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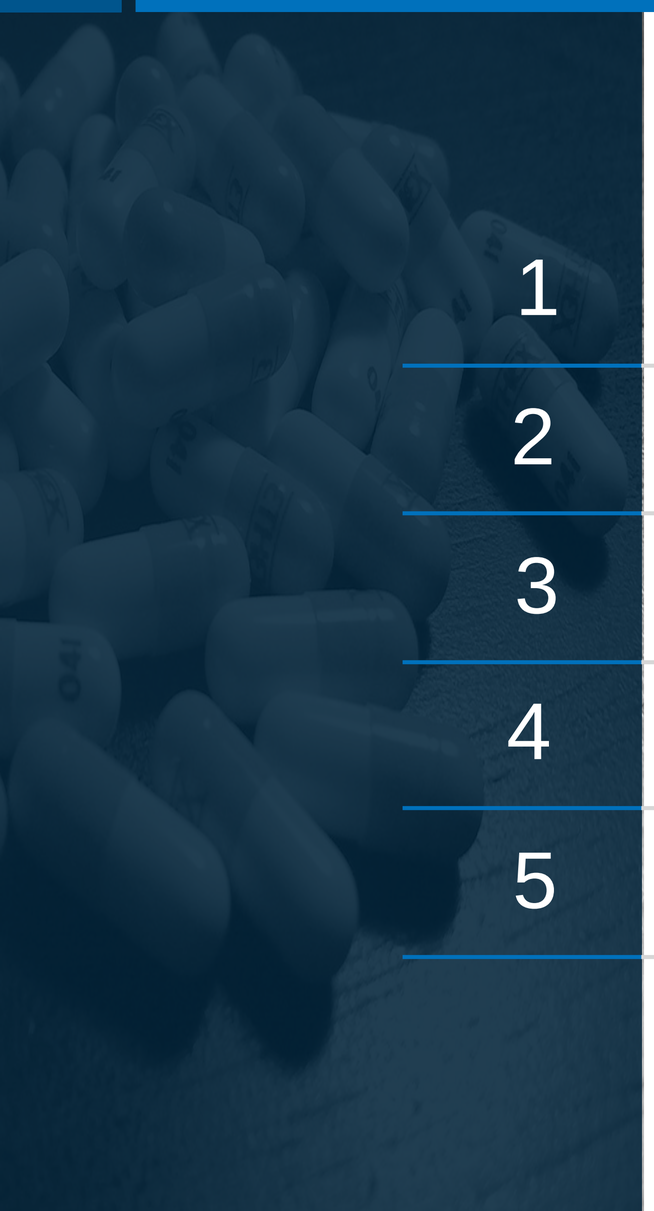
The Opioid Epidemic: What Mental Health Professionals Need to Know

Person-Centered Addiction Medicine Treatment

Ian McLoone, LPC, LADC

August 12, 2016

Agenda



1. The Opioid Epidemic: history, course, and statistics
2. Policy developments: federal and state initiatives
3. Treatment considerations: current trends in SUD care
4. Anti-relapse medications
5. Questions and Discussion

Contact Information

I am happy to discuss any of this information further

Ian McLoone, LPC, LADC

ianmcloone@alltyr.com

651.237.771
8

332 Minnesota
St. W1260
St. Paul

The Opioid Epidemic: History, Course, Statistics

Definition of Opioids

“Opioids are a class of drugs that include the illicit drug heroin as well as the licit prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others.”

“Opioids are chemically related and interact with opioid receptors on nerve cells in the brain and nervous system to produce pleasurable effects and relieve pain.”

- ASAM, 2016 Opioids Facts and Figures

Major Events in the History of Opioids

Brownstein, M. J. (1993). A brief history of opiates, opioid peptides, and opioid receptors. Proceedings of the National Academy of Sciences, 90(12), 5391-5393.

3000 BC
Opium Cultivation

There is agreement among scholars that at least as far back as 3000 BC opium was cultivated by the Sumerians - inhabitants of modern day Iraq

300 BC
Homer's Odyssey

Helen, Zeus' daughter, gives an opiate-based preparation to her guests to "help them forget their grief over Odysseus' absence"

700-1300 AD
Opium trade expands

Arab traders first bring opium to India and China 700-1000 AD. Then it makes its way from Asia Minor to Europe. By 1600, reports of misuse and dependence found in manuscripts

1806
Morphine isolated

Serturmer isolates the active ingredient in opium and names it after Morpheus, the god of dreams

1850s
Hypodermic needle invented

Morphine becomes widely used in surgical settings and pain treatment in general

Major Events in the History of Opioids

Brownstein, M. J. (1993). A brief history of opiates, opioid peptides, and opioid receptors. Proceedings of the National Academy of Sciences, 90(12), 5391-5393.

