Welcome!

The Nevada Opioid Center of Excellence (NOCE) is dedicated to developing and sharing evidence-based training and offering technical assistance to professionals and community members alike. Whether you're a care provider or a concerned community member, NOCE provides resources to support those affected by opioid use.

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Medications for Opioid Use Disorders

The Basics

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Introduction

- *Dr. Krista Hales, DBH LADC-S*
- *14+ years in substance use disorder prevention / treatment / recovery advocacy field*
- *Community Affiliations: SAMHSA Subject Matter Expert, NV Governor's Behavioral Health Board, Shine A Light Foundation, There is No Hero in Heroin Foundation (TINHIH), Southern NV Opioid Advisory Counsel, and lead for several events.*

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Learning Objectives

- *Gain a comprehensive understanding of Medications for Opioid Use Disorder (MOUD), including their benefits and applications in treating opioid addiction.*
- *Explore the specific medications used in MOUD, including Buprenorphine, Methadone, and Naltrexone, and how they are implemented in opioid addiction treatment.*
- *Learn effective methods for engaging with clients about their opioid use and educating them on available treatment options, empowering them to make informed decisions.*
- *Utilize the Stages of Change framework to assess and determine client readiness for substance use treatment.*
- *Discuss evidence-based treatment options for clients with polysubstance use disorders, focusing on substances such as alcohol and cocaine*

First things first…

What do you know about Medications for Opioid Use Disorder?

Put it in the chat!

History of MOUD

- *The first medication assisted treatment option for Opioid Use disorders was developed in the 1960's in response to the post WWII heroin epidemic occurring in NYC (French Connection). At the time, heroin related overdose was the leading cause of death in NYC in young adults.*
- *Recognition that traditional avenues of treatment weren't working well, and even several attempts at a "maintenance" treatment had not worked well.*
- *Methadone maintenance began as a research project at The Rockefeller University in NYC under the direction of Dr. Vincent P. Dole and Dr. Marie E. Nyswander.*
- *Nyswander and Dole's work created the foundation of the current model used in methadone maintenance treatment*
- *Key findings*
    - *No euphoric/analgesic effects at stable doses*
    - *Doses between 80-120mg held at level to block the euphoric and tranquilizing effects of continued opioid misuse*
    - *No change in tolerance level over time*
    - *Could be taken once a day*
    - *Relieved craving attributed to relapse*
    - *Medically safe and nontoxic*

Key Legislation Related to MOUD

- *Harrison Narcotic Act 1912: On its surface, a tax act on distribution and dispensing of opium and coca. However, some language within the act was later used to prosecute physicians who were providing opium based products to persons known to have an opium addiction to "maintain their habit." Lead to a series of law suits and physicians arrests.*
- *Narcotic Treatment Act 1974: Created a requirement that practitioners conducting methadone treatment register as a Narcotic Treatment Program (NTP)*
- *The Drug Addiction Treatment Act of 2000 (DATA 2000): Created the waiver which allows physicians to prescribe certain opioids (buprenorphine) to treat opioid addiction without having to register as a NTP – Narcotic Treatment Program*
- *Consolidation Appropriations Act of 2023: Removed the federal requirement for practitioners to submit a notice of intent to prescribe medications, like buprenorphine, for the treatment of opioid use disorder. Any practitioner who holds a DEA registration that allows them to prescribe schedule III narcotics can prescribe buprenorphine through their practice.*
- *Continued discussion regarding the regulation / licensure of Opioid Treatment Providers (OTPs) for methadone maintenance treatment.*

