South Carolina Birth Outcomes Initiative Presents:

Treatment Options for Opioid Substance Use in Pregnant and Postpartum Women

September 22, 2016

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South Carolina Hospital Association

continuing medical education and continuing nursing education accreditation and credit

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Nurses who participate in the webinar and complete an evaluation will receive 1.4 contact hours.

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Relevant financial relationships will be disclosed to participants at the webinar. Faculty members are required to disclose off-label/investigative uses of commercial products/devices.

The activity planning committee members have disclosed that they have no relevant financial relationships. There is no commercial support for this activity.

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In order to receive continuing education credit hours, please complete the evaluation that will be sent by email following the webinar.

Nurses will have ability to print their CE certificate upon completion of the evaluation.

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For any questions about continuing education, please contact Monty Robertson by email at Monty.Robertson@scdhhs.gov or by phone at 803-898-3866.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Treatment Options for Opioid Substance Use in Pregnant and Postpartum Women

South Carolina Birth Outcomes Initiative

SCDHHS

September 22, 2016

Disclaimer

Disclaimer: The information in this webinar is for educational purposes only, and is not meant to substitute for medical or professional judgment. Medical information changes constantly. Therefore the information contained in this webinar or on the linked websites should not be considered current, complete or exhaustive.

This webinar is being recorded.

Objectives

- To understand the disease concept of addiction why we use medications to treat opioid use disorder
- To understand the medications utilized and the comprehensive approach for treatment of an opioid use disorder
- To understand the services provided and structure of Opioid Treatment Programs in SC.

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Medication Assisted Treatment in Pregnancy

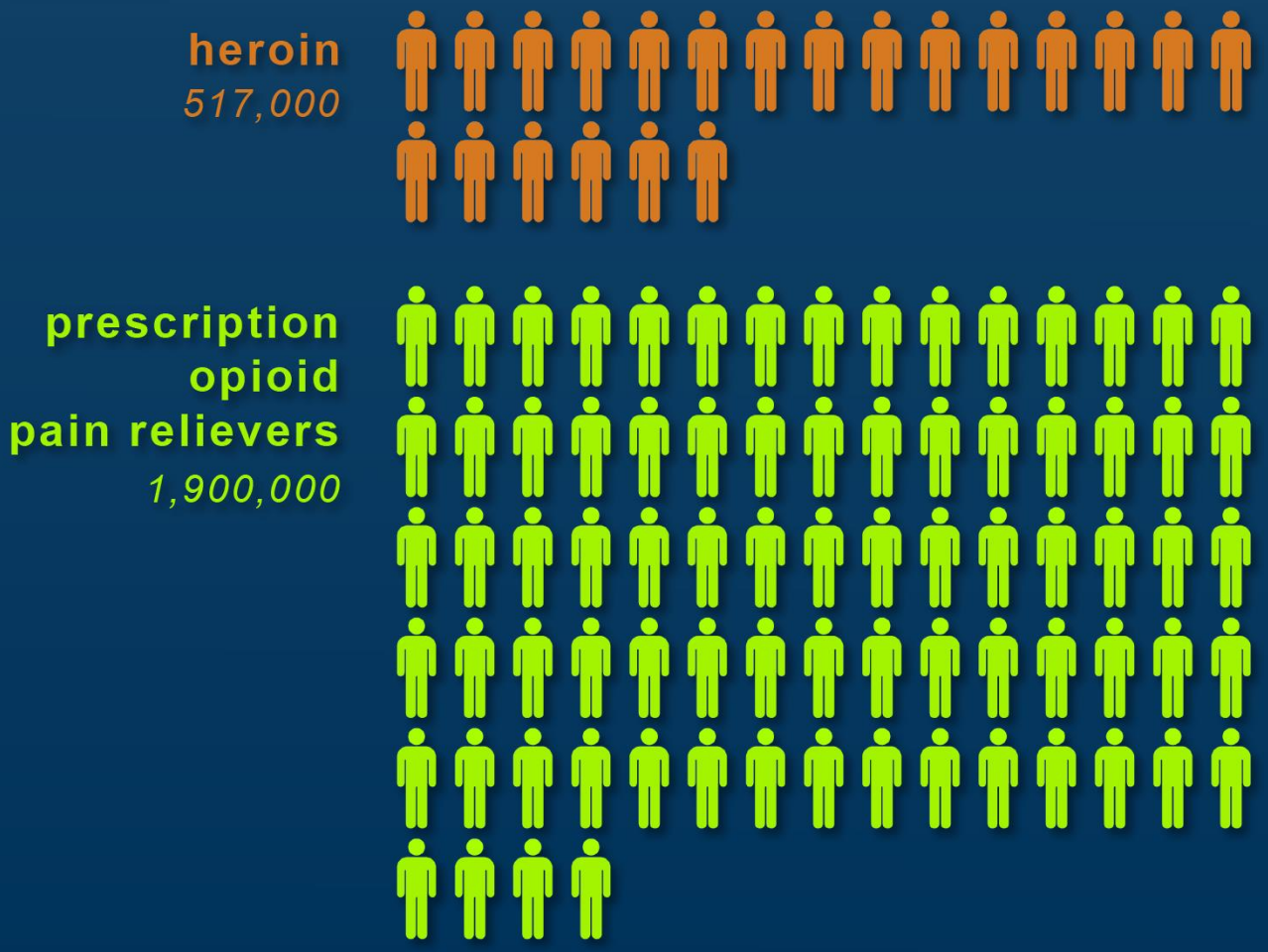
John Emmel, MD
Department of Alcohol and Other Drug Abuse Services

INTRODUCTION

- Today's subject: opioid use disorder
- Opioid drugs used for thousands of years
- Medicine has used them for hundreds of years
- Prescription of opioids regulated since Harrison Narcotic Act of 1914
- People have "misused" opioids for as long as they've been around
- But in the last 15 years: epidemic of opioid addiction

