MAT for Special Populations:
The Whos, Whys & Hows of Access for All

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Disclosure Information

David R. Gastfriend M.D., DFASAM

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Options/Stock: Alkermes; Intent Solutions
Consultant Fees: BioCorRx, Indivior, Kaleo, Purdue, RCA
IBM Watson/Truven Health Analytics,
Rand Corp, US WorldMeds
AGENDA:

9:00 AM  Introductions & Workshop Agenda
9:15 AM  Who: Epidemiology of the Opioid Epidemic
9:30 AM  Why: Biological & Clinical Parameters
10:00 AM Break
10:15 AM Why: MAT Specific Issues
11:00 AM How: Sub-populations
11:15 AM Returning Citizens
12:00 PM Lunch
AGENDA:

1:00 PM    Adolescents
1:20 PM    Pregnant Women
1:40 PM    Racial & Ethnic Minorities
2:00 PM    Break
2:15 PM    The Homeless
2:35 PM    Rural Americans
3:00 PM    Native Americans
3:15 PM    Veterans
3:30 PM    How: Delivering Collaborative Care
4:00 PM    Conclusion
Purpose of the Webinar

- Although the Opioid Epidemic is killing a broad swath of Americans, there are important subgroups who are at even greater risk.
- Their vulnerability and specific needs deserve particular attention.
- MAT selection and delivery must be considered in light of these epidemiologic, biological and other clinical parameters.
- Focused attention to outreach, wrap-around services, and collaborative care can save lives, and build recovery and health for these patients, their communities, and society as a whole.
Objectives:

As a result of this workshop, participants will be able to:

- Understand the epidemiology of the opioid epidemic among key special populations
- Describe the brain receptor and clinical effects of MAT agents & approaches in these subgroups
- Engage & deliver effective care with MAT to a broad range of those in need due to OUD
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- **Cannabis**: 13.9% (37.6 million users > age 12)
- **Rx Drugs**: 6.9% (18.7 million users)
- **Cocaine**: 1.9% (5.1 million users)
- **Hallucinogens**: 1.8% (4.9 million users)
- **Inhalants**: 0.6% (1.7 million users)
- **Methamphetamines**: 0.5% (1.4 million users)
- **Heroin**: 0.4% (948,000 users)

HEROIN PAST YEAR USE

- 900K (2002: 0.2%)
- 600K (2015: 0.3%)
- 948,000 (2016: 0.4%)

# Heroin Users: 135% rise
# Heroin Deaths: 533% rise
- Opioid misuse continues its inexorable growth

11.8 MILLION PEOPLE WITH OPIOID MISUSE (4.4% OF TOTAL POPULATION)

- **11.5 MILLION** Rx Pain Reliever Misusers (97.4% of opioid misusers)
- **6.9 MILLION** Rx Hydrocodone
- **3.9 MILLION** Rx Oxycodone
- **228,000** Rx Fentanyl
- **948,000** Heroin Users (8% of opioid misusers)
- **641,000** Rx Pain Reliever Misusers & Heroin Users (5.4% of opioid misusers)
MH & SUD in America 2016 (past year, 12+ years)

Among those with a substance use disorder about:
- 1 IN 3 (37%) struggled with illicit drugs
- 3 IN 4 (75%) struggled with alcohol use
- 1 IN 9 (12%) struggled with illicit drugs and alcohol

Among those with a mental illness about:
- 1 IN 4 (23%) had a serious mental illness

7.5% (20.1 MILLION) People aged 12 or older had a substance use disorder
3.4% (8.2 MILLION) 18+ had both substance use disorder and a mental illness
18.3% (44.7 MILLION) People aged 18 or older had a mental illness

(SAMHSA, 2017)
Epidemiologic Trends: Florida

- 952 heroin & 1,390 fentanyl deaths in 2016
- 4/5 new heroin users began misusing Rx pain meds
- Hardest hit counties: Palm Beach (205), Broward (180), Miami-Dade (139), Duval (81)
- Most fentanyl deaths include Palm Beach (313), Duval (239), Miami-Dade (164), Broward (146), Orange (57)
- Heroin & fentanyl deaths ↑ 30% & 97%, respectively

FL Prescription Drug Monitoring Program (PDMP): 2016-17
- 7% drop in # patients Rxed schedule II-IV substances
- 69.3% drop in # patients with multiple-provider episodes

(FL Dept. of Health, 2017)
Epidemiologic Trends: Florida

- Schedule II-IV controlled substance prescribing is highest in the Panhandle, rural areas of north Florida & the Melbourne area