1898
Heroin synthesized

Discovered in the search for a safer, more effective, less addictive alternative to morphine

1914
Passage of Harrison Act

Opiates and cocaine were taxed heavily and then ultimately made illegal, leading to the creation and surge of black market availability

1939, 1946
First synthetic opioids

Demerol and Methadone, respectively, were developed as the first two structurally unrelated compounds that produced opiate-like effects

1942
First antagonist developed

Weijlard and Erikson develop nalorphine, finding it can reverse respiratory depression and precipitate withdrawal syndrome

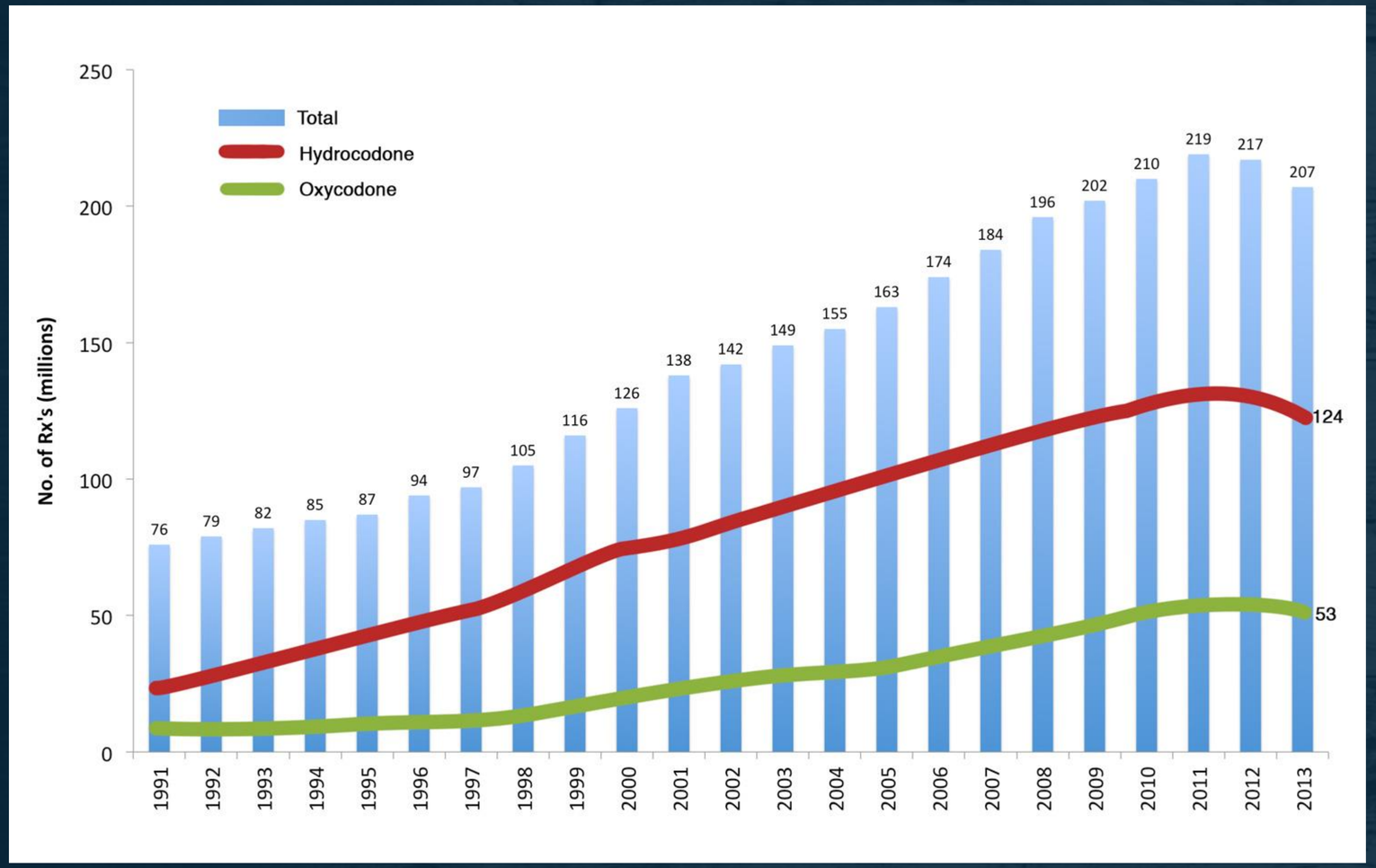
1960s-90s
Other developments

By the 1960s, actions of agonists, partial agonists and antagonists were being investigated, as was MMT. In the 1970s, Vicodin and Percocet were introduced, though most Drs were conservative in pain treatment

