Medication Assisted Opiate Addiction Treatment: Considerations for the Criminal Justice System

Ted Parran JR. M.D.  FACP
Carter and Isabel Wang Professor of Medical Education
CWRU School of Medicine

tvp@cwru.edu
The Natural History of Opioid Addiction: A public health perspective on the disease of addiction
The Natural History of Opioid Addiction

• High mortality rate
• High incarceration rate
• High relapse rate

BUT ALSO …

• More than 50% eventual “sobriety” rate (if you include stable OMT with abstinence as “sober”)

SO THE GOAL IS …

• Keep them alive, increase sobriety and decrease relapse!
Ever Addicted and still alive after 40 years?

- Only 38% of original group – “we lose lots of them”
- 10% incarcerated
- 18% actively addicted / daily use
- 16% on OMT (methadone maintenance)*
- 58% abstinent**
- Totally contrary to popular myth

* More patients are on OMT today due to increased slots in methadone and DATA 2000 buprenorphine availability
** If roughly 50% of OMT patients are otherwise abstinent, then the “% abstinent” rate is ~ 68%
The Pharmacotherapy of Opiate Addiction: MAT (medication assisted treatment)

• Why Do It? (re: the patient or probationer)
  – It decreases relapse
  – It decreases re-incarceration
  – It decreases death rates
  – ... SO IT IMPROVES LIVES

• Why Do It? (re: the provider or probation officer)
  – IF it does all of the above ... then it makes dealing with these people easier and less troublesome and more efficient (and more enjoyable).
MAT – can we *(you)* really require it?

• *Can MAT be required by the Courts??***
  – Some say “no” … some say “yes” … and some say “it doesn’t matter”

• **IF** the Court requires **FULL** adherence with the treatment plan … and then the Court **only** uses treatment programs that routinely put MAT in the treatment plan … it is the treatment program and not the Court that requires the MAT!
MAT: 2 Approaches

• Harm Reduction:
  – Pharmacotherapy first ??? Addiction TX second
  – E.g. historical methadone maintenance experience
  – E.g. “stand alone Suboxone”

• Adjunct to or Addition to Treatment:
  – Treatment first
  – Then add in MAT to try to improve outcomes
  – E.g. Intensive Outpatient Counseling & 12 step meeting attendance … plus Methadone or Buprenorphine or Naltrexone

• For the Justice System clients … AVOID HARM REDUCTION and REQUIRE ADDITION TO TREATMENT
MAT with opioid dependence:
What Are The Medications???

• Methadone: “opioid maintenance treatment”
  – ONLY if part of a Methadone Treatment Program
  – ONLY if you contact the Program and designate that this is a “Justice System Client” who must be abstinent (not harm reduction)!

• Buprenorphine: “opioid maintenance treatment”
  – Not harm reduction (as above)

• Naltrexone: “opioid blocker treatment”
  – Pills (naltrexone) or Shots (Vivitrol)
Addiction Relapse Rates: \textit{Duration} of RX

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- nicotine abstinence
- heroin abstinence
- alcohol abstinence
MAT: *Duration* of RX (>\(\geq\)=2yrs)

- Methadone maintenance data:
  - In patient doing well
  - Duration of *two years* or longer
  - Produced improvements in morbidity and mortality

- AA data:
  - Lead in Home Group after one year
  - Sponsor others after *two years*

- Anything that AA and methadone treatment agree on *MUST* be important … so > *two years* duration
MAT options in opioid addiction

- Opioid **blocker** therapy
  - Which blocker approach to use?
    - Oral naltrexone (PILLS)
    - Injected naltrexone (SHOTS / longer-term implants)
    - Combination of oral and injected naltrexone (BOTH)

- Opioid **maintenance** therapy (methadone or buprenorphine)
  - Which agonist to use?
    - Methadone program
    - Buprenorphine program, (SL or implants)

- Blocker or maintenance MAT double sobriety*
Opioid BLOCKER Therapy

• Oral naltrexone: (the pills)
  – Advantages: easy, anyone can RX, only involves RX, higher blood levels, less cumbersome, much cheaper, works three times a week or daily.
  – Disadvantages: lower compliance, only demonstrated to have reasonable compliance in coerced populations (i.e. probationer and physician studies)
  – **Must** be built into parole / probationary language
  – **Must** have “supervised self admin” in IOP / aftercare
  – **Must** have “observed self-admin” at PO visits
Opioid BLOCKER Therapy

• **Injected naltrexone: (the shots)**
  – Advantages: once monthly injections document compliance, gives the sense of control (for the Medical Board / PO / Court), no need to deal with supervised / observed administration.
  – Disadvantages: riskier (it is a procedure), lower blood levels, much more expensive, tricky re: insurance coverage, not many injection centers.
  – **Must** be built into parole / probationary language
  – ? 3-6-9 month implants are being launched (without FDA approval) 2015-2016.
Opioid BLOCKER therapy - summary