MEDICATIONS FOR OUD

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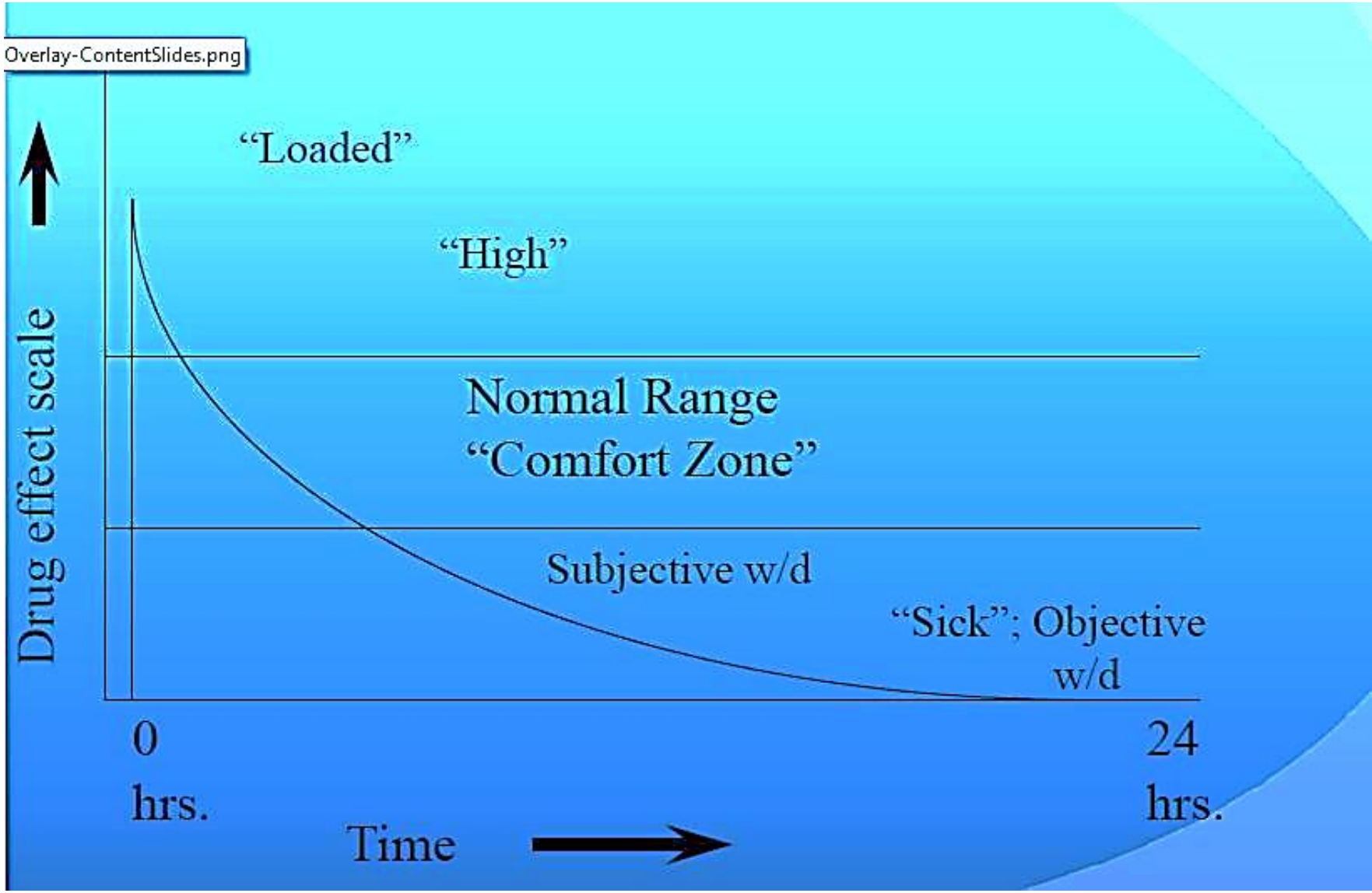
Methadone

- *Long-acting synthetic opioid*
- *Full-agonist (binds to receptor)*
- *Comes in a variety of forms:*
  - Pill form, diskette, liquid
  - Most OTPs use liquid methadone (greater dose individualization, correlated to lower diversion)
- *When used in proper doses in maintenance treatment, methadone does not create euphoria, sedation, or an analgesic effect.*
- *Doses must be individually determined*
- *Can be prescribed by physicians ONLY for the management of pain (most often in pill form)*
- *Can only be administered through an OTP for the treatment of addiction*