Heroin vs. Prescription Opioids

Drug dependence or abuse in the past year 2013*

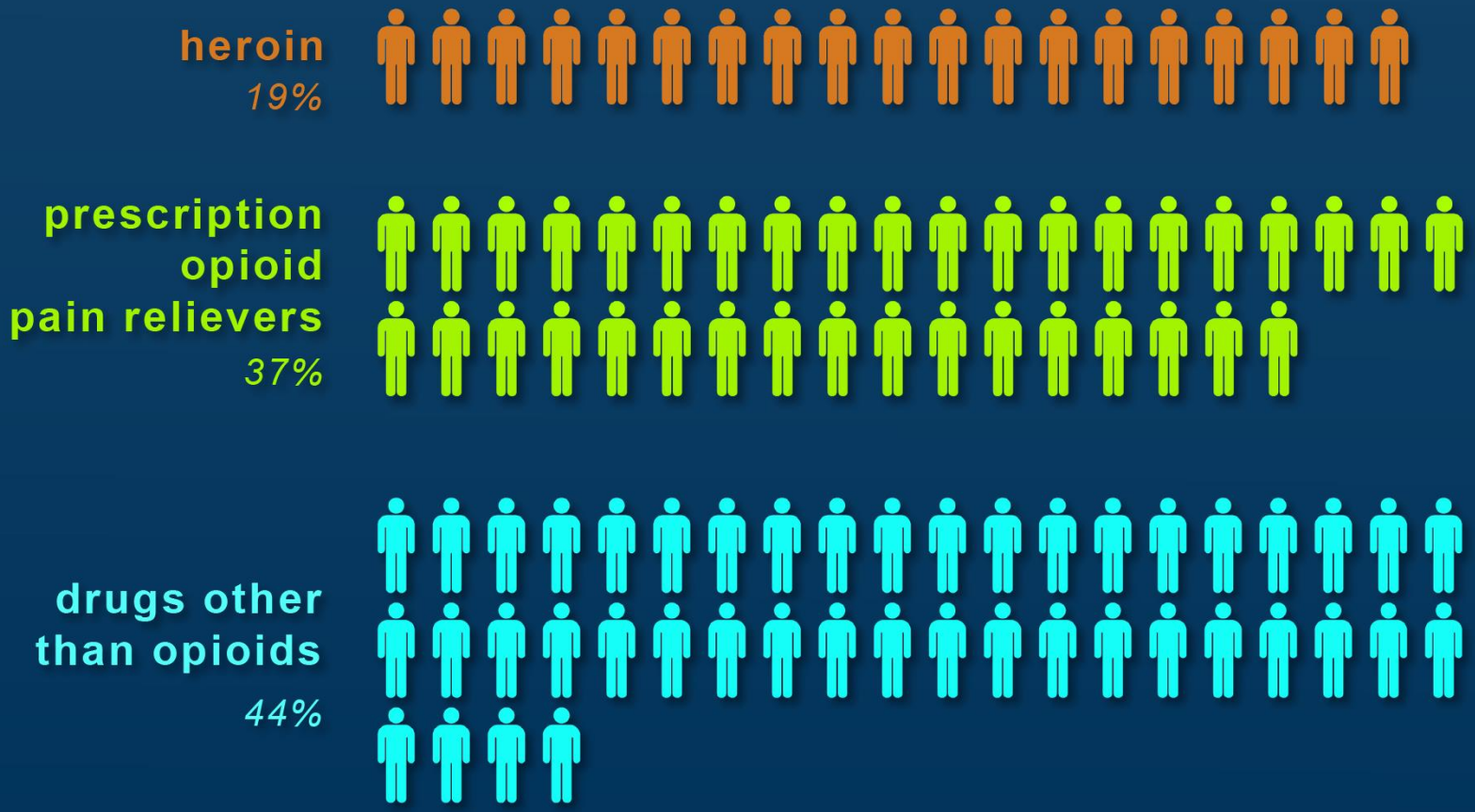


** Note that the terms dependence and abuse as used in the NSDUH are based on the diagnostic categories used in DSM-IV; in the DSM-V, those categories have been replaced by a single Substance Use Disorder spectrum.*

Source: National Survey on Drug Use and Health (NSDUH)

ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

2013 Overdose Deaths in the U.S.



43,982 deaths from all drug overdoses in 2013

source: National Center for Health Statistics at the CDC

ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

Treatment Gap

Use of pain relievers or heroin in the past month 2012

28% ≈ *1.5 million*
opioid and heroin patients receiving medications *

72% ≈ *3.7 million*
no treatment received

5,197,000 total users surveyed

**Number of individuals receiving buprenorphine or naltrexone from IMS plus number of patients receiving methadone from NSSATS. Source: IMS Total Patient Tracker, September 2014 and SAMHSANSSATS. Buprenorphine data exclude forms indicated for pain. Oral naltrexone factored for opioid dependence use. Methadone patients from SAMHSA, N-SSATS 2012.*

ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

Contributors to the epidemic

Human “nature”/genetics

Availability of Rx opioids, at least partially due to the “enlightening” of physicians in the late 1990s about our inadequate treatment of pain, accompanied by unprecedented pharmaceutical company marketing of opioids

Availability of purer heroin, making intranasal use an effective route of use, which vastly increased the number of willing users

Nomenclature

- DSM-I through IV: opioid use, misuse, abuse, dependence
- Addiction
- DSM 5
- Opioid use disorder
- The “disease” debate
- Lawyers and doctors agreed publically in the 1950s that alcoholism is a disease

Addiction the Disease

- A disease OF the brain
- Chronic
- Treatable
- Not curable
- Can be fatal if not treated

Alan Leshner, Ph. D. 1998, then Director of NIDA

- The brain of someone addicted to drugs is a changed brain; it is qualitatively different from that of a normal person in fundamental ways, including gene expression and responsiveness to environmental clues

Leshner (cont)

- Just as depression is more than a lot of sadness, drug addiction is more than a lot of drug use. The addict cannot voluntarily move back and forth between abuse and addiction because the addicted brain is, in fact, different in its neurobiology from the nonaddicted brain.

Chronic Disease

- Once you have it, you've got it
- "Disease" implies there is a "medical" component
- Causes are usually multifactorial
- Treatments must usually be multi-modal
- Response rates are variable and depend on the patient, the treatment itself, and outside factors

Drug Dependence, a Chronic Medical Illness

- Title of an article in JAMA, Oct 4, 2000, Vol. 284, no. 13, pp 1689-1695
- Compares drug dependence to type 2 diabetes, hypertension, and asthma
- Genetic heritability, personal choice, and environmental factors are comparably involved
- Medication adherence and relapse rates similar across these illnesses

Chronic Disease Comparison

Diabetes

- Genetic predisposition
- Lifestyle choices are a factor in development of the disease
- Severity is variable
- There are diagnostic criteria
- Once diagnosed, you've got it

Addiction

- Genetic predisposition
- Lifestyle choices are a factor in development of the disease
- Severity is variable
- There are diagnostic criteria
- Once diagnosed, you've got it

Disease Comparison (cont.)

Diabetes

- Primary treatment is lifestyle modification
- Small percentage of patients comply with same
- Medications can help
- Patients often don't comply with medical regimen

Addiction

- Primary treatment is lifestyle modification
- Small percentage of patients comply with same
- Medications can help
- Patients often don't comply with medical regimen

Disease Comparison (cont.)

