Acadia Healthcare’s
Jackson Comprehensive Treatment Center (CTC)
Offering

Medication Assisted Treatment (MAT)
for Opiate and Heroin-related
Substance Use Disorders

Jerri Avery, Ph.D.
Clinic Director
Why integrated care?

Diminished lifespan by mental illness or disorder

– Recurrent depression: 7-11 years
  – Bipolar disorder: 9-20 years
  – Schizophrenia: 10-20 years

– Drug and alcohol abuse: 9-24 years
Medication Assisted Treatment

Therapeutic Treatment + FDA-Approved Medications
Medication Assisted Treatment
Treats Two Categories of Substance Users
Secular Recovery

Faith-based Recovery

Twelve Steps

Medication-Assisted Recovery

Natural Recovery

“The roads to recovery are many.”

AA Cofounder Bill W., The AA Grapevine, Sept. 1944

The Science on MAT for Opioid Addiction

- Increases patient retention
- Improves social functioning
- Decreases drug use
- Decreases infectious disease transmission
- Decreases criminal activities
- Decreases risk of overdose and death

- Connock et al., 2008; Johnson et al., 2000; Kakko et al., 2003; Zaric, Barnett & Brandeau, 2000
Largest # of Adopters

Cumulative adopters of Hybrid Seed Corn in Iowa between 1927 and 1941
Classic diffusion study by Ryan & Gross

Early Adopters
Mid-stage Adopters
Late-stage Adopters

# of Cumulative Adopters

0
50
100
150
200
250
300

Education
Incentives
Requirements

Time

Arthur C. Evans, PhD.
MAT + Therapy

- Re-establish normal brain functioning
- Reduce Cravings
- Prevent Relapse

Outpatient Opioid Treatment Programs

Medication
- Buprenorphine Products (Suboxone™, Subutex™), Methadone, Vivitrol™

Individual & Group Counseling

Ongoing patient-focused treatment planning with team approach

Medication Evaluations and Titration Plans

TB Testing, RPR Testing, Pregnancy testing, HIV/Hep C screening

Urine Drug Screens (random)

Placement for Higher Level of Treatment
The Language of Meds

Methadone
Full Agonist

Buprenorphine Products
Partial Agonist

Suboxone
Buprenorphine + Naloxone

Subutex
Buprenorphine
Antagonists

Naltrexone

• Vivitrol Injection
• Revia

Naloxone

• Narcan
• Evzio
FDA-Approved Medications for Opioid Dependence

- Naltrexone (oral)
- Naltrexone extended-release (Vivitrol - injectable)
- Buprenorphine
- Buprenorphine-Naloxone
- Methadone
Addiction

Role failure: Recurrent use resulting in failure to fulfill role obligation

Risky behavior: Recurrent use in situations which it is physically hazardous

Run in with the law: Recurrent substance-related legal problems

Relationship problems: Continued use despite interference with social or interpersonal functioning
Typical Withdrawal Symptoms

- Cold shakes.
- Chills and sweating.
- Fever-like symptoms.
- Mood swings.
- Anxiety and depression.
- Bone pain.
- Vomiting.
- Insomnia.
- Diarrhea.
Methadone for Opioid Addiction

• Maintenance treatment used for decades in the U.S.
• Long-acting opioid agonist – imitates the action of an opiate by occupying and activating the body’s opiate receptors
• Taken orally
• *Long period of metabolism so doesn’t generate the extreme euphoria of heroin or opiate prescription medications* in PROPERLY prescribed doses
• Multiple randomized controlled trials over four decades support methadone maintenance to reduce cravings, use of opioids, and overdose
• Usually improves health and social functioning
  – Mattick, et al., 2009; SAMHSA, 2005; Sees et al., 2000
Buprenorphine ONLY

• Schedule III drug
  – Can be prescribed by a physician if achieve DEA Waiver

• Numerous randomized clinical trials indicating is safe and effective
  – Barnett, et al., 2001; Mattick, et al., 2008; Thomas et al., 2013)

• Study indicated relapse rates were high following tapering – even after 12 weeks of tx (Weiss, et al., 2011)
Can be used for withdrawal and induction

If Naloxone is injected, it can cause a acute withdrawal syndrome

Adding Naloxone reduces risk of misuse or injecting to create euphoric effect
<table>
<thead>
<tr>
<th><strong>Methadone</strong></th>
<th><strong>Buprenorphine</strong></th>
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<tbody>
<tr>
<td>Full Agonist</td>
<td>Partial Agonist (exhibits a ceiling effect – safe even at high doses)</td>
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<tr>
<td>Planned Withdrawal</td>
<td>Reduces or eliminates withdrawal symptoms</td>
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<tr>
<td>Prevents Opioid Withdrawal Symptoms</td>
<td>Reduces Cravings</td>
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<tr>
<td>Reduces Cravings</td>
<td>Doesn’t produce Euphoria</td>
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<tr>
<td>Acts on Opiate Receptors</td>
<td>Available for sublingual administration</td>
</tr>
<tr>
<td>Rarely administered to persons under 18</td>
<td>Physicians use special certification</td>
</tr>
<tr>
<td>Dispensed from Certified Clinics, usually orally on daily basis</td>
<td>Less abuse potential than full agonist</td>
</tr>
<tr>
<td>– Requires approval of the DEA, SAMHSA and DMH</td>
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Naltrexone for Opioid Addiction & Alcohol Use Disorders

- Approved by the FDA in 1984 for the treatment of alcoholism

- **Must be opiate-free for 10 days prior to administration**

- Long-acting opioid antagonist – blocks opioid receptors that are involved in opioid’s euphoric effect

- Displaces opioids on the patient’s opioid receptors and then binds to the receptors for 27-30 hours (oral) or up to 30 days (monthly injection)

- Leaves receptors unavailable for activation

- More costly

- Efficacy is related to adherence to treatment, which is often low for oral naltrexone

Johansson, et al., 2006; Swift, et al., 2011
OTP Therapeutic Requirements

Counselor to client ratio 1:40

*Minimum* schedule (Individual, group, or family)
- One hour per week for first 90 days
- Two hours for days 91 through 180
- One hour per month thereafter

Priority given to pregnant women & IV drug users

Review of protocol for treating pregnant women by medical director

Must include random urine screens
Take-home Dosages for Methadone

• Phase 1:  First 90 days
  – Daily dosing (closed Sundays)
  – Two UDS

• Phase 2:  Second 90 days
  – Two take-home doses each week
  – 1 UDS

• Phase 3:  6+ months
  – Three take-home doses each week
  – 1 UDS

• Phase 4:  9+ months
  – Six take-home doses each week
  – 1 UDS

• Phase 5:  Second Year
  – 13 take-home doses
  – 1 UDS

• Phase 6:  3+ Years
  – One month take-home
  – 1 UDS
Dosage

- Dosages and changes must be ordered by medical director
- Documented in case record
- Document exact milligrams
- Initial dosage cannot exceed 30 mg unless the physician documents that 30 mg did not suppress symptoms
  - Maintenance doses usually 30-120 mg/day
  - Studies show a dose-response relationship
  - Persons on higher doses stay in treatment longer
Buprenorphine Waiver

Year One: 30 patient Limit

Year Two: 100 patient Limit

Year Three: 275 patient Limit
Mississippi in 2017

Certified Physicians with 30 Patients: 48

Certified Physicians with 100 Patients: 100
Online Training

https://pcssnow.org/

For Physicians, PAs, and NPs
Addiction is a disease. It’s not a moral failing. Seek help.

Jeffrey and Jim Moore