24 Hour Response to Heroin Use



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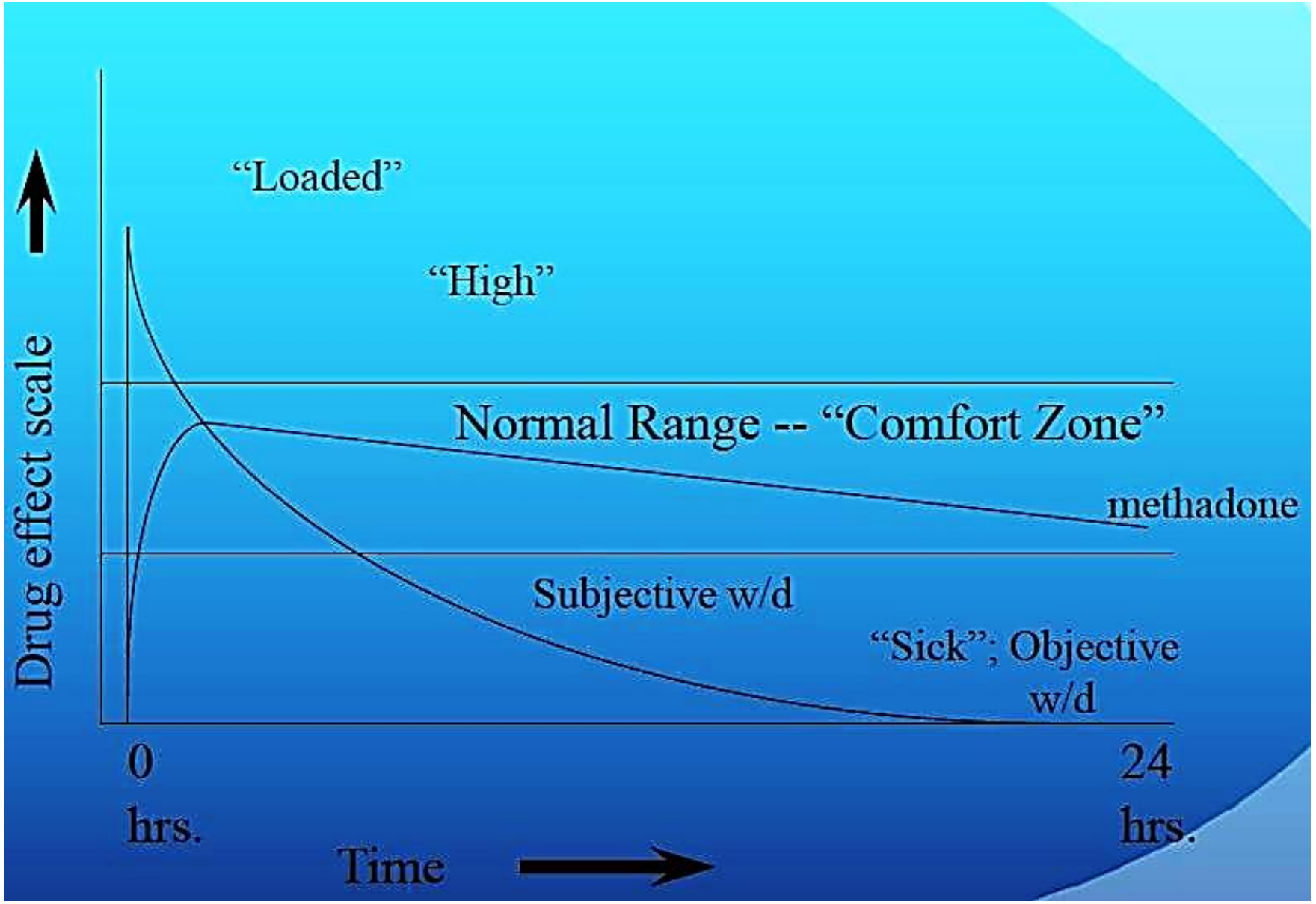
24 Hour Response to Methadone Maintenance