Then, in 1996, OxyContin is Born

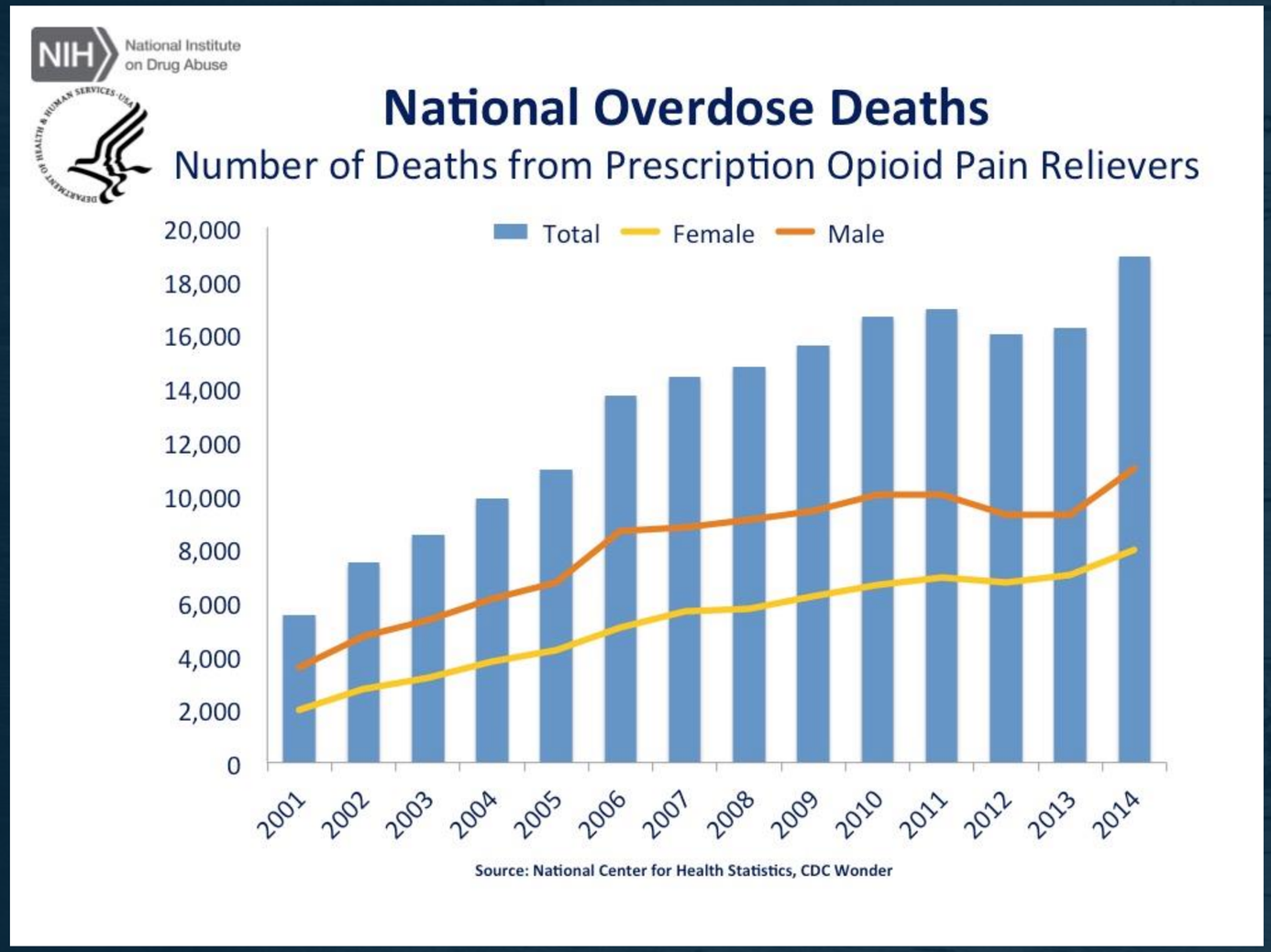
- Purdue Pharma aggressively marketed the painkiller as safe, non-addictive, and “abuse deterrent” due to its time-release protective coating.
- By 2000, it accounted for $1.1 billion in sales, a 2000% increase from its first year. In 2010, that number reached $3.1 billion.
- Its introduction coincided with a major push by industry groups to treat chronic non-cancer pain more aggressively than ever, identifying pain as the “5th vital sign.”
- Ultimately, the rate of opioid prescribing in general increased substantially, with over ¼ of opioid prescriptions coming from primary care providers

Prescriptions for Opioids Surge...



- Between 1991-2011, opioid prescriptions nearly tripled, climbing from 76 million to 219 million, respectively.
- The US accounts for nearly 100% of worldwide hydrocodone Rxs and 81% of worldwide oxycodone Rxs