(FL Dept. of Health, 2017)
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Healthy Opioid Receptor Activity

**Dopamine**
- Eating when hungry
- Drinking when thirsty
- Rewards survival behavior

**Endorphins**
- Pain relief
- Stress relief
- Emotional bonding


Opioid Agonists & Partial Agonists

**Agonists**
- Opioid analgesics
- Illicit opioid (e.g., heroin)
- Methadone
- Activates opioid receptors
- Excess dopamine release

**Partial Agonists**
- Buprenorphine
- Same as agonists, but ceiling effect
Opioid Antagonist

Antagonist
- Naltrexone
- Blocks opioid receptor
- Preferentially binds to the opioid receptors
- Displaces opioids
Full and Partial Agonists vs. Antagonists

An agonist has an active site of similar shape to the endogenous ligand binding to the receptor and producing the same effect.

An antagonist is close enough in shape to bind to the receptor but not close enough to produce an effect. It also takes up receptor space and so prevents the endogenous ligand from binding.

<table>
<thead>
<tr>
<th>Opioid Effect</th>
<th>Log Dose</th>
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<tbody>
<tr>
<td>Full Agonist (Methadone)</td>
<td></td>
</tr>
<tr>
<td>Partial Agonist (Buprenorphine)</td>
<td></td>
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<tr>
<td>Antagonist (Naloxone)</td>
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Brain Reward: Clinical Pharmacology

- Nucleus Accumbens
- Ventral Tegmental Area
- Arcuate Nucleus
- GABA (Dopamine)
- Opioid Peptides
- Dopamine
Brain Reward: Clinical Pharmacology

- **Ventral Tegmental Area**
- **Nucleus Accumbens**
- **Dopamine**
- **GABA**
- **Opioid Peptides**
- **Arcuate Nucleus**
- **Naltrexone**
fMRI Cue Activation by Alcohol Images

Myrick et al., 2008
Brain Structure: Two Regions – Cortex & Limbic

Cortex
- Decision making
- Thinking
- Reasoning
- Learning

Limbic Region
- Basic Drives
- Experience of Reward, Euphoria

Fowler JS et al., 2011
Brain Structure:
Two Regions – Cortex & Limbic

Cortex
Role:
- Decision making
- Thinking
- Reasoning
- Learning

Limbic Region
Role:
- Basic Drives
- Experience of Reward, Euphoria

Interventions
- Psychosocial Therapies
- 12 Step Programs
- Monitoring

Interventions
- Agonist Medications
- Antagonist Medications

Fowler JS et al., 2011
Goals of Anti-Opioid Pharmacotherapy

- **Withdrawal Management**: Not considered treatment; Detox without continued meds dominates; is inadequate care
- **Early recovery protection**: period of highest risk for OD
  - Death rates upon prison release = 12-100x that of general population
  - Harm reduction, e.g., from HIV and HEP C transmission
- **Anti-craving**: stabilize urges/impulses to permit counseling
- **Stress Response Normalization**: OUD disrupts ACTH/Cortisol
- **Extinction**: of both positive and negative cue response
- **Biological Stabilization**: Eating, diurnal cycle, sexual function, capacity for self-care / activities of daily living / treatment retention, general healthcare, relationship bonding
- **NOT Recovery**: Disease acceptance, coping skills, rehab
The Stages of Change Model of Recovery

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

Addiction → Maintenance → Recovery

Precontemplation → Contemplation → Preparation → Action
Google implemented new restrictions on advertising related to searches for addiction treatment after “misleading experiences” involving treatment centers, a company spokeswoman said.

Dominick Reuter/Agence France-Presse — Getty Images
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Brain Reward:
With us throughout evolution
Both Reward/Motivation ("Go" signals) & Inhibitory Control ("No Go") disrupted in addiction – address BOTH in prevention & treatment

https://www.drugabuse.gov/sites/default/files/addictionscience.ppt
Clinical Aspects: Agonists vs. Antagonists

- **VIVITROL**
  - No drug reward
  - Moderate level of accountability

- **SUBOXONE**
  - Moderate drug reward
  - Moderate level of accountability

- **METHADONE**
  - Strongest drug reward
  - Highest level of accountability

Motivation vs. Stability Diagram

- Y-axis: Motivation (0 to 12)
- X-axis: Stability (1 to 10)
A Biopsychosocial Disorder Requires Treatment + Chemistry

Medications (All FDA-approved Agents)

Behavioral Therapies (Including Contingency Management)

Medical Detoxification Services

Recovery Support Services

Sanctions: measured, prompt, scientifically sound
MAT + Counseling? Or not?