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Buprenorphine

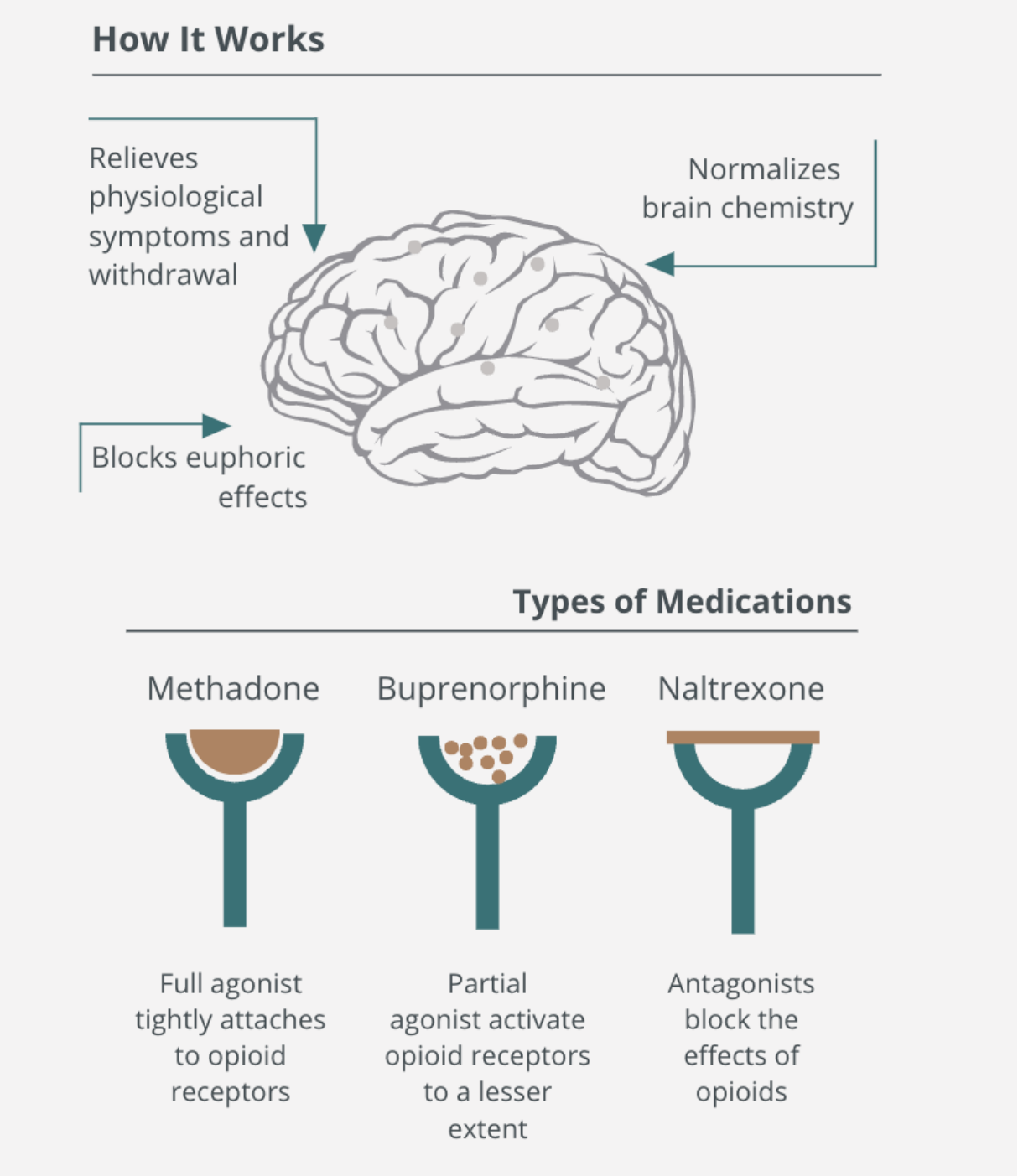
- *Long-acting synthetic opioid*
- *Partial Agonist (binds but no response)*
- *Brand names include: Suboxone, Subutex, Bunavail, Zubsolv, Sublocade (injectable), Brixadi (injectable), Probuphine (subdermal implant)*
- *Sold as both a single product (buprenorphine only) or as a combination product (buprenorphine/naloxone), typically taken sublingually (under the tongue)*
- *Combination product reduces the likelihood of diverting the medication to intravenous use (when injected, naloxone causes opioid withdrawal symptoms)*
- *Can be dispensed through an Opioid Treatment Program OR can be given as a prescription by physicians through their practice (referred to as OBOT – Office Based Opioid Treatment)*