...And Overdose Deaths Surge Too

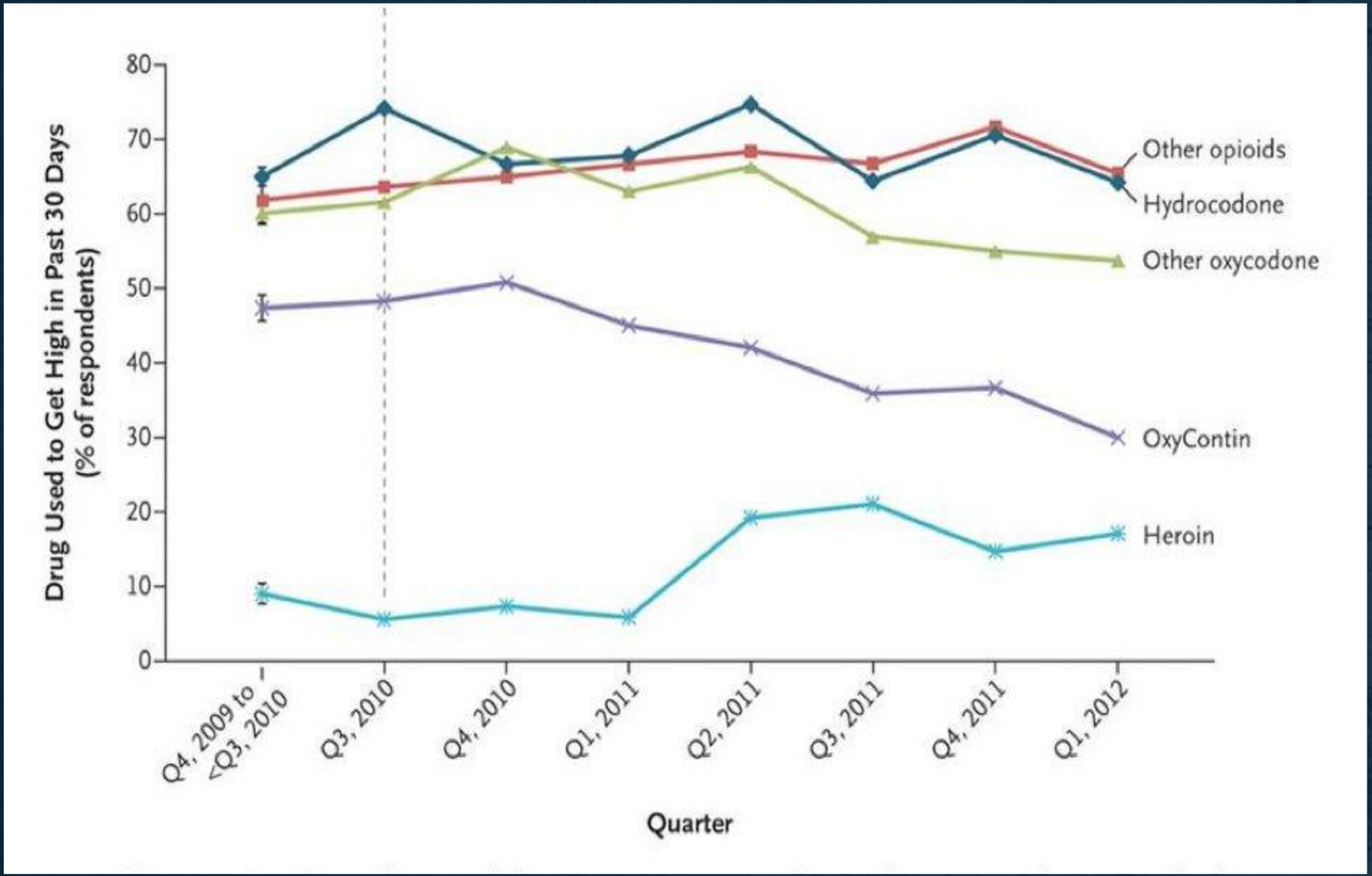


- Nationwide, deaths attributed to Rx opioids nearly quadrupled between 2001-2014
- In Minnesota, overdose death rates climbed steadily between 2000-2013, only recently showing modest improvements

Opioid Epidemic

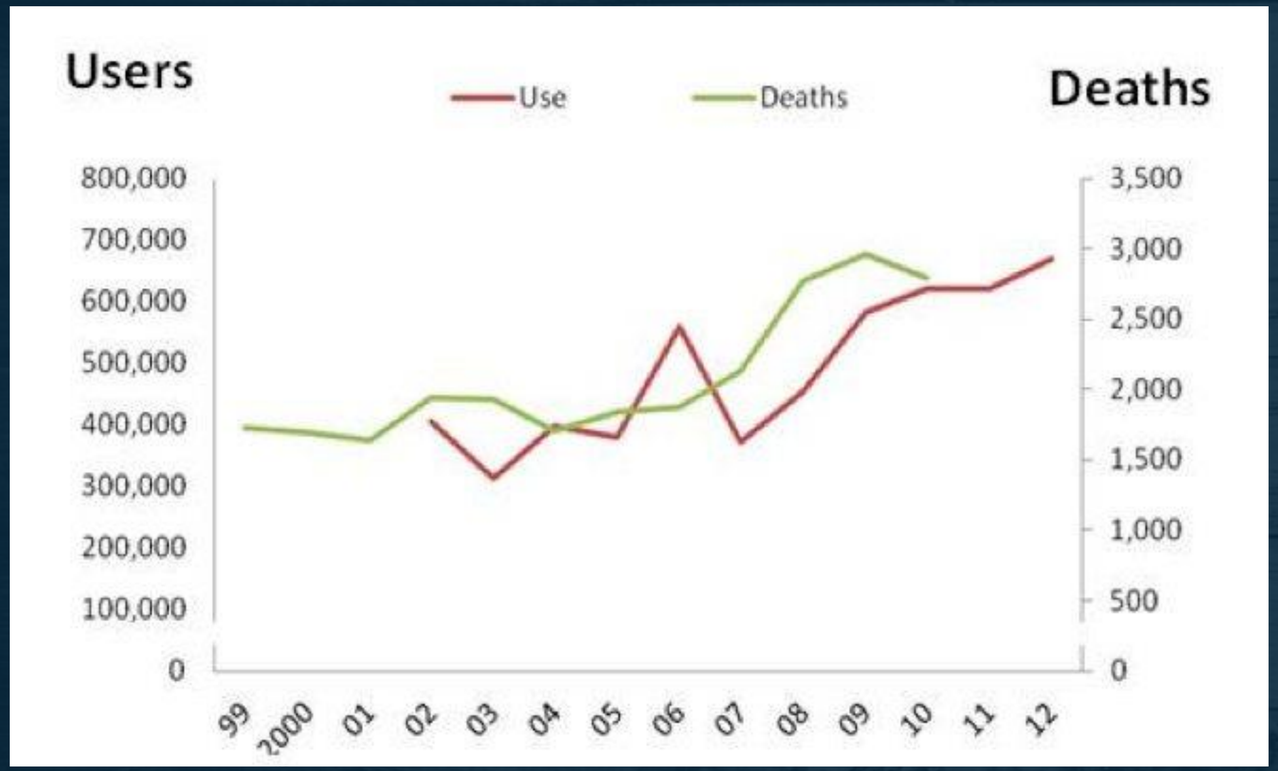
> “Drug overdose is the leading cause of accidental death in the US, with 47,055 lethal drug overdoses in 2014 (double the rate from decade prior). Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription pain relievers, and 10,574 overdose deaths related to heroin in 2014.”
>
> - Centers for Disease Control and Prevention