Diabetes

- Patients who are partially compliant are the rule, and outcomes are better than those who do not get treatment
- Support systems improve outcomes

Addiction

- Patients who are partially compliant are the rule, and outcomes are better than those who do not get treatment
- Support systems improve outcomes

Disease Comparison (cont.)

Diabetes

- Since suboptimal patient compliance is expected, medication use is titrated to maximize outcome

Addiction

- Since suboptimal patient compliance is expected…….wait till motivated? let them do more "research"? withhold medication till they try harder?

Disease Comparison (cont.)

Diabetes

- Even in highly motivated patients, only a small percentage will succeed without medication. "Abstinence" from medication is lowest priority

Addiction

- Abstinence is still often the primary goal, without which treatment (and the patient) is judged a failure???

Conclusion

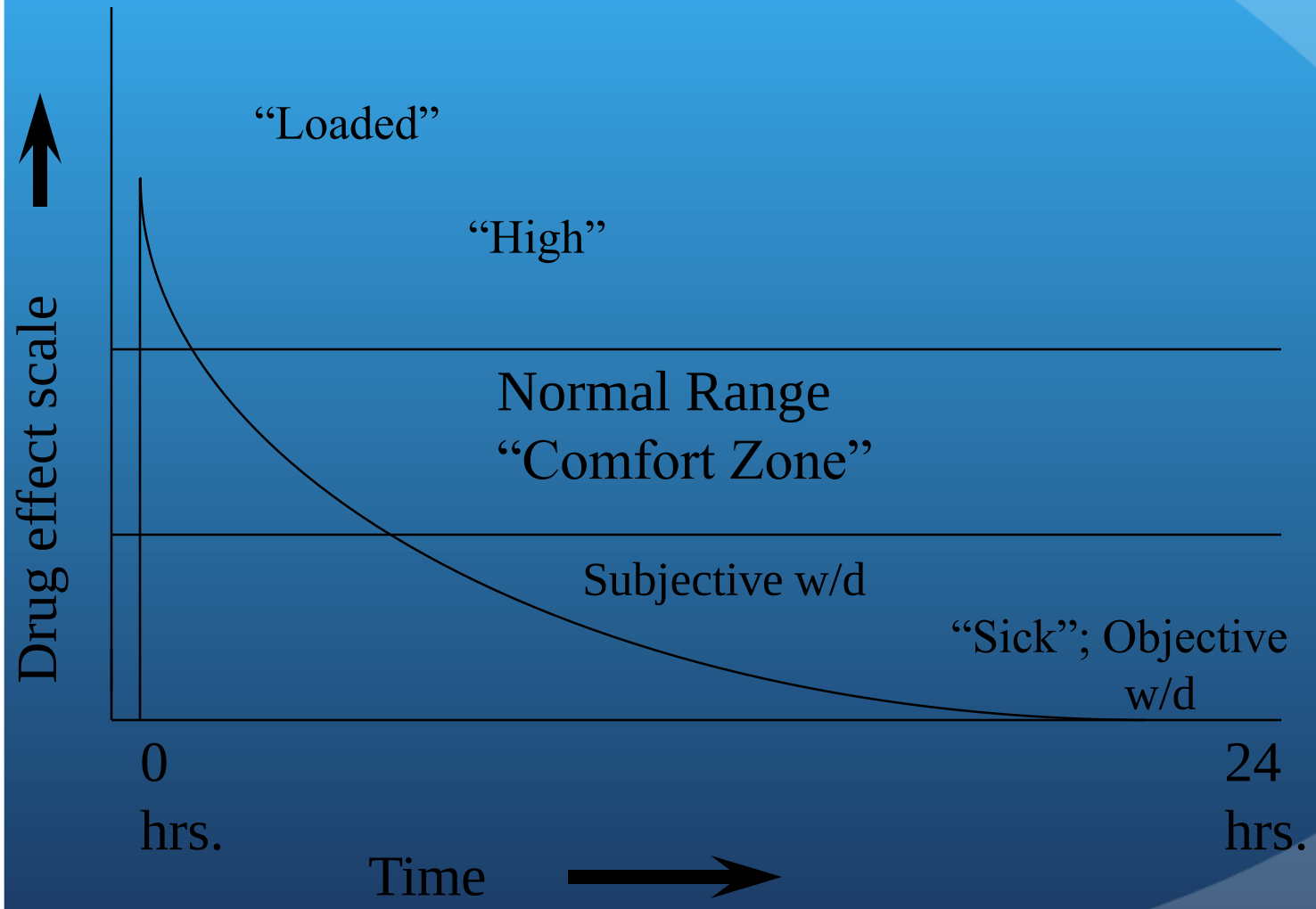
- Chronic disease may be controllable, but not usually curable
- Medications, if available, are useful to promote this “disease control”
- Results will be suboptimal
- There is a “disconnect” between treatment of addiction vs. other chronic diseases