Naltrexone

- *VIVITROL® is a once-a-month injectable form of naltrexone. It was originally approved, and is still used, for the treatment of Alcohol Use Disorder. It was later also approved for use in the treatment of Opioid Use Disorder. Implant version is not FDA approved at this time.*
- *Naltrexone is an opioid antagonist, which means it prevents chemicals from binding to receptors.*
- *Because of this, persons starting treatment with VIVITROL ® for an Opioid Use Disorder must already have achieved a period of abstinence from illicit opioids. As such, VIVITROL ® has been found to be an effective medication to prevent relapse following inpatient treatment or detoxification, following completion of another form of MAT, or following incarceration.*
  - These are times when persons with an opioid use disorder are especially vulnerable to relapse, and (due to loss of tolerance) are also at increased risk of *overdose* as a result of the relapse.

Visualize the Difference

Addiction Policy Forum



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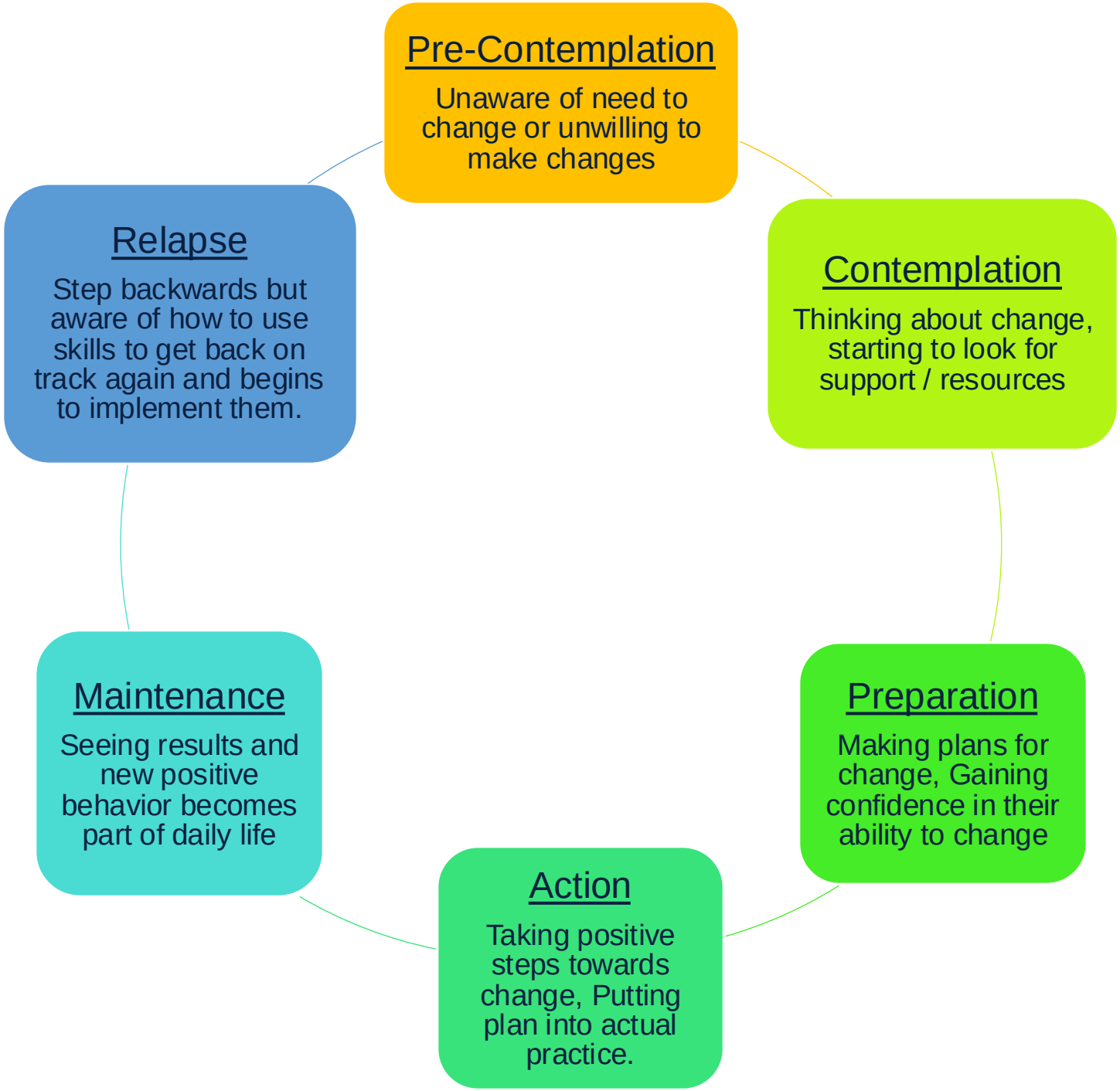
TREATMENT