- Recommended by national practice guidelines, e.g., ASAM
- Yet, BUP studies are emerging that counter this assumption
- Most such studies are short-term (3-6 months)
- Most do not assess recovery behavior beyond relapse
- NIDA Rx Opioid Random-Controlled Trial (RCT): (N=266): In patients who also used heroin & received BUP + adequate counseling, 66.7% had good outcomes, vs. 35.0% without adequate counseling (p=.016) (Weiss et al., 2014)
MMT: Reduction in Crime

Among 6 Methadone Maintenance Treatment (MMT) sites, crime days per pt. per year before (black bars) vs. during MMT.

(Adapted from Ball & Ross, The Effectiveness of Methadone Maintenance Treatment, 1991)
MMT vs. BUP: Cognitive Function

During Month 1 of Treatment:
- Delayed reaction time & verbal memory deficits: Methadone > BUP > CTRLs (Rapeli P et al. ISAM 2006)

After Maintenance is Established:
- ≈ Reaction time: MMT 100 mg vs. CTRLs (Gordon, Psychopharm 1970)
- ↓ Working memory: MMT 70 mg (Mintzer & Stitzer. DAD 2002)
- ↓ Verbal memory: MMT 35 vs. 17.5 mg (Curran et al. Psychopharm 2001)
- ↓ Visual memory vs. CTRLs: MMT 66 mg & BUP 9 mg (Pirastu et al. DAD 2006)
Adolescents

- As brain matures, gray matter declines in cortex (NIDA, 2017)
Neurobiology of Opioid Use Disorder

- Opioids: at substantia nigra & VTA interneurons, rapidly & briefly bind MOP-r, GABAergic inhibition of DA neurons

- **↑Dopaminergic Reward**: Initial positive reinforcement; later, regulatory changes via mRNA or protein/peptides

- **Recurrent withdrawal** negatively reinforces recurrent use, via regulatory changes that persist for weeks/months

- **Negative Reinforcement**: mediated via
  - Upregulation of the KOP-r/dynorphin system (may underlie aversion, dysphoria/anhedonia, and depression-like or anxiety-like states)
  - Stress-responsive brain areas via the hypothalamo-pituitary-adrenal (HPA) axis

(Kreek et al., J Clin Investigation 2012)
OUD Behavior: Mediators/Moderators

- Maturation, sanctions
- Support, counseling
- Opportunity, Outward Bound
- Contingency Management
All Populations: NIDA Principles

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Treatment must attend to multiple needs of the individual, not just drug use.
- Multiple courses of treatment may be required for success.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
All Populations: Abstinence → Recovery

After 5 years – if you are sober, you probably will stay that way.

It takes a year of abstinence before less than half relapse.

<table>
<thead>
<tr>
<th>Duration of Abstinence at Year 7</th>
<th>% Sustaining Abstinence through Year 8</th>
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<tbody>
<tr>
<td>1 to 12 months (n=157; OR=1.0)</td>
<td>36%</td>
</tr>
<tr>
<td>1 to 3 years (n=138; OR=3.4)</td>
<td>66%</td>
</tr>
<tr>
<td>3 to 5 years (n=59; OR=11.2)</td>
<td>86%</td>
</tr>
<tr>
<td>5+ years (n=96; OR=11.2)</td>
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NIDA
Methadone: For Whom?

- Demographics alone: don’t provide much guidance
- Age of opioid use initiation
  - May have some value,
- Addiction history
  - Length & severity (i.e. heroin use, injection history)
  - Premorbid functioning
- Patients with anxiety often find Methadone calming

(ASAM National Practice Guidelines, 2017)
Methadone: For Whom?

- Long history with chaotic lifestyle
- IV route of drug administration
- Needs close, daily supervision
- May have difficulty persisting with treatment
- High risk for diverting medication
- May benefit from take home contingency management
- Wants to continue some subjective sense of opioid dependence
- Has chronic pain problems & needs/expects opioids
- Pregnant or planning to become pregnant
- Is prepared for long-term or even lifelong dosing

(ASAM National Practice Guidelines, 2017)
Buprenorphine: For Whom?

- Able to maintain a treatment plan without the daily supportive contacts/structure of a clinic
- Has structure in daily life (e.g., employed)
- Has a strong sober support system
- Has adequate stress management skills
- Pregnant women
- Wants to continue a subjective sense of opioid reinforcement, but less than with methadone
- Does not need ongoing or planned opioid pain medication

(ASAM National Practice Guidelines, 2017)
Buprenorphine: For Whom?