Medication Assisted Treatment

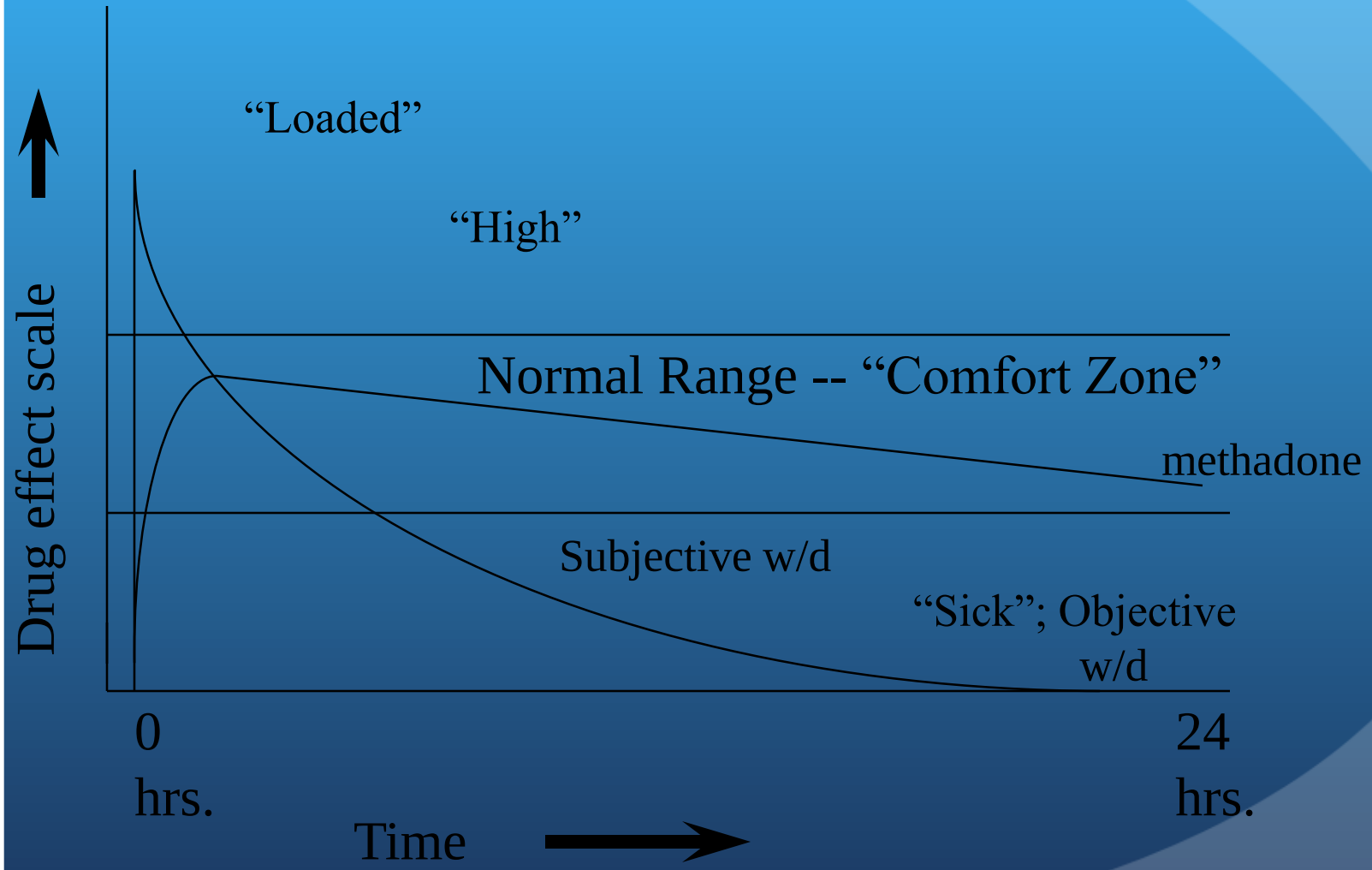
In this context, MAT means:

Opioid Maintenance Treatment (OMT)

Heroin-Simulated 24-Hr. Dose/Response



Methadone 24 Hour……..at Steady State



Why Opioid Maintenance?

Theory

- Stable brain levels eliminate alternating euphoria and withdrawal that encourage continued use

Reality

- Opiate-dependent patients rarely report euphoria after use, or craving at 24 hr.

Why Opioid Maintenance?

Theory

- Hence, long-acting opioids are less reinforcing, reducing abuse potential

Reality

- Patients' "illicit" use of methadone or buprenorphine is primarily to "hold" them until they can get more short-acting opiates. Use of these substances rarely meets DSM-IV abuse or dependence criteria

Why Opioid Maintenance?

Theory

- These stable levels appear to allow a “repair” or “return toward normal” of opioid receptor systems in the brain

Reality

- Research confirms “improved” opioid systems, including, e.g., the hypothalamic-pituitary-adrenal axis, which affects stress response, immunity, and other systems

Why Opioid Maintenance?

Theory

- Given the foregoing, the phrase “just substituting one drug for another” completely fails to capture the idea

Reality

- In fact, patients stabilized on methadone or buprenorphine, “look” more like normal non-addicted individuals, both psychometrically and in their behaviors

Why All the Negative Press?

- Continued social stigma attached to addiction, especially if you're pregnant
- Continued stigma on the part of the treatment community---outcomes-based science still has not yet replaced ideology
- Opiate-addicted individuals, especially if they are pregnant, stigmatize themselves, believing they are "guilty"

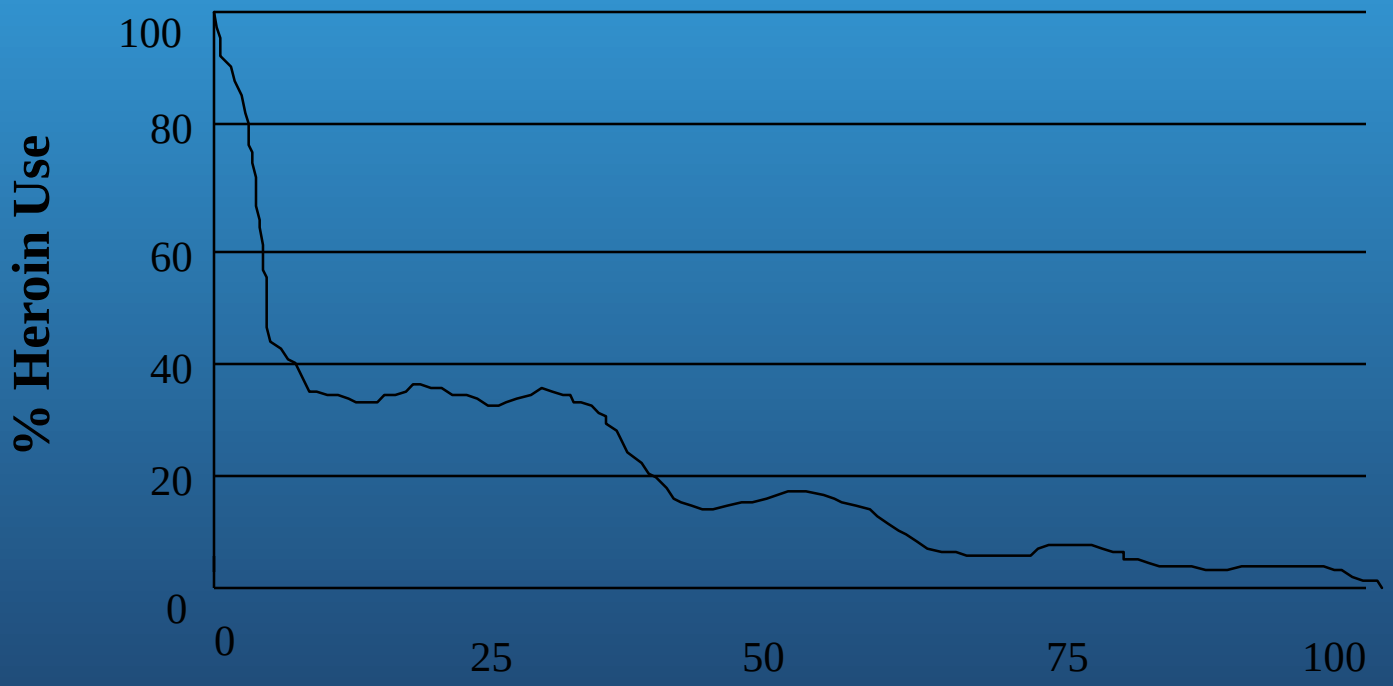
Correlates of Good Outcomes in Opioid Maintenance

