Medication-Assisted Treatment: Policy Guided by Evidence

July 2017

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Drug Poisoning Deaths Involving Opioid Analgesics, 2009 to 2013

Source: Centers for Disease Control and Prevention/National Center for Health Statistics [NCHS]. *Multiple Cause of Death 1999-2012* on CDC WONDER Online Database, released 2014. Data for 2013 are unpublished from NCHS (December 30, 2014).
Drug Poisoning Deaths Involving Heroin 2009 to 2013

Source: Centers for Disease Control and Prevention/National Center for Health Statistics [NCHS]. *Multiple Cause of Death 1999-2012* on CDC WONDER Online Database, released 2014. Data for 2013 are unpublished from NCHS (December 30, 2014).
Medication Assisted Treatment

- Coordinated Effort Across the Federal Government: Federal Interagency Treatment Work Group
- Standard of Care for Opioid Use Disorders
- Longer Engagement in Treatment/Decrease in Recidivism
- Overdose Prevention
Using Medication to Address Drug Abuse in Criminal Justice Settings

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March 31, 2015
What is Addiction?

➢ A developmental brain disease expressed as a compulsive behavior.

➢ The continued use of a drug despite negative consequences.
Presentation Overview

➢ What is addiction?

➢ Medications used to treat addiction.

➢ Medications used to treat opiate addiction.
Addiction Is A Disease Of The Brain

Decreased Brain Metabolism in Drug Abuse Patient

No Cocaine Abuse

Cocaine Abuser

Brain Activity

High
Low
Medications are a **Fundamental Component of** Effectively Addressing Drug Abuse for Criminal Justice Involved Populations
FDA Approved Medications for Alcohol & Nicotine

➢ For alcohol dependence:
  ➢ Disulfiram
  ➢ Acamprosate
  ➢ Naltrexone (tablet, injectable)

➢ For nicotine dependence:
  ➢ Varenicline, Bupropion
  ➢ Patch, gum, lozenge
FDA Approved Medications for Opioid Addiction

- Methadone
- Buprenorphine (generics)
- Buprenorphine/Naloxone (Bunavail, Zubsolv, Probuphine, Suboxone and generics)
- Naltrexone (Revia)
- Naltrexone- IM Injection (Vivitriol)
Types of Opioid Treatment Medications

Opioid Agonists
1) Full agonist: Methadone (oral)
2) Partial agonist: Buprenorphine (sublingual)

Opioid Antagonist
3) Naltrexone (oral)
4) Extended-release Naltrexone (injection)
I. Opioid Agonists
Methadone and Buprenorphine

➢ Activate the opioid receptors
➢ Reduce heroin craving
➢ Alleviate withdrawal
➢ **Block** other opioids’ euphoric effects
➢ Buprenorphine-partial agonist (Ceiling effect)
➢ Methadone-full agonist (NO Ceiling effect)
Methadone Formulations

➢ Liquid methadone
  ➢ Use in opioid treatment programs

➢ Tablets
  ➢ Provided mainly by prescription for pain (Pain Clinics)
  ➢ Generally not used for SUD treatment
  ➢ Source of diverted methadone
  ➢ 95% overdose deaths from Methadone
What is the Evidence for the Effectiveness of Methadone Maintenance?

Review of 11 randomized clinical trials with 1,969 patients concluded that methadone is superior to placebo in:

- Retaining patients in treatment
- Reducing illicit opioid use

Probation/Parolees

- Reduced self-report heroin drug use
- Reduced positive drug tests
- Reduced days of illegal activity

Mattick et al, 2009; Kelly et al, 2003
What is the role of medication?
Methadone Experiment: 6 Mo Post Release (N=201)

Where Is Methadone Provided?

- **Only** in Opioid Treatment Programs (OTPs)
  - Counseling and urine drug testing
  - Clinic administered dosing with eventual take home doses [contingent on treatment adherence]
    - Urine drug testing
    - Pill counts
    - Counseling
Buprenorphine Formulations

➢ **Combination of Buprenorphine with Naloxone**
  ➢ Buccal and Sublingual Buprenorphine is well-absorbed
  ➢ Naloxone (Narcan) is a short-acting opioid antagonist
  ➢ Presence of Naloxone decreases buprenorphine/naloxone’s abuse potential because its injection precipitates withdrawal

➢ **Buprenorphine Alone**
  ➢ Limited indications for us - Methadone conversion (7da),
  ➢ Pregnancy,
  ➢ Naloxone intolerance - medically documented (pulmonary, hepatic, gastrointestinal)
Effects of Buprenorphine Dose on $\mu$-Opioid Receptor Availability

Greenwald, MK et al, Neuropsychopharmacology 28, 2003
What is the Evidence for the Effectiveness of Buprenorphine Maintenance?

Review of 24 randomized clinical trials with 4,497 patients concluded that buprenorphine is superior to placebo:

- Retaining patients in treatment
- Reducing illicit opioid use
- Saving lives
- Harm reduction

Mattick et al. 2008
Where is Buprenorphine Provided?