- Less likely appropriate candidate for OBOT (Office-based Buprenorphine Opioid Therapy):
  - Dependence on high doses of benzodiazepines, alcohol, or other CNS depressants
  - Significant psychiatric co-morbidity
  - Multiple previous treatments (methadone) and relapses

(ASAM National Practice Guidelines, 2017)
Buprenorphine: For Whom?

- Cautions: Active alcohol, sedative/hypnotic/anxiolytic use
- Better if cardiac risk (prolonged QTC) that precludes methadone
- For patient who is able to tolerate a 12-24 hrs without opioids
- Has a daily schedule, routine, & environmental supports
- Can manage week-to-week visits without serious risks
- Is not active with alcohol BZx, or other sedative/hypnotics

(ASAM National Practice Guidelines, 2017)

- **Treatment Matching** is key: There is no superior approach – except the one that works for the particular patient!
- Segregated care = **BAD** care; patients need integrated care
Predictors of Continued Use of Extended-Released Naltrexone (XR-NTX) for Opioid-Dependence: An Analysis of Heroin and Non-Heroin Opioid Users in Los Angeles County

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ABSTRACT

Extended-release naltrexone (XR-NTX) is associated with an increased number of opioid-free days, improved adherence rates in substance use disorder treatment programs, and reduced cravings and drug-seeking behaviors. There is little evidence on the predictive associations between baseline characteristics of opioid-dependent patients and XR-NTX utilization. Some studies have demonstrated better pharmacotherapy adherence and/or retention rates among non-heroin opioid users compared to heroin users. This study examines predictive associations between characteristics of patients and XR-NTX utilization, as well as participants’ urge to use opiates. Our findings suggest that XR-NTX may contribute to decreases in urges to use among both heroin and non-heroin opioid users. Non-heroin opioid users and heroin users were retained in XR-NTX treatment for comparable periods of time. However, those who identified as homeless, injected opioids (regardless of opioid-type), or were diagnosed with a mental illness were less likely to be retained in treatment with XR-NTX.

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Special Populations in General

- XR-NTX may contribute to decreases in urges to use among both heroin and non-heroin opioid users.
- In Russia, Nunes et al., (2015) examined XR-NTX & 25 different clinical and demographic variables, and found no significant interactions (Nunes et al., 2015)
- In Los Angeles, non-heroin opioid users and heroin users were retained on XR-NTX for comparable periods of time.
- However, those who identified as:
  - Homeless
  - Injected opioids (regardless of opioid-type)
  - or diagnosed with co-occurring mental health disorder were less likely to be retained in treatment with XR-NTX. (Cousins et al., 2015)
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Special Populations:

- Returning Citizens
- Adolescents
- Pregnant Women
- Racial & Ethnic Minorities
- The Homeless
- Rural Americans
- Native Americans
- Veterans
Special Populations in General

- SAMHSA’s National Treatment Episode Data Set found 7 client characteristics associated with completing Substance Use Disorder Treatment:
  - (1) non-Latino White
  - (2) female
  - (3) older than 40
  - (4) more than 12 years of education
  - (5) employed
  - (6) use of alcohol as primary substance
  - (7) less than daily substance use at admission

(SAMHSA, 2009)
Special Populations in General

- In U.S., of those 12 years or older, past month prevalence of drug use was:
  - 3.1% among Asians
  - 8.8% among Hispanics
  - 9.5% among Whites
  - 10.5% among Blacks
  - 12.3% among Native Americans / Alaskan Natives
  - 14.0% among Native Hawaiians / Pacific Islanders
  - 17.4% among persons of 2 or more races

(NSDUH, SAMHSA-2013)
Special Populations in General

- Among non-heroin opioid users, baseline characteristics predicted reduced opioid use during a 12-week buprenorphine intervention, such as:
  - Sociodemographics -- age, lifetime major depressive disorder
  - History of substance use – having only used opioids orally or sublingually
  - Receiving no prior opioid dependence treatment. (Dreifuss et al., 2013)
- Homeless, patient who use needles (regardless of opioid-type), or have Co-Occurring Mental Health Disorder may require more intensive behavioral therapy to encourage XR-NTX adherence. (Sullivan et al., 2006)
KNOXVILLE, Tenn. (WATE) — Sixty-seven percent of fatal overdose victims with incarceration history within the last five years died within 18 months of their release from custody, according to a report by the Knox County District Attorney’s Office.
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Mortality Upon OUD Re-entry from Prison

Relative Mortality Risk = 12x the general population

Returning Citizens

- In a meta-