Stage of Change Framework



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Screening Tools and Resources

- *SBIRT*
  - Screening, Brief Intervention, and Referral to Treatment
  - Quickly assess severity of use, identify level of care need, focus on insight/awareness and motivation to change, and connect to appropriate level of care.
- *TAPS1 & TAPS2*
  - Tobacco, Alcohol, Prescription Medication, and Other Substances
  - Utilizes SBIRT questions
  - Can be self-administered and does come in electronic format
  - If positive on TAPS1 (5 questions), will give the patient the TAPS2, which scores this risk severity
- *DAST 10 (Adults) & DAST 20 (Adolescents)*
  - Drug Abuse Screening Test
  - Can be self-administered or completed in interview format
  - Does NOT include alcohol or tobacco
  - Identifies negative consequences associated with use and their risk.

Two Models of MOUD

Opioid Treatment Programs (OTP)	Office-Based Opioid Treatment (OBOT)
• Direct administration of medication (methadone or buprenorphine) on a daily basis. • Individuals stable on the medication and abstaining from substance use, who have actively engaged in a recovery process and are demonstrating improved overall functioning can earn/accrue “take-home” medication. • Heavily regulated by federal agencies (CSAT, DEA) and state agencies (DHEC, Board of Pharmacy) • Accreditation requirements (CARF, Joint Commission, etc.) • Behavioral interventions, s. a. individual/group counseling, are required components of care. • Low rates of diversion due to heavy monitoring and required diversion control measures/plan	• Buprenorphine prescribed by physicians in an office setting. • Previous restrictions: Can treat up to 30 patients in the first year. After one year can apply to increase the limit to 100. After one year at the 100 patient limit, can apply to increase the limit to 275 (with additional requirements) • Must have DEA license to prescribe schedule III narcotics. • Should be able to demonstrate the capacity to refer to counseling/behavioral health treatment

Engaging Clients in Discussion

- *Decision to start MOUD needs to be a patient & doctor decision.*
- *However, you can make sure they are well-informed about their options before they make that decision.*
- *In an OTP setting,*
  - Discuss all options available to the patient whether you provide them or not. If you do not provide all three options, you should refer to a provider that allows the patient to enroll in the medication of their choice.
  - Encourage active participation in treatment by including the patient in the treatment planning process. This means you need to meet them where they are at, not where you want them to be.
- *In an OBOT setting,*
  - Ensure ALL staff is educated on MOUD and treatment options.
  - Have all staff trained in SBIRT, even if they do not have direct client care. SBIRT allows staff to be more educated and less judgmental to those who need a harm reduction approach to their recovery.
  - Approach conversations with patients as “this is another option on the table, especially if you have tried other options.”
  - Keep an open mind and do not push an agenda on the patient.
  - Have connections to behavioral health providers! The medication alone is not going to support the patient’s needs.
  - Consider having Peer Support on staff.

Typical Admission Criteria in an OTP

- *18 years of age or older*
- *Minimum 1 year history of Opioid Misuse (distinct from dependence)*
- *Meets criteria for an Opioid Use Disorder based on criteria set in the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5*
- *Admission process:*
  - Screening to ensure federal and state admission criteria are met
  - Biopsychosocial Assessment
  - Physical Examination by program physician
  - Health History and Communicable Disease Risks screening
  - Urine Drug Screen
  - Blood work
  - (RPR, CBC, PPD, etc.)

