research in Substance Abuse.

For more information visit: www.pcssmat.org
For questions email: pcssmat@aaap.org

Twitter: @PCSSProjects
Fall Webinar Series

MAT Roundtable: Lessons Learned from CBHOs Implementing MAT for Opioid Dependence
November 17, 2015, 12:30 PM ET

During this roundtable, join leaders in community behavioral health – including Lynn Fahey, CEO of Brandywine Counseling and Community Services and Raymond Tamasi, President and CEO of Gosnold on Cape Cod – who will share their organizations’ experiences with successful and replicable models of mental health and MAT integration.

To register, visit: http://www.thenationalcouncil.org/events-and-training/webinars/
For more information, contact Jake Bowling, at JakeB@thenationalcouncil.org

Please find recordings and slides for the following webinars at http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/

MAT and Opioid Use Disorders 101
Making the Case: How MAT Improves MH Care for those with OUDs
Thank you!