- PILLS - Easier and cheaper
- SHOTS – make monitoring simpler
- SHOTS & PILLS – shots for 2-3 months followed by PILLS is one more cost effective approach.
- It MUST be required by probation / parole
- ? Emerging longer-term implants
Opioid maintenance treatment

• Intoxication with opioids (and nicotine) does not produce significant judgment impairment.
• Discrete receptor system (like nicotine, and unlike alcohol, cocaine / amphetamines)
• Potential for blocker OR replacement therapy -
  – nicotine replacement therapy
  – opioid maintenance therapy
• Is it “A DRUG FOR A DRUG”?  
  – Yes (of course) !!!!!!
• If used right it is “a medication to help improve success of a sobriety program”
Opioid maintenance treatment

• Duration of therapy: best if 2 years or longer
• Need for comprehensive longitudinal approach (i.e. build OMT into a full treatment program).
• Need abstinence from all other euphoria producing substances … so need OMT to be integrated into a well rounded sobriety program.
MAT maintenance: outcome data

• Opiate maintenance therapy (methadone OR buprenorphine) on balance results in improvement in every domain of life function … especially if combined with good treatment:
  – family
  – health
  – legal
  – employment
  – financial
Opioid maintenance therapy: METHADONE

- Developed in 1960’s … Licensed in early 1970’s.
- The most regulated drug in history.
- The most researched addiction treatment modality in history.
- The most misunderstood addiction TX ever.
- Works **well** – **if** used as addition to treatment … in a good quality Methadone Program.
Opiate maintenance - methadone

• What's a “GOOD” methadone program?
  – Release of information for all health care / social service / legal providers … with frequent contact
  – Tox screening monthly or more often – results avail.
  – Counseling
  – Flexible TX Plan … harm reduction OR abstinence
  – The TX Plan should be CLEAR (and shared)
  – Dose =/< 120mg/d
  – Discourage other controlled RX drugs (benzos etc.)
  – Increasing intensity of treatment over time if non-adherent (problem urines due to still using)
Opioid maintenance: buprenorphine

• Developed in 1980’s … Licensed in late 2002.
• Combined with *naloxone* (to discourage IV use)
  – Suboxone / Zubsolve
• Non-combined product (just buprenorphine)
  – Subutex / generic buprenorphine
• Non-combined - ONLY used in pregnancy
• All non-pregnant patients should be on **combined**
• Works **well** – **if** used as addition to treatment … in a good quality buprenorphine program.
Opioid Intrinsic Activity

Full Agonist
Morphine, Oxycodone
METHADONE

Partial Agonist
BUPRENORPHINE

Antagonist
NALOXONE, NALTREXONE

Opioid effect
- Analgesia
- Sedation
- Respiratory depression

% Efficacy

Log Dose of Opioid
SL burpenorphine v. methadone

• Advantages v. methadone
  – Works as well / lower abuse potential (not C II) / less withdrawal upon cessation / less dangerous in over-dose

• Disadvantages v. methadone
  – more expensive / less studied / SL not PO / since prescribed and not administered = much much more diversion

• Buprenorphine diversion = relatively therapeutic (used for TX or to avoid W/D)
Opiate maintenance - buprenorphine

- What's a “GOOD” buprenorphine program?
  - Release of information for all health care / social service / legal providers … with frequent contact
  - Tox screening / Counseling / PMP checks required
  - Dose =/< 16mg/d … most patients on 4-12mg/d
  - Requires combined bup-naloxone product mostly
  - NO other controlled RX drugs (benzos etc.)
  - Increasing intensity of treatment over time if non-adherent (problem urines due to still using)
  - Accepts insurance payments for visits
Emerging buprenorphine news

• Changing State Medical Board rules
• Implants – ? once a month / ? once every three month implants just FDA approved
• Unclear if it can be repeated after 3 months
• Roughly equivalent to 8mg SL/d – only one dose
• Better adherence: SL actually = erratic levels
• Clearly less diversion potential
PO Monitoring When on MAT

• Constant awareness of client’s level of participation in Tx. Prog. (releases!!!!!!!!!!!!)
• Ask Tx. Prog. Re: PMP & tox results / continued use of MAT / presence and progress in TX.
• Obtain patient and collateral report of sobriety and full adherence with the treatment program.
• 12 Step Monitoring:
  – Ask client AND sponsor: how often / which meetings / what “step” working on … PLUS signed slips.
• ANY slip in adherence = relapse risk increase!!!!
Summary: MAT for Opioid Addiction

• Opiates work on specific receptors
  – Therefore there are viable blockers and maintenance

• Effectiveness of MAT:
  – Naltrexone (pill or shot) ~40-60% sobriety
  – Methadone ~ 40-60% sobriety
  – Buprenorphine ~ 50-60% sobriety

• Duration – 24+ months

• Dose – lowest effective dose

• EVERY opioid addict should be on one of these three medications
Questions?