Medication Assisted Treatment (MAT) Training

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Trends – Opioid Epidemic
How Did We Get Here?

Ohio #4 in Accidental Overdoses

The Perfect Storm

Pain
Fifth Vital Sign

Cheaper Heroin

Pill Mills Closed

Stricter Regulations with OAARS System

Mexican Cartel

Ohio’s Great Highway System

The Economic Depression
Fentanyl Crisis

Fentanyl
Synthetic and short-acting opioid analgesic
100 times more potent than Morphine
50 times more potent than Heroin
Primary use is for managing acute or chronic pain associated with advanced cancer
As reported in OhioMHAS’News on February 21, 2018, the Ohio Department of Health has issued an advisory on the increase in fentanyl-related overdose deaths involving non-opioids, such as cocaine and methamphetamine. This advisory urges first responders to administer naloxone for all drug overdoses, even when non-opioids are suspected.
Carfentanil is:

- A synthetic opioid used by veterinarians to sedate large animals such as elephants
- NOT intended for human consumption
- Up to 2,500 times stronger than heroin
- Emerged recently in Ohio in areas such as Summit County, Hamilton County, Cuyahoga County and others
- EXTREMELY LETHAL
- Immediate death for many
The Washington Post reported that Ohio is “ground zero” for the drug Carfentanil in the United States.

A tiny dose, a fraction of the weight of a paper clip, could send 500 people to the morgue.
Lethal Dose

2016 Statistics from CDC

• According to the CDC there were 4,050 reported unintentional overdose deaths in Ohio.
Fentanyl Statewide Statistics
ODH 2016

Fentanyl and related drugs were involved in 58.2 percent (2,357) of all unintentional drug overdose deaths in 2016.

In 2015, fentanyl was involved in 37.9 percent (1,155).

In 214, fentanyl was involved in 19.9 percent (503).

The Impact

• On Safety Forces
• On Hospital Systems
• On Corners Office
• On Children & Family Services
• On Court System’s
• On Schools
• On Treatment Centers
• Recovery Homes
Stigma of Addiction

A stigma is defined as a mark of disgrace associated with a particular circumstance, quality, or person. Shame, disgrace, dishonor, humiliation.

Wikipedia, 2018
• The concept of stigma refers to negative stereotypes assigned to a people when their attributes are considered both different from, or inferior to, societal norms.

What are the negative stereotypes assigned to people with a substance use disorder?

Wikipedia, 2018

• There is an extensive body of literature documenting the stigma associated with alcohol and other drug problems. No physical or psychiatric condition is more associated with social disapproval and discrimination than substance dependence.

Drug Policy Alliance
• According to research, the majority of healthcare professionals hold negative, stereotyped views of people who use illicit drugs.

• Stigma is a major factor preventing individuals from seeking and completing addiction treatment and from utilizing harm reduction services such as MAT.

• In a vicious cycle, the social exclusion created by stigma can increase the need for a variety of services.

Drug Policy Alliance

• Decades of research have revealed addiction to be a disease that alters the brain. We now know that while the initial decision to use drugs is voluntary, drug addiction is a disease of the brain that compels a person to become singularly obsessed with obtaining and abusing drugs despite their many adverse health and life consequences.

Drug Policy Alliance
The Disease of Addiction

Science has come a long way in helping us understand how drugs of abuse change the brain. Research has revealed that addiction affects the brain circuits involved in reward, motivation, memory, and inhibitory control. When these circuits are disrupted, so is a person’s capacity to freely choose not to use drugs, even when it means losing everything they used to value. In fact, the inability to stop is the essence of addiction, like riding in a car with no brakes.

Addiction

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.

It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

National Institute on Drug Abuse, 2007
Predisposition for Addiction

- Genetic Factors: Account for about half of the likelihood that an individual will develop addiction.

- Environmental factors interact with the person's biology and affect the extent to which genetic factors exert their influence.

- Resiliencies the individual acquires (through parenting or later life experiences) can affect the extent to which genetic predispositions lead to the behavioral and other manifestations of addiction.