Services in an OTP

- *Counseling based on an Individualized Treatment Plan*
  - Individualized Treatment Plans are developed *collaboratively* with the patients, are measurable and time specific, and based on the patient's strengths, needs, abilities and preferences
- *Case Management*
  - Coordinated referrals to other community services and resources, such as medical and dental care, housing, SNAP, mental health services, etc.
- *Nurse Consultation*
  - Care coordination with primary medical care providers, assistance with accessing care for communicable disease (such as Hepatitis C), and psychoeducation for communicable diseases
- *Annual Physicals*
- *Drug-Screening*
- *Medication In-House*
  - Taken once daily for the management of withdrawal and cravings, and stabilization of functioning

Determining Medication

- *Methadone: Higher tolerance, longer history of substance misuse, additional use to opioids, high risk behaviors and home environments, pregnancy, co-occurring disorders*
- *Buprenorphine (or formulation of): Lower tolerance, shorter history of substance misuse, more stable home environment, few risk taking behaviors, can be used to reduce risk of NAS/NOWS in pregnant women*
  - Sublocade (injection) – must stabilize on 24mgs or less of oral Buprenorphine for a minimum of 7 days
  - Brixadi (injection) – Oral test dose of 4mg first. If no precipitated withdrawal, can begin weekly dosing.
  - Probuphine (implant) – must stabilize on 8mgs or less of oral Buprenorphine for a minimum of 90 days
- *Vivitrol: Most stable recovery environment/support system, recovery process began before medication is administered*

BY THE NUMBERS

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Effectiveness of MOUD

- *With over 50 years to support it, methadone treatment is considered the most effective treatment for chronic heroin dependence*
  - NIH: "the safety and efficacy of MAT has been unequivocally established. …[M]ethadone maintenance coupled with relevant social, medical and psychological services has the highest probability of being the most effective of all treatments for opioid addiction."[1]
- *One study found that those who receive MOUD are 75% less likely to have a substance use-related death than those who do not receive MOUD*[2]
- *MOUD has been shown to improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity; increase patients' ability to gain and maintain employment, improve birth outcomes among women who have substance use disorders and are pregnant, and lower a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse.*[3]

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1. "Confronting an Epidemic: The Case for Eliminating Barriers to Medication-Assisted Treatment of Heroin and Opioid Addiction," Legal Action Center, March 2015.
2. Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, SAMHSA, 2008.
3. https://www.samhsa.gov/medication-assisted-treatment/treatment

Cost Benefits

- *The average cost for 1 full year of methadone maintenance treatment is approximately $4,700 per patient, whereas 1 full year of imprisonment costs approximately $18,400 per person.*[4]
- *A review of literature on the cost-benefit and cost-effectiveness of MOUD concluded that methadone and buprenorphine are both cost-effective treatments for heroin or other opioid addiction, and that methadone is typically the most cost-effective therapy of these two.*[5]

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[4] Understanding Drug Abuse and Addiction: What Science Says; National Institute on Drug Abuse
[5] Review of Cost-Benefit and Cost-Effectiveness Literature for Methadone or Buprenorphine as a Treatment for Opiate Addiction; Center for Health Program Development and Management (Center) at the University of Maryland, Baltimore County

Documented Outcomes of MOUD

- *Reduction in use of opioid and all illicit drugs*
- *Reduction in criminal activity*
- *Reduction in needle sharing*
- *Reduction in HIV and Hepatitis B/C Infection rates and transmission*
- *Reduction in commercial sex work*
- *Reduction in number of reports of multiple sex partners*
- *Reduction in suicide*
- *Reduction in lethal overdose*
- *Improvements in social health and productivity*
- *Improvements in health conditions*
- *Retention in treatment*

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Local Data in Nevada

Surveys from Behavioral Health Group (formerly Center for Behavioral Health) from 2017 – 2021.

- *27% increase in adequate employment within 5 months of admission*
- *19% increase in physical health improvement within 1 year of admission*
- *21% increase in mental health improvement within 6 months of admission*
- *37% decrease in IV/IM substance use within 1 year of admission*
- *72% of patients report no use / 24% report reduced opioid use within 1 year of admission*
- *66% reduction in discharge rate when implementing additional services (peer support, co-occurring disorder counseling, syringe access, etc.)*

LET'S TALK IT!