Relationship Between Rx Opioids and Heroin use



- More recently, as awareness of opioid risk has grown and greater controls over rx-ing and dispensing do too, more and more people are switching to heroin

Relationship Between Heroin use and Heroin OD



- As heroin use rates have started climbing, so have overdose death rates
- The number of past-year heroin users in the United States nearly doubled between 2005 and 2012, from 380,000 to 670,000

?

What are we doing about it?

- Policy changes
- Public health initiatives
- Treatment interventions

Policy developments: federal and state initiatives

Policy Initiatives

CARA - Comprehensive Addiction and Recovery Act

Steve’s Law - Narcan and Good Samaritan Legislation

CDC Opioid Guidelines

Comprehensive Addiction and Recovery Act

- Recently signed by President Obama.
- Expands access to ARMs in the criminal justice system.
- Provides investment in diversion programs and drug courts.
- May expand the use of PDMPs.
- Expands buprenorphine prescribing authority to nurse practitioners and physician assistants.
- Failed to ensure much-needed funding, so future impact of the law is hard to predict.

Steve’s Law: 911 Good Samaritan and Naloxone Bill

- Passed in 2014 after lobbying and pressure by SRHF and others.
- Legalized the prescribing and use of Narcan/Naloxone - the opioid overdose antidote - to anyone who needs it.
- Also guarantees users can call 911 to report an overdose without fear of prosecution for possession of paraphernalia, personal drugs.
- First responders are getting trained and equipped with OD antidote - and it’s working!

CDC Opioid Prescribing Guidelines

- If opioids are used for acute pain, 3 days or fewer will often suffice; more than 7 days will rarely be needed.
- Consider the full range of therapeutic options for chronic pain, including combinations of non-opioid and nonpharmacologic therapy.
- When starting opioids for chronic pain, prescribe immediate-release formulations instead of extended-release/long-acting opioids.
- Use the lowest effective dose. Reassess benefits and risks if the dose reaches 50 morphine milligram equivalents (MME) per day; avoid or carefully justify a dosage of 90 MME/day.
- When starting opioids, and periodically, order urine testing and review state prescription drug monitoring program (PDMP) pharmacy tracking data.
- Avoid prescribing opioids and benzodiazepines concurrently

Treatment Considerations: current trends in SUD care

Current Trends

Integrated Mental Health and SUD Care

Integration of Neuroscience

Recovery-oriented Systems of Care (ROSC)

DHS - ADAD Initiatives

Obamacare!

Integrated MH and SUD Care

All symptoms are treated in the same place, at the same time, preferably by the same clinicians.