- Culture also plays a role in how addiction becomes actualized in persons with biological vulnerabilities to the development of addiction.

- Other Factors: Stress, trauma, lack of healthy support etc.

- No single factor will determine whether a person will become addicted to drugs or not.

American Society of Addiction Medicine, 2011

Recovery

- Recovery is a process

- Recovery does not always = total abstinence

- The measures that indicate recovery has changed to include improvement in daily living (i.e. not re-offending, not overdosing, no additional communicable disease).

- Recovery can include a MAT regimen
7 MYTHS About MAT

MAT – What it is, Myths, Modalities and Benefits
How do you feel about MAT treatment for Opioid Users?

**MYTH #1:**
**MAT Trades One Addiction For Another**

- **FACT:** MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery.
MYTH #2:
MAT Is Only For The Short Term

• FACT: Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from cessation.

• FACT: Patients with long-term abstinence can follow a slow taper schedule under a physician’s direction, when free of stressors, to attempt dose reduction or total cessation.

National Council for Behavioral Health

MYTH #3:
Many Patients’ Addiction Conditions Are Not Severe Enough to Require MAT

• FACT: MAT utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient.

National Council for Behavioral Health
MYTH #4:
MAT Increases The Risk For Overdose In Patients

• FACT: MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression.

National Council for Behavioral Health

MYTH #5:
Providing MAT Will Only Disrupt and Hinder a Patient’s Recovery Process

• FACT: MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery.

National Council for Behavioral Health
MYTH #6:  
There Isn’t Any Proof That MAT Is Better Than Abstinence

• **FACT:** MAT is evidence-based and is the recommended course of treatment for opioid addiction. The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment.

National Council for Behavioral Health

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MYTH #7:  
Most Insurance Plans Don’t Cover MAT

• **FACT:** As of May 2013, 31 state Medicaid FFS programs covered methadone maintenance treatment provided in outpatient programs. State Medicaid agencies vary as to whether buprenorphine is listed on the Preferred Drug List (PDL), and whether prior authorization is required (a distinction often made based on the specific buprenorphine medication type). Extended-release naltrexone is listed on the Medicaid PDL in over 60 percent of states.

National Council for Behavioral Health
Medication Assisted Treatment (MAT) for opioid addiction is the use of medications such as buprenorphine, naltrexone, and methadone (in combination with counseling and behavioral therapies) to provide a whole-patient approach to treatment.

MAT works to:
- Stabilize brain chemistry
- Block the euphoric effects of opioids
- Relieve physiological cravings
- Normalize body functions

National Council for Behavioral Health

What is MAT?
3 MAT Options

Vivitrol/Naltrexone

Methadone

Suboxone/Subutex

History of Naltrexone/Vivitrol

- Naltrexone has been around for decades as a treatment for those struggling with opioid or alcohol dependence, first in pill form and now as a once-a-month injection marketed under the name Vivitrol.

- In the 1980s naltrexone was only available in the pill form. It became evident that many found it hard to commit to taking pills consistently, especially when they knew that by skipping doses, they will be able to feel high from opioids or alcohol within a couple days.

- The arrival of the extended-release form of naltrexone, Vivitrol, approved in 2006 for alcohol dependence and in 2010 for opioid dependence, eliminated these concerns for those who feared they may have trouble with compliance.
History cont.

- Vivitrol, the extended-release injectable, is recognized as the most effective form of naltrexone – and it does not come cheap at about $1,000 per injection. That single dose, however, provides protection for an entire month and, more importantly, helps users stick with treatment.

- It is an investment that can pay off. A recent study in the Journal of Substance Abuse and Treatment determined that using Vivitrol can actually lead to lower healthcare costs overall, in part because it can decrease the time spent in residential treatment facilities.

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**Naltrexone/Vivitrol for Opioid Use Disorders and Alcohol**

- **Opioid antagonist**
- **Non-addictive**
- **Once monthly injectable**
- **Used with counseling**
- **Has no street value**
- **Requires detox**
What is Vivitrol/Naltrexone?