- Adequate dosing
- Length of retention in treatment (this is true for all addiction treatment services)
- Consistent therapeutic relationship with a single counselor
- Psychosocial services, including psychiatric evaluation and treatment when needed

Towards a Better Opioid Maintenance Program

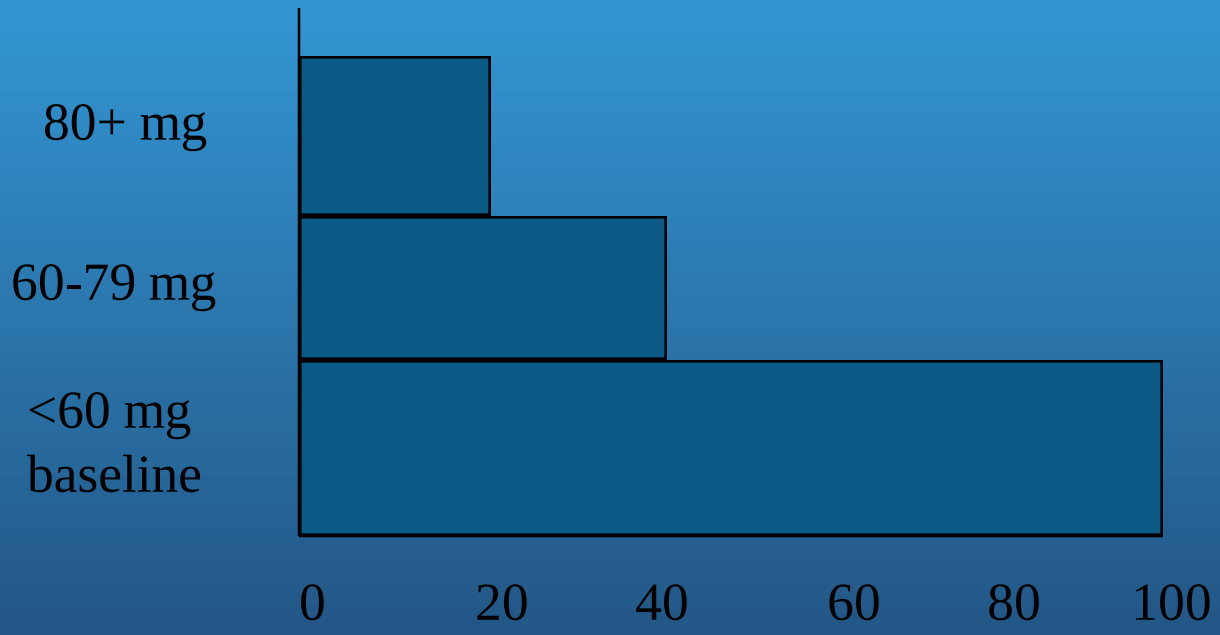
- Dosing should be individualized
- Usually doses of methadone will be 80-120mg., but could be as low as 20 mg. or as high as several hundred mg. Doses of buprenorphine will be 8-24mg
- Methadone serum levels are useful (we use blood levels of meds in many other areas of medicine to assure adequate therapeutic effect); no bup levels readily available yet

Recent Heroin Use by Current Methadone Dose



adapted J. C. Ball, 11/18/88

Risk of Leaving Treatment Relative to Dose



Adapted from Caplehorn and Bell
Med. J. of Australia

Medications

- Methadone is a pure opioid agonist: the higher the dose the greater the effect
- Buprenorphine is a partial agonist: after a certain dose, more does NOT give more effect
- Thus, in more severe opioid dependence, buprenorphine may not have an adequate opioid replacement effect, compared with methadone
- Buprenorphine is not approved for pregnancy, but research is favorable and it is now used often

Medications (cont)

- Methadone can only be given in federally licensed programs; rules are strict, which can create barriers; patient monitoring is frequent, which helps compliance and retention
- Buprenorphine can be given in a typical office setting if the physician has training and a federal waiver; rules are minimal, which can help access to treatment; but monitoring is less, allowing more misuse and easier relapse

Pregnancy Considerations

- Misuse of short-acting opiate drugs is associated with complications: miscarriage, infections, premature delivery, low birth weight and others
- Other factors influence outcomes: access to prenatal care, socioeconomic status, use of nicotine/alcohol/non-opiate drugs, and other factors

(Cont)

- Relapse to opiate drugs after a detoxification (medically supervised withdrawal) is >90%
- After decades of research, the standard of care is: methadone maintenance treatment through pregnancy
- Measurable/treatable neonatal abstinence syndrome is preferable to fetal abstinence syndrome
- Buprenorphine appears to be equal in efficacy and is often used in current practice

Pregnancy: Proper Dose

- Individualized
- Methadone dosing may need to be higher later in pregnancy due to increased volume of blood and tissue distribution; split dosing is advisable at times
- It's not how many milligrams go down the throat, but rather what gets to the brain and how long it stays there that matter
- Patient report of effectiveness is generally reliable in adjusting dose

Medically Supervised Withdrawal During Pregnancy?

- Not advised due to high risk of relapse
- But patients may (1) refuse meds, (2) not tolerate meds, (3) have financial or geographic barriers to getting meds
- Slow taper in second trimester is advised, avoiding increased chance of miscarriage in the first trimester and premature labor in the third
- Can use methadone or buprenorphine
- Should have some type of fetal monitoring, even if just instructions to mother about fetal activity

Outcomes

- Applies to methadone-maintained mothers, but probably applies to buprenorphine
- May have slightly lower birthweight/head circumference than non-drug using, but still better than illicit opiate users
- Ultimate development, when other variables are taken into account, no different than normal
- Neonates are NOT ADDICTED

NAS (neonatal abstinence syndrome)

- Neonatal abstinence syndrome may occur, but often does not, exact frequency uncertain
- Occurrence/severity not consistently correlated with maternal dose of med
- Occurrence/severity may be improved when neonate stays in room with mother vs NICU placement
- Treatment, e.g., weaning with meds, prevents complications
- AAP says morphine or methadone are preferred. Buprenorphine may be a future possibility. Phenobarbital and clonidine are adjunctive