Consistently outperforms “parallel” or “consecutive” approaches

Usually requires team-based approach

Lots of coordination, consultation, and supervision

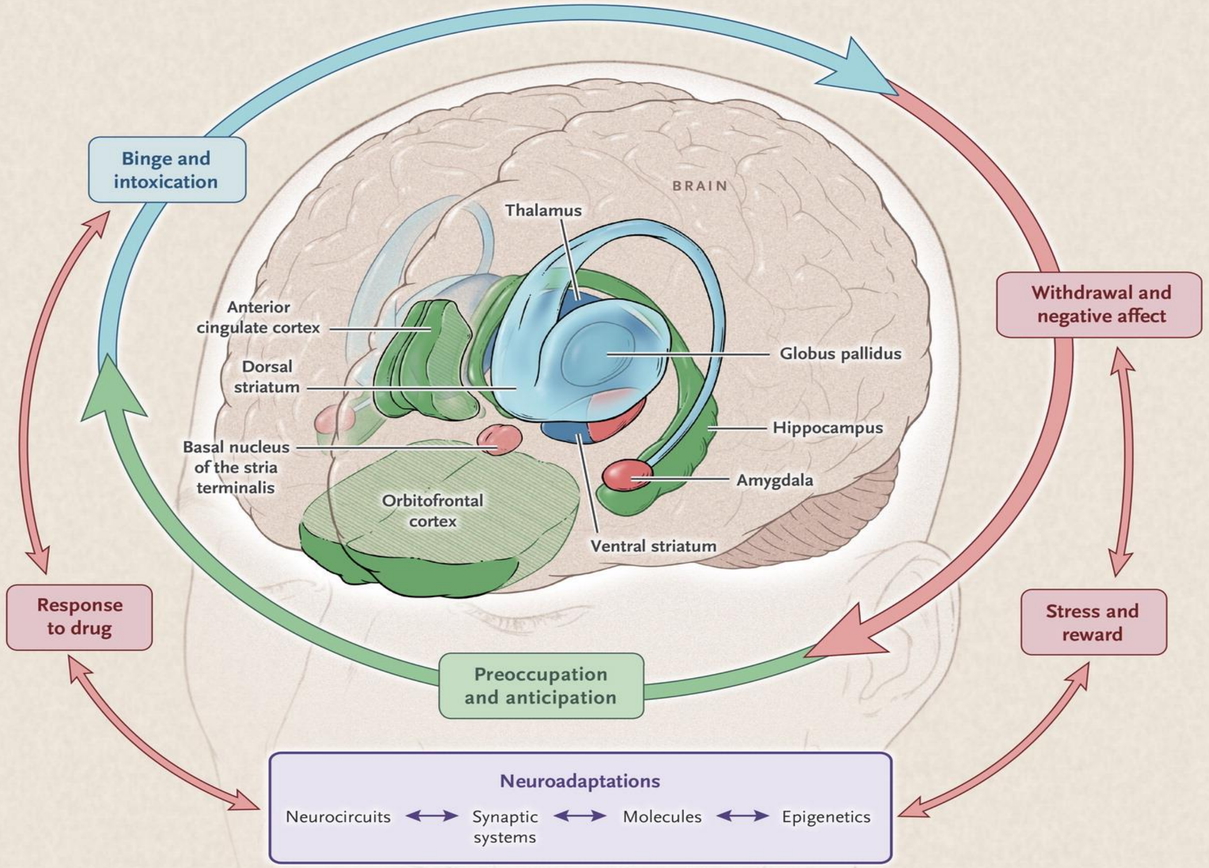
Encourages advanced training, requires MH Professionals

Clinicians are held to a high standard of competency

Chronic-care model, longitudinal treatment

Setbacks are expected, mulitple tools are used, focus on engagement as priority

Integration of Neuroscience

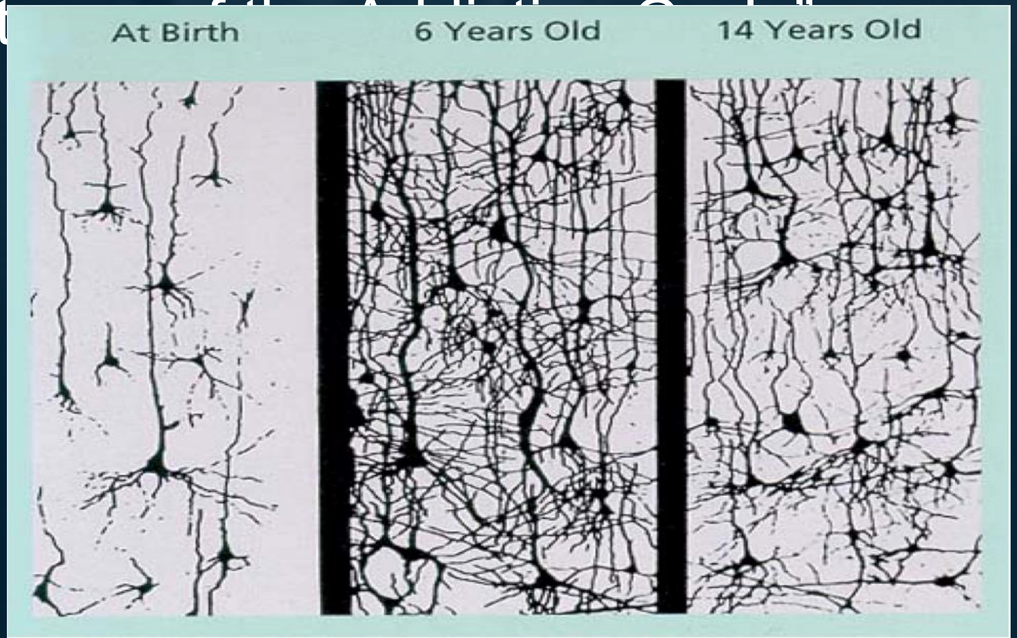


Stage of Addiction	Shifting Drivers Resulting from Neuroadaptations		
Binge and intoxication	Feeling euphoric	Feeling good	Escaping dysphoria
Withdrawal and negative affect	Feeling reduced energy	Feeling reduced excitement	Feeling depressed, anxious, restless
Preoccupation and anticipation	Looking forward	Desiring drug	Obsessing and planning to get drug

Behavioral Changes		
Voluntary action Abstinence Constrained drug taking	Sometimes taking when not intending Sometimes having trouble stopping Sometimes taking more than intended	**Impulsive action** Relapse Compulsive consumption

The field of neuroscience has yielded incredible new findings which are working their way into clinical practice

- Brain anatomy - 100 billion neurons - & genes
- Pharmacological effects of drugs, alcohol and medications
- The importance of the different brain regions in the development and maintenance of addiction
- “St



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Recovery-Oriented Systems of Care:

- Providing a continuum of services, rather than crisis-oriented care
- Care that is age- and gender-appropriate and culturally competent
- Accessible services that engage and retain people seeking recovery;
- Where possible, care in the person’s community and home using natural supports

What is recovery?