- Antagonist – blocks opioid receptors interfering with reward effects.
- Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine.
- Naltrexone binds and blocks opioid receptors, and is reported to reduce opioid cravings.
- There is no abuse or diversion potential with naltrexone.

Challenges with Naltrexone/Vivitrol

- Mandatory withdrawal period (recommended 10 days)
- Relapse on another drug (i.e. cocaine)
- Not engaged immediately into treatment
- Opting out of ongoing injections
- Attempts to overcome opioid blockade due to Vivitrol may result in fatal overdose
- Cost
Vivitrol Physical Response

• None if using other opiates or alcohol.

• Can still get high off of other classes of drugs (i.e. stimulants).

• No high effects at all from vivitrol.

• Can overdose if taking other CNS depressants on vivitrol.

Methadone
Methadone

In the 1960s Methadone was found to be an effective and important drug for treating pain as well as drug treatment for heroin addiction. Methadone has sedative effects, and if taken in high doses can create euphoria that can lead to addiction.

Methadone

Methadone is the most highly regulated and controlled area in addiction treatment, and also one of the most highly regulated in all medicine. In the eyes of the public, policy makers, as well as health and social service providers, there is an unfortunate stigma associated with methadone and people who receive Methadone Maintenance Treatment (MMT).
**Methadone Agonist Therapy**

- Activates opioid receptors
- Abuse is possible
- Clients may alternate between opioids and methadone or sell their excess take home supply
- Methadone treatment follows structural procedures such as required daily visits
- Methadone treatment should be considered a longer term treatment because there is a high probability in relapse to opioids if ending treatment in less than a year

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**Methadone**

- It is a synthetic opioid.
- It is a slow releasing synthetic opioid.
- It is taken orally.
- It is mixed with an orange tang mix.
- It begins to take affect within 30 minutes.
- Peak level within 4 hours.
- Its effect can last for 24 to 36 hours.
- Tolerance.

*A 40 to 60 mgs of Methadone can be lethal to a non-tolerant adult.*
Challenges with Methadone

- Methadone has its own special “time-release” mechanism that allows it to remain stored in the liver unchanged and gradually released into the blood as metabolism occurs. Methadone accumulation in the body can result in harmful or toxic levels.

- Interactions between other prescribed medications.

- Take home doses.

- Accidental Overdoses

Methadone

Methadone Physical Response

- Will amplify the high if using another opiate.

- Slight high from the methadone itself but diminishes quickly.

- Methadone can provide an individual with a high for a few reasons. While it provides relief from cravings and blocks the feeling of euphoria, the medication itself has several properties that can allow a high effect.
Methadone

Potentially negative aspects of methadone include:

- A long half-life in the body.
- Ingredients stay in the body after the drug’s effects wear off.
- Possible interactions with other drugs.

Buprenorphine/Suboxone/Subutex
Suboxone began as a pain reliever for treating severe, chronic pain. In very small doses it proved to be more effective than morphine. With a chemical makeup similar to heroin and morphine, its reason for success is that it doesn’t give the patient or user the euphoric feeling that other opioids give.

**Buprenorphine/Suboxone/Subutex**

1. If suboxone is mixed with another opioid, their mutual depressant qualities may exacerbate one another, which can prove fatal, especially in users with respiratory problems.

2. The key difference between suboxone and other opioids is the added naloxone component, which serves to counter the actions of opioid drugs.

3. If a heroin user were to take suboxone simultaneously with heroin, it may send the user into an immediate withdrawal.
**Suboxone/Subutex**  
**Partial Agonist Therapy**
- Activates opioid receptors but produces a diminished response
- Taking central nervous system depressants such as alcohol, sedatives and tranquilizers is really dangerous
- Can be more addictive than the opiates that the patients are trying to get free from
- Although it does not have similar narcotic effects that some opiates have, it does have a lightly nostalgic and calming opiate euphoric effect
- The use of Suboxone has been one of the most controversial issues in the medical history until today
- Diversion of Suboxone
- Doctor weekly, bi-weekly, or monthly visits

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**Buprenorphine Injectable Form**

In November 2017, the Food and Drug Administration approved a monthly injection of buprenorphine, the new product known as Sublocade.

Benefits of the monthly injection may help patients reduce relapses, and possibly dispel misconceptions about the drug’s potential for abuse.
Patients who get Sublocade will receive an abdominal injection administered by a health professional after starting a daily regimen of sublingual buprenorphine tablets for at least seven days.

Sublocade differs from Vivitrol in that it does not require a detox period before patients can receive their first injection.

**Buprenorphine Injectable Form**

**Suboxone Physical Response**

- Synergy effect if used with other opiates.

- While it is an opioid, and it does block pain receptors and induce a mild euphoria, this effect is thought to plateau if large doses are taken, meaning that after a certain amount, it will no longer produce any effect.

- The addition of naloxone to buprenorphine in Suboxone is meant to act as an abuse-deterrent, as naloxone is an opioid agonist.
Suboxone Physical Response

- Suboxone may be abused by individuals battling addiction to a short-acting opioid drug like heroin, by using it in between doses to keep withdrawal symptoms from occurring.

- Suboxone is often called on the street, are more commonly abused for this purpose than to get high. The medication can still produce a euphoric effect, as it still acts on the same opioid receptors in the brain and creates a flood of dopamine in the brain.

Suboxone & Subutex

- The primary difference between Suboxone and Subutex is that one of these medications also contains a substance called “naloxone.” while the other one does not:

- Subutex contains a single active ingredient: buprenorphine (Can be prescribed to pregnant women).

- Suboxone contains two active ingredients: buprenorphine and naloxone
Naloxone

- Naloxone is added to the formulation to keep people from abusing the medication. For example, one were high on heroin and took an intravenous dose of naloxone, they would crash into an immediate state of opiate withdrawal.

- Naloxone works as an opiate antagonist. It will fill the opiate receptors in the brain and it won’t let other drugs activate these receptors, but unlike buprenorphine (which fills and activates receptors) naloxone will not activate opiate receptors. With all receptors full but not activated, a person feels immediate and intense withdrawal pains.

Suboxone

- If Suboxone is taken as directed (by letting the pill dissolve under the tongue) the small amount of naloxone contained within has no noticeable effect. The buprenorphine will travel to the brain, and person will feel relief from withdrawal symptoms.

- If a person attempts to abuse Suboxone by injecting it, the naloxone becomes fully activated and they will go into a full state of withdrawal. This state of withdrawal cannot be reversed by taking heroin or other opiate drugs.

- Unless a person abuses suboxone, there is no functional difference between the two medications. Subutex is sometimes used for the first dose or couple of doses under a doctor’s care, but for continuing use and for a take-home prescription, people are normally prescribed Suboxone.

- If a person decides on buprenorphine treatment, they will more than likely get prescribed Suboxone for continuing use. Unless they abuse the medication to try to get high, then Suboxone will work exactly and equally as well as Subutex.
Benefits of MAT

Medication-assisted treatment of opioid addiction is associated with:

- Decreases in the number of overdoses from heroin abuse.
- Increases retention of patients in treatment.
- Decreases drug use, infectious disease transmission.
- Decreases in criminal activity.

(SAMHSA, 2014)

Benefits of MAT

- Medication-assisted treatments remain grossly underutilized
  - Mostly where stigma and negative attitudes persist among clinic staff and administrators.
  - This leads to insufficient dosing or limitations on the duration of use of these medications.
  - Which often leads to treatment failure.
Opioid Treatment Programs
Comprehensive MAT Program

Detox → Residential (if needed) → Intensive Outpatient Program (IOP) → Outpatient Program (OP) 8 weeks → Aftercare/continuing care groups 10 weeks

Physician Follow ups (as required) → Individual Counseling (Weekly sessions while on MAT) → Psychiatric Care (Monthly sessions or more if required) → 12 Step meetings weekly → Non-Traditional Case Management (Weekly sessions while on MAT)

Medical Care (As required) → Urine Screens (Random weekly while on MAT) → Recovery Housing

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QUESTIONS & ANSWERS

References


References


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