- **OTPs**
- Physician office based or Community Health Clinics (physician must be certified)
- **Inpatient Drug Treatment Programs**
- **Outpatient Drug Treatment Programs:**
  - Physician qualified:
    - Counseling and drug testing on-site
II. Opioid Antagonists
Opioid Antagonist Treatment

Naltrexone
- Binds with but doesn’t activate the Mu (opioid) receptors
- Highly effective pharmacologically

Oral Naltrexone
- Hampered by poor patient adherence
- Useful for highly motivated patients

Extended release Naltrexone
- FDA-approved to treat alcohol and opioid dependence
- Intramuscular injection
- Therapeutic range ~ 30 days (hepatic, renal function, etc)
Detoxification vs. Maintenance

- **Detoxification:**
  - Shorter-term
  - Alleviate symptoms of withdrawal
  - Limited/no brain chemistry changes

- **Maintenance:**
  - Longer-term
  - Prevent relapse to drug use
  - Allows brain chemistry stabilization
How Effective is “Detoxification”?

- Effective at reducing withdrawal symptoms
- Can be used as a lead-in to Naltrexone or non-medication psychosocial treatments
- Poor clinical outcomes (relapse rate 65-80% @ 30 days)
- Relapse associated increased risk negative outcomes: overdose death, recidivism, revocation of probation/parole, recurrence of co-occurring disorders
What Are the Characteristics of Effective Maintenance Treatment?

- Dosing-individualized to patients’ clinical situation
- Treatment period- open/clinically determined
- Appropriate Psychosocial services
- Co-occurring disorders evaluated/treated
- Minimize diversion
  - Treat with buprenorphine/naloxone
  - UDT- methadone, buprenorphine metabolites, other
  - Accountability for medication doses (counts, etc)
Methadone, Buprenorphine, Naltrexone in Criminal Justice System

- Suitable for use in multiple settings:
  - Jail/Prison ease withdrawal, continue community treatment, initiate treatment pre-release
  - Probation, Parole
  - Drug Courts, Diversion Programs
  - Veteran treatment centers
- Effective at reducing opioid use, HIV/HCV risk, return to functional behaviors
Recovery

• A process of

  CHANGE

• through which individuals

  IMPROVE

• their health and wellness,

  LIVE

• a self-directed life and

  STRIVE

• to reach their full potential
Resources

➢ SAMHSA for treatment locators:
  ➢ http://findtreatment.samhsa.gov/

➢ SAMHSA for buprenorphine locator:
  ➢ http://buprenorphine.samhsa.gov/
  ➢ bwns_locator/dr_facilitylocatordoc.htm

➢ State Alcohol and Drug Abuse Administrations
➢ American Society of Addiction Medicine: State Chapter
➢ American Academy of Addiction Psychiatry: State Chapter
➢ National Association of Drug Court Professionals
➢ NAABT
Summary

➢ There are a number of medications approved by the FDA for treatment of opioid, alcohol, nicotine dependence

➢ Methadone, Buprenorphine & Naltrexone are effective treatments for opiate addiction

➢ Treatment access and availability is still restricted
➢ All SUD medication assisted treatment is underutilized in the criminal justice system and healthcare system

➢ Wider use of medications can save lives, improve the health of the individual, reduce recidivism, enhance public safety, build strong communities and stabilize individuals recovery
Discussion

• Thank-you

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BJA’s Solicitation Revisions for MAT

https://www.bja.gov/Funding/15DrugCourtSol.pdf

Deadline April 16, 2015

**Please see highlighted revised language on pages 1, 6-7, and 28**
• Applicants must also demonstrate that the drug court for which funds are being sought will not deny any eligible client for the treatment drug court access to the program because of their use of FDA-approved medications for the treatment of substance use disorders. Please see page 6 for additional information.
Applicants must demonstrate that the drug court(s) for which funds are sought will not deny any eligible client for the drug court access to the program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium).

Specifically, methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual’s opioid use disorder must be permitted.
Similarly, medications available by prescription must be permitted unless the judge determines the following conditions have not been met:

• the client is receiving those medications as part of treatment for a diagnosed substance use disorder
• a licensed clinician, acting within their scope of practice, has examined the client and determined that the medication is an appropriate treatment for their substance use disorder
• the medication was appropriately authorized through prescription by a licensed prescriber
In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial. Grantees must assure that a drug court client will not be compelled to no longer use MAT as part of the conditions of the drug court if such a mandate is inconsistent with a licensed prescriber’s recommendation or valid prescription.
• Under no circumstances may a drug court judge, other judicial official, correctional supervision officer, or any other staff connected to the identified drug court deny the use of these medications when made available to the client under the care of a properly authorized physician and pursuant to regulations within an Opioid Treatment Program or through a valid prescription and under the conditions described above. A judge, however, retains judicial discretion to mitigate/reduce the risk of abuse, misuse, or diversion of these medications.
MAT Policy for Jurisdictions Without Access to MAT

• Medication-Assisted Treatment (MAT) is an evidence-based substance abuse treatment protocol and SAMHSA supports the right of individuals to have access to FDA-approved medications under the care and prescription of a physician. BJA and SAMHSA support the right of individuals to have access to FDA-approved medications under the care and prescription of a physician.

• BJA and SAMHSA recognize that not all communities have access to MAT due to a lack of physicians who are able to prescribe and oversee clients using anti-alcohol and opioid medications. This will not preclude the applicant from applying, but where and when available, BJA and SAMHSA support the client’s right to access MAT. This right extends to participation as a client in a BJA/SAMHSA-funded drug court.
Questions & Answers

For more information on drug courts visit

The National Drug Court Resource Center

www.ndcrc.org