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Stigma & Myths

- *Belief that they're using the medication "to get high"*
  - REALITY: Methadone or buprenorphine at stable doses do not produce euphoria. *Numerous* studies have been done on methadone maintenance patients have shown that methadone, used as a medication, does not hinder a person's ability to function in any mental or intellectual capacity.
- *It's simply "substituting one drug for another"*
  - REALITY: The medications used in treatment for OUD are fundamentally difference from short-acting opioids misused by persons with an OUD
  - REALITY: Research confirms "improved" opioid systems, including, e.g., the hypothalamic-pituitary-adrenal axis, which affects stress response, immunity, and other systems
- *"You just want to keep them on treatment for life" or "You're enabling them by keeping them on medication" or "it's a crutch."*
  - REALITY: Research consistently shows better outcomes with adequate treatment length. Studies show longer lengths of time in methadone treatment yields better outcomes. For some, remaining on the medication long-term may provide the best likelihood of sustained recovery and well-being.
    - **Medication Assisted Recovery (MAR):** A non-stigmatizing description of the recovery *made possible* through successful use of MOUD. No medication can cure OUD; however, medication can play a critical and even lifesaving role in helping people achieve and sustain long-term recovery.
  - REALITY: The use of Medications in the management of Chronic Disease is *not new.*

Who are MOUD patients?

- *People who use heroin or opioid pain pills*
- *Bartenders*
- *Sex Industry Workers*
- *Pregnant Women*
- *Construction Workers*
- *Mechanics*
- *School Teachers*
- *Nurses*
- *Social Workers*
- *Lawyers*
- *Business Owners*
- *Politicians*
- *Veterans*
- *Your Neighbor…*

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*
- *Primary treatment is lifestyle modification*
- *Medications can help*
- *When patient is non-compliant with lifestyle modification, medication use is titrated to maximize outcome*

Opioid Use / MOUD

- *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*
- *Primary treatment is lifestyle modification*
- *Medications can help*
- *When patient is non-compliant with lifestyle modification .....They don't want it bad enough? Administratively discharge? Wait till motivated? Withhold medication till they try harder?*

Your Questions

- *Does NV Health Plan assist with medication expenses?*
  - Currently Nevada Medicaid plans cover all expenses within an OTP/OBOT setting but there may be prescription co-pays. These co-pays are standard prescription rates.
  - Additionally, most manufacturers have discount coupons or GoodRX can be utilized.
  - Advocate for your patients/clients to consult with their insurance provider and pharmacist.
- *How do the courts view MOUD in the recovery process?*
  - This varies. Both the Northern and Southern parts of the state have MOUD speciality courts and most Judges are MOUD friendly. However, there may be other various factors involved in the guidelines of the courts that affect their acceptance.
  - It is important to remember that MOUD is protected under ADA regulations as long as they individual is not engaging in continued substance use.

Your Questions

- What are the safety guidelines for MOUD during pregnancy, and where can this population seek treatment?
  Generally speaking, there are multiple steps.

If mother is actively using and becomes pregnant:

- Mother needs to be evaluated by a medical professional (emergency room or OBGYN office)
- Induction of medication can take place in either location and both mother and baby should be monitored.
- Buprenorphine reduces risk of NAS/NOWS but methadone is considered standard treatment option.
- Routine prenatal care along with counseling and supportive services should occur throughout pregnancy.
- Mother should be prepared for potential CPS involvement upon delivery or post-delivery.

If mother is on MOUD and becomes pregnant:

- If on vivitrol, mother should meet with provider to discuss ceasing medication or switching.
- Maintain medication and communicate with provider about need for adjustment in dosage.
- Continued prenatal care / support from all providers.

PROGRAMS THAT CAN ASSIST PREGNANT MOMS WITH OUD:

- EMPOWERED Program through Roseman University
  - Empoweredmoms.org
- MOTHER Program through High Risk Pregnancy Center
  - HRPregnancy.com

Your Questions

- *How do we get providers on board with including MOUD services in their practices?*
  - Have open honest conversations – what are their barriers/hesitations?
  - Do they have connections to local resources that can help them?
  - Are they equipped to handle the process of screening/treatment?
- *What options are there for rural areas?*
  - OTPs (methadone) are for the most part in urban cities. However, OBOTs are an option or telehealth.
  - OTP locations can be found at nevadaopioidtreatment.org
  - OBOTs can be found through SAMHSA's treatment finder.

Testimonial – Dr. Julie Cope

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Additional Questions?

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