Breastfeeding

- Benefits outweigh any potential problems
- Methadone and buprenorphine show minimally in breast milk, not shown to cause any developmental issues.
- Withdrawal appears to be ameliorated
- Unclear whether this small quantity of medication or the act of breastfeeding itself is the beneficial factor

Conclusion

- Opiate dependent pregnant patients should be encouraged to use MAT, i.e., opioid maintenance treatment for the duration of pregnancy
- Supervised medical withdrawal remains an option for some, currently advised to be accomplished in the second trimester
- As an additional thought, the stressful post-partum period is likely not an optimal time to wean the mother from MAT

Medication Assisted Treatment in Pregnancy

John Emmel, MD
Department of Alcohol and Other Drug Abuse Services

Jonas Coatsworth, MA, LPC, CAC-II

President

South Carolina Association for the Treatment of Opioid Dependence (SCATOD)

What is an Opioid Treatment Program (OTP)?:
Introduction and Basic Principles of Treatment

W. Jonas Coatsworth MA, LPC, CAC-II

President

South Carolina Association for the Treatment of Opioid Dependence (SCATOD)

Goals for Webinar

Goals:

1. To increase the understanding with the use of Medication Assisted Treatment (MAT) within an Opioid Treatment Program (OTP) modality to treat opioid use disorders.
2. To increase insight into the history, services provided, and nuances of this modality of care.
3. To identify what constitutes effective treatment for an opioid use disorders.
4. To gain understanding with the use of MAT for pregnant women and post-partum.
5. To review some of the myths/stigma that exist with MAT for opioid use disorders.

Terminology

Addiction vs. Substance Use Disorder

Addiction is the term most heard in popular culture to describe what we know call a substance use disorder.

Substance Use Disorder (SUD) is the term recently devised by the American Psychiatric Association (APA) in 2013. It is used in the fifth version of the Diagnostic and Statistic Manual (DSM-V) that replaced the diagnostic terms used for years, substance abuse and substance dependence.

Program vs. Clinic

Methadone clinic was the terminology for what we refer to as Opioid Treatment Program today.

Addiction vs. Physical Dependence

What is the South Carolina Association for the Treatment of Opioid Dependence (SCATOD)?

- SCATOD serves as the designated affiliate organization in South Carolina for the American Association for the Treatment of Opioid Dependence (AATOD).
- AATOD works with federal and state agency officials concerning opioid treatment policy throughout the United States. AATOD represents over 1000 OTP's in 30 states across the country, as well as, the District of Columbia and Mexico.
- The Association also convenes conferences on an 18-month cycle. These conferences focus on evidence-based clinical practice, current research breakthroughs, and organizational developments affecting the current and future opioid treatment system.
- AATOD is also embarking on a major Medicaid reimbursement utilization initiative in 2016, focusing on 17 states that currently do not provide Medicaid reimbursement to OTPs for the use of any medications and services in treating opioid addiction.

What is the South Carolina Association for the Treatment of Opioid Dependence (SCATOD)?

- There are 20 OTP's in the state of South Carolina and 18 of those are members of SCATOD.
- http://dpt2.samhsa.gov/treatment/directory.aspx
- The intent and purpose of the association is to promote:
  1. Goodwill and cooperation among its members
  2. The growth and development of Opioid Treatment Programs (OTP's)
  3. Education of the general public in its understanding of Opioid Use Disorder and the medications utilized for treatment for Opioid Use Disorder
  4. Collaborative relationships with other behavioral health agencies, community partners, and medical providers to enhance the quality of patient care in the provision of services to patients and their families

What is the South Carolina Association for the Treatment of Opioid Dependence (SCATOD)?

BHG XXXIX, LLC dba BHG Aiken Treatment Center	*410 University Parkway*	*Aiken*
Southwest Carolina Treatment Center, LLC	*341 W. Beltline Blvd.*	*Anderson*
Department of Alcohol and Other Drug Abuse Services of Charleston County	*5 Charleston Center Dr.*	*Charleston*
Crossroads Treatment Center of Columbia	*1421 Bluff Road*	*Columbia*
Palmetto Carolina Treatment Center	*325 Inglesby Parkway*	*Duncan*
Recovery Concepts of the Carolina - Upstate	*1653 E. Main St.*	*Easley*
Starting Point of Florence	*1341 N. Cashua Drive*	*Florence*
Metro Treatment of South Carolina, LP	*377 Rubin Center Drive*	*Fort Mills*
Greenville Metro Treatment Center	*602 Airport Rd.*	*Greenville*
Crossroads Treatment Center of Greenville, PC	*157 Brozzini Court*	*Greenville*

Phoenix Center Medication Assisted Treatment Program	**130 Industrial Drive**	**Greenville**
Greenwood Treatment Specialists	**110 Court Avenue West**	**Greenwood**
Starting Point of Darlington	**1451 Retail Row**	**Hartsville**
Center of HOPE of Myrtle Beach, LLC	**104 George Bishop Pkwy.**	**Myrtle Beach**
Center for Behavioral Health South Carolina, Inc.	**2301 Cosgrove Ave., Suite F**	**North Charleston**
Crossroads Treatment Center of Charleston, PC	**2470 Mall Drive,**	**North Charleston**
Recovery Concepts, LLC	**124A Boardwalk Drive**	**Ridgeland**
Crossroads Treatment Center of Seneca	**209 Oconee Square Drive**	**Seneca**
BHG XXXVIII, LLC dba BHG Spartanburg Treatment Center	**239 Access Road**	**Spartanburg**
Metro Treatment of South Carolina	**421 Capitol Square**	**West Columbia**

Brief History of MAT for Opioid Use Disorder

- After WWII, America came into control of the medication, which the American pharmaceutical company Eli-Lilly began manufacturing under the brand name Dolophine in 1947.
- By the 1950s, American doctors were using methadone for the treatment of opioid dependence, but doctors still poorly understood how best to use this new medication for addiction treatment.
- In the 1960s, Vincent Dole, M.D., of Rockefeller University, won a New York City Health Research Council grant to study heroin addiction treatments. It was Dole who eventually developed the modern methadone protocol of a single daily dose.