2009: “Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.”

2011: “Recovery from Mental Disorders and Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

— SAMHSA

Minnesota DHS-ADAD Model of Care of SUDs Legislative Report - 2013

- Identified the need to change the entire system of care from acute, episodic to chronic, longitudinal
- Recommended changing rule that requires discharge and service termination
- Endorsed ROSC model of an enhanced continuum of care, peer support and flexible services
- Recommended increased diversity and emphasis on growing multicultural workforce

The Affordable Care Act

Substance Use Disorder Treatment Hugely Impacted:

- ★ Over 30 million newly-insured Americans.
- ★ SUDs added to list of “Essential Health Benefits” - previously, 80% of Tx publicly funded.
- ★ Preventive care covered 100%
- ★ Guaranteed coverage for pre-existing conditions.
- ★ Increase in the number of people who meet criteria for treatment.

Anti-Relapse Medications

Why Use ARMs?

- Improve outcomes
- Improve retention
- Reduce risk of recurrences
- Reduce ODs

Anti-relapse Medications

Suboxone/
Buprenorphine

Methadone

Naltrexone

Vivitrol

But, first:
Myth vs Fact

Slides adapted from
Adrienne C. Lindsey, MA, DBH

Myth:
Use of ARMs is just replacing one addiction with another

Fact:

- Prescribed/monitored by a medical provider
- FDA-approved
- regulated potency
- curbs cravings and withdrawal symptoms

Addiction vs. Dependence

compulsive use

cont’d use despite consequences

using a substance to get “high”

physiologically reliant on a substance

dependence on medications is common (e.g. insulin, beta blockers, antidepressants, antipsychotic medications)

utilize the medication to

Slides adapted from Adrienne C. Lindsey, MA, DBH

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Myth:
Medications don’t work

Fact:

In just about every measurable way, they do!

Slides adapted from
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Myth:
If someone is already abstinent, they don’t need medications

Fact:

Drug overdose is a leading cause of death for individuals being released from jail or prison.

Slides adapted from
Adrienne C. Lindsey, MA, DBH

Myth:
12-Step Programs like AA/NA do not support MAT/medications

Fact:

“No A.A. member should ‘play doctor;’ all medical advice and treatment should come from a qualified physician.” --A.A. General Service Office (Member Medications & Other Drugs brochure)

Wise Words

“…just as it is wrong to enable or support any alcoholic to become readdicted to any drug, it’s equally wrong to deprive any alcoholic of medication, which can alleviate or control other disabling physical and/or emotional problems.”

- AA General Service

More Wise Words

“NA as a whole has no opinion on outside issues, including prescribed medications. Use of psychiatric medication and other medically indicated drugs prescribed by a physician and taken under medical supervision is not seen as compromising a person’s recovery in NA.”

- NA “How it works”

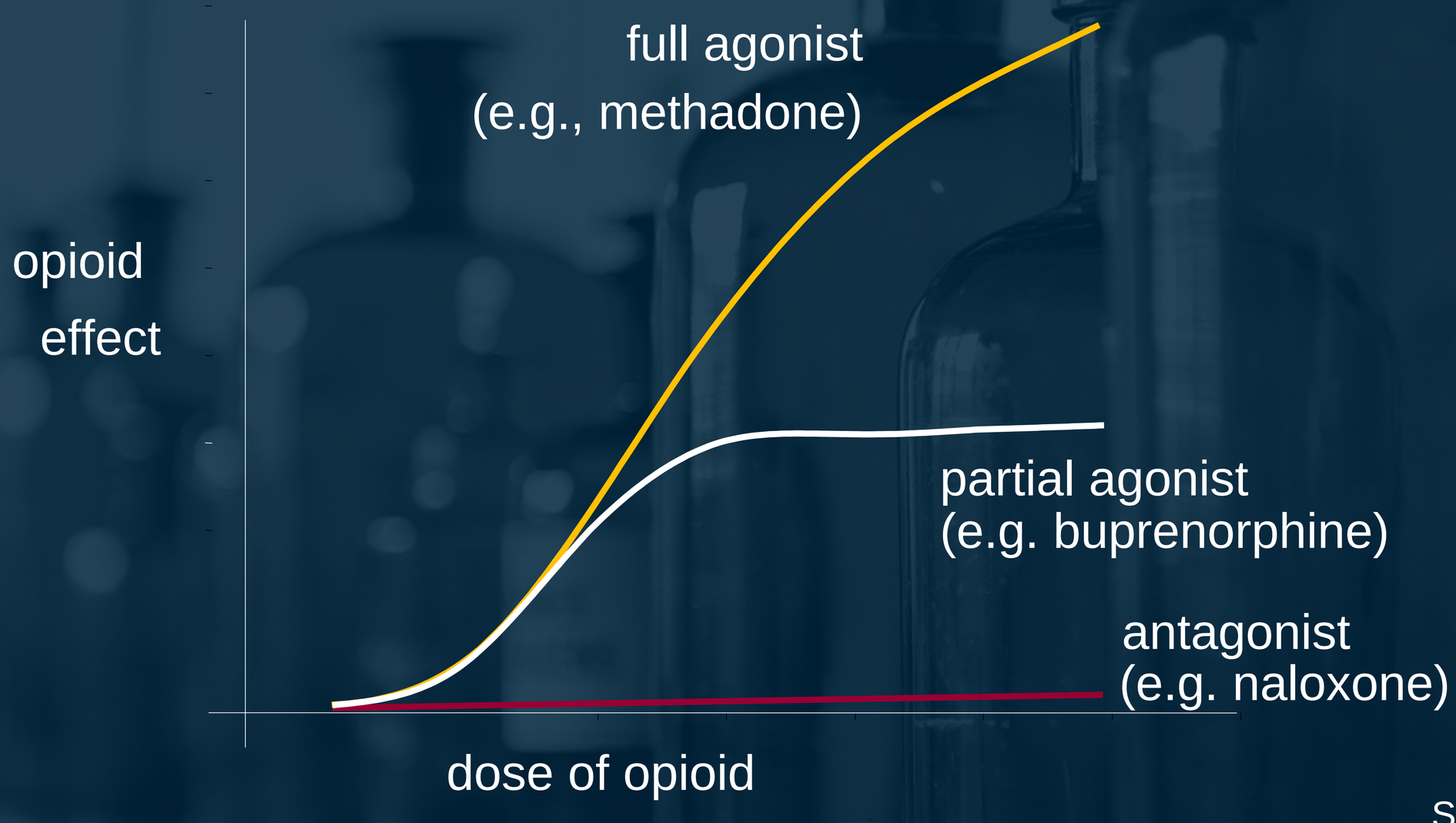
Medications for Opioid use Disorder

Methadone

Naltrexone/Vivitrol

Buprenorphine

How do Opioids Work?



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Methadone

The “gold standard” in opioid addiction treatment. Introduced in US in 1960s

Full agonist, once-daily dosing, also used to treat moderate-severe pain

Dosing: Average effective dose 80-120 mg/day

Dose begins @ 30mg, then titrates up 3mg or more/day

Pros: Affordable, highly effective, safe in pregnancy, convenient once-daily dosing

Research consistently shows methadone is cost-effective, increases employment and reduces criminal activity

Cons: Must be dispensed in OTP, strict regulations, burdensome attendance requirements

Common side effects: constipation, excessive sweating, risk of overdose esp w/alcohol

Naltrexone, Vivitrol

Opioid antagonist: binds to opioid receptors, maintains state, blocks other opioids

Prevents user from getting high in event of recurrence

Pros: Blocks the high of opioids, non-addictive, no risk of misuse, monthly injection very convenient

Probably most effective when agonist medications are unavailable

Dosing
Tablets: 50mg once/day
Vivitrol: 380mg monthly intramuscular injection

Dose begins @ 30mg, then titrates up 3mg or more/day

Cons: No effect on craving or withdrawal, very hard to maintain adherence, high risk of OD, not much evidence

Anecdotal reports that by day 21 or so after injection, the full effect wears off

Buprenorphine

- Opioid partial-agonist: binds to opioid receptors, partially activates them
  - Provides craving relief AND blocks additional opioids
- Dosing:
  16mg or higher 1x/day
  Available in film, tablet, buccal film, and implant
  - Dose begins @ 8mg, then titrates up to effective dose
- Pros: Blocks the high of opioids, provides full craving relief, presence of naltrexone prevents IV use
  - Office based prescribing helps reduce stigma, does not require daily attendance
- Cons:
  Can be expensive, few doctors accept insurance, fewer sober housing options
  - Primary side effects constipation, excessive sweating (though not as bad as methadone)

What does the research say?

- There has never been a single RCT that showed an abstinence-based treatment could outperform agonist medications.
- At least 80% of patients treated without meds return to opioid use (in some studies, as many as 93-100%). Whereas treatment retention rates are 60-80% with medications while only 15% continue to use opioids.
- Dosing must be adequate.
- Open-ended treatment is key, forced tapers DO NOT WORK
- Patient choice is key. As long as they are well-informed, let them decide!

Who is Appropriate for Maintenance Treatment?

- Adults with long-term opioid addiction (arbitrary length of time: >12 m0nths)
- Willingness to use medications
- Especially if previously attempted treatment/recovery
- Is currently abstinent but struggling with cravings, low mood, agitation, etc., all of which are symptoms of opioid deficiency syndrome

So - What Do We Need to Know?

- With opioid addiction and overdose rates reaching epidemic proportions, MH Professionals must be armed with the knowledge and skills to offer the best available treatment to our clients.
- Currently, there are several FDA-approved anti-relapse medications available, but their use is still controversial in many circles.
- Multiple local and national initiatives are aimed at affecting change.
- Be aware of promising future directions and potential changes.

Questions and Discussion

THANK YOU!

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