Brief History of MAT for Opioid Use Disorder

- In 1971, Nixon ordered the creation of the first federal program for methadone treatment of opiate addiction
- By 1971, Dole's methadone treatment program was in use by 25,000 opiate addicts. But by 1973, controversy over the medication program (which critics dismissed as just switching one addiction for another) led to strict government controls over the prescription and use of methadone – controls that exist to this day.
- Narcotic Addiction Treatment Act 1974

Brief History of MAT for Opioid Use Disorder

- 1972-2001 FDA regulated OTP's
- Drug Addiction Treatment Act 2000
- 3 current FDA-approved medications
- Current/Future focus with increasing access to MAT in OTP's
  - Innovative models within states
  - Increasing access in jails, drug courts
  - Addressing stigma with CPS and criminal justice systems

OTP Data

Demographics…slightly more male, than female

Substance Use Trends…rise in heroin admissions

Efficacy of MAT… (Charleston Center)

Benefits of OTP's…Structure

Barriers…Financial and Physical

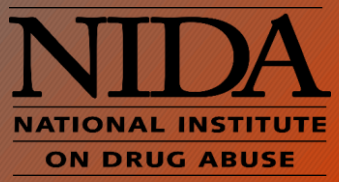
Regulation of Opioid Treatment Programs

- In the United States, the treatment of opioid dependence with medications is governed by the Certification of Opioid Treatment Programs, 42 Code of Federal Regulations (CFR) Part 8.
- This regulation created a system to accredit and certify opioid treatment programs (OTPs).
- OTPs provide medication-assisted treatment (MAT) for people diagnosed with an opioid-use disorder.
- MAT patients also must receive counseling, which can include different forms of behavioral therapy.
- The provisions of 42 CFR 8 enable DPT to focus its oversight efforts on improving treatment rather than solely ensuring that OTPs are meeting regulatory criteria.
- The regulation also preserves states' authority to regulate OTPs. Oversight of treatment medications used in MAT remains a multilateral system involving states, SAMHSA, the Department of Health and Human Services (HHS), and DEA.

Regulation of Opioid Treatment Programs

- SAMHSA's Division of Pharmacologic Therapies (DPT), part of the SAMHSA Center for Substance Abuse Treatment (CSAT), oversees the certification of OTPs.
- OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body to dispense opioid treatment medications.
- All OTPs also must be licensed by the state in which they operate and must register with the Drug Enforcement Administration (DEA), through a local DEA office.
- In South Carolina, the Department of Health and Environmental Control (DHEC) regulates OTP's in conjunction with clinical oversight from the State Opioid Treatment Authority (SOTA).
- The Board of Pharmacy also regulates the pharmacy within OTP's.

Definitions of a Substance Use Disorder: National Institute of Drug Abuse (NIDA, 2009)



People use substances for a variety of reasons. It becomes drug abuse when people use illegal drugs or use legal drugs inappropriately. This includes the repeated use of drugs to produce pleasure, alleviate stress, and/or alter or avoid reality. It also includes using prescription drugs in ways other than prescribed or using someone else's prescription.

Addiction occurs when a person cannot control the impulse to use drugs even when there are negative consequences—the defining characteristic of addiction. These behavioral changes are also accompanied by changes in brain functioning, especially in the brain's natural inhibition and reward centers.

Definitions of a Substance Use Disorder: National Institute of Drug Abuse (NIDA, 2009)

Definition:

1. Complex illness characterized by intense, and at times, uncontrollable drug craving, along with compulsive drug seeking, and use that persists even in the face of devastating consequences
2. Although use may start voluntarily, over time a person's ability to choose to not to do so becomes compromised then seeking and consuming the drug becomes compulsive
3. This behavior largely results from the effects of prolonged drug exposure on brain functioning
4. Addiction is a brain disease that affects multiple brain circuits, including those involved with reward and motivation, learning and memory, and inhibitory control over behavior
5. Progressive, chronic, and treatable
6. Biopsychosocial…and spiritual

Definitions of a Substance Use Disorder: American Society of Addiction Medicine (ASAM)

Short Definition of Addiction:

1. Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

2. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Diagnosis of a Substance Use Disorder DSM-V

The new DSM describes a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The substance is often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.

3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

4. Craving, or a strong desire or urge to use the substance.

5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.

Diagnosis of a Substance Use Disorder DSM-V

7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.

8. Recurrent use of the substance in situations in which it is physically hazardous.

9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

10. Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    - A markedly diminished effect with continued use of the same amount of the substance.

11. Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for that substance (as specified in the DSM- 5 for each substance).
    - The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

The substance use disorder is further classified mild, moderate, or severe depending on the amount of symptom presentation

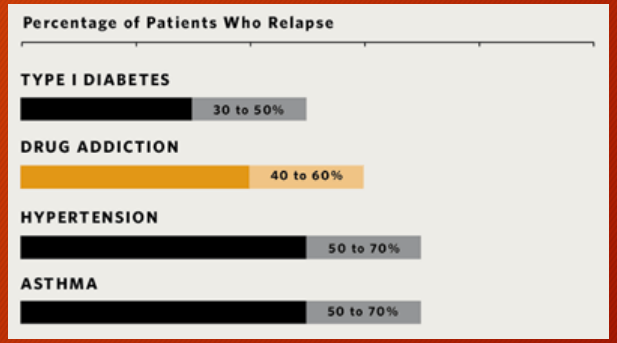
Chronic Disease Model of Addiction

A SUD is a lot like other diseases (diabetes, heart disease, asthma, etc.) where there is a disruption in normal, healthy functioning to an underlying organ (the brain), has serious consequences, it is preventable and treatable, and if left untreated it will last a lifetime.

Within the OTP system, the general practice is to treat a SUD as a treatable, chronic, progressive disease with biological, psychological, and social components…otherwise referred to as biopsychosocial. Treatment and recovery also encompass a biopsychosocial philosophy to address the needs of the patient/client. We also understand that relapse is often a part of the recovery process and help patients/clients work on recovery management (relapse prevention) throughout the treatment process.

Chronic Disease Model of Addiction: Relapse

- Relapse rates people with a SUD can be compared with those suffering from other chronic diseases like diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, a substance use disorder should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.



- Source: McLellan et al., JAMA, 284:1689-1695, 2000

Relapse

Does relapse or a return to substance use mean that treatment has failed or someone is incapable of a change?

No!

The chronic nature of addiction means that relapsing to drug use is, not only possible, but also likely.

Treatment of chronic diseases involves changing deeply imbedded behaviors. For the addicted patient, lapses back to drug use indicate that treatment needs to be reinstated or adjusted, or that alternate treatment is needed (NIDA, 2009).

Biopsychsocial Model of Addiction

Biological factors

There is evidence that some people inherit a higher risk of substance use disorder than others.

Psychological factors

Any powerfully rewarding experience encourages a person to repeat the experience. There are many aspects of behaviors associated with a substance use disorder—including the rituals, the environmental factors, and the thoughts and feelings that are involved—that can help us understand "addictive" behaviors.

Social factors

Addictions are strongly shaped by our relationships with other people (family, friends), what we see around us (media) and by interpersonal processes.

Opioid Overdose

Opioid overdoses are mostly accidental and happen most commonly when someone has abstained from the substance long enough for the tolerance to lower, then a return to use at a previous amount causes death.

Potentially fatal when combined with other CNS depressants, especially alcohol and benzodiazepines (Xanax, Valium, Klonopin, and Ativan).

High prevalence of Intravenous (IV) route of administration which leads to an increased risk for infectious diseases (HIV, Hepatitis C).

Principles of Effective Treatment (NIDA, 2009)

- ✓Addiction is a complex, but treatable disease, that affects brain function and behavior.
- ✓No single treatment is appropriate for everyone.
- ✓Treatment needs to be readily available.
- ✓Effective treatment attends to multiple needs of the individual and not just the substance use.
- ✓Remaining in treatment for an adequate period of time is critical.

Principles of Effective Treatment (NIDA, 2009)

- ✓Counseling, individual and/or group, and other behavioral therapies are the most common forms of substance use disorder treatment.
- ✓Medications are an important part of treatment, especially when combined with counseling and other behavioral therapies.
- ✓Treatment and services must be evaluated continually and modified as necessary to ensure it is meeting the changing needs.
- ✓Many individuals with a substance use disorder also have a mental health issue (co-occurring disorders).

Principles of Effective Treatment (NIDA, 2009)

- ✓Medication-assisted detoxification is only a first step and does little to address a long-term substance use disorder by itself.
- ✓Treatment does not need to be voluntary to be effective.
- ✓Substance use must be monitored continually through treatment as relapses do occur.
- ✓Treatment programs should monitor for HIV, TB, Hepatitis B and C, and other infectious diseases in order to reduce risk and modify/change behaviors.

OTP: SCREENING AND INTAKE

Before an appointment is scheduled…..

- Must be determined they meet federal criteria for admission
- Determination if this is the appropriate level of care
- Review the financial, transportation, support needs/feasibility
- Education provided on the 3 FDA-approved medications to treat Opioid Use Disorder
- Intake includes all legal paperwork, informed consent, etc.

OTP: ADMISSION, ASSESSMENT, AND TREATMENT PLANNING

Admission: H&P, EKG, UDS, PPD, Labs, Case Management

Assessment: Biopsychosocial domains

Treatment Planning: Individualized, collaborate with the patient on goals, goals are derived form the problems/needs identified in assessment. Reviewed every 90 days for the 1st year and 6 months thereafter

Treatment: Includes groups, individual, care coordination, skill building, education, addressing co-occurring disorders

OTP: PREGNANT WOMEN

- Pregnancy testing on admission for women of childbearing age and any taper (voluntary or administrative).
- Priority population (along with HIV, IV Use)
- Refer for confirmatory testing
- Arrange with a MAT “friendly” pre-natal care provider
- Sign ROI’s to allow for transfer of information
- Regularly coordinate communication for updates/follow up
- Educated on Mandated Reporter responsibilities

OTP: Barriers for Pregnant Women

- Issues:
  - Shame
  - Lack of education…(medication, treatment, pre-natal care, delivery process, post-partum, NAS, and aftercare)
  - Myth/Stigma
  - Funding
  - Transportation

Education to Expecting Mothers

- What is the medication, how does it work, how does it affect you and the unborn child?
- Review the concerns for expecting mothers
- Review safety of being in treatment vs. remaining in active “addiction”, leaving treatment abruptly, tapering options
- Reinforce decision to seek treatment
- Address fears of parenting, breastfeeding, treatment post-partum

MAT Stigma: SUD's vs. Other Chronic Diseases

- How long should the treatment last for a chronic disease?
- Do the patients become "cured" of a chronic illness?
- What barriers exist for treatment addressing a chronic illness?
- What happens if someone is non-compliant with treatment?
- Do the patients regularly get "kicked out" of treatment?
- How easy is it to get funding for these treatments?

OTP and MAT: Myths, Stigma, and Misconceptions

- It is substituting one drug for another…
- They are not truly in recovery…
- They are still getting high…
- Patients on a stable dose are addicted…
- Patients who are on a stable dose are not able to function “normally”
- Methadone is not advisable in pregnant women

OTP and MAT: Misconceptions during Pregnancy

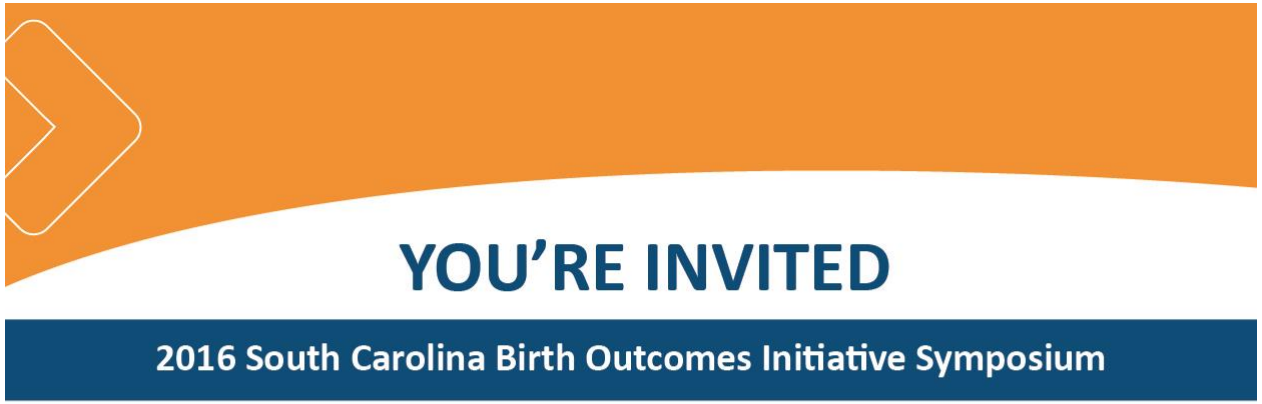
- The baby will be born with birth defects….
- The baby will be addicted…
- The baby will suffer…
- The higher the dose, the worse the withdrawal…
- It is OK to quit abruptly…

Conclusion

- MAT for Opioid Use Disorder can be done safely in a monitored, regulated environment that addresses the needs of the patient
- More work is to be done to increase accessibility
- More work is to be done to reduce stigma
- More work is to be done with coordination amongst providers to adequately address needs and problems with more frequent collaboration

Questions?

2016 SCBOI Symposium



South Carolina Birth Outcomes Initiatives

Thank You!

Please visit:

https://www.scdhhs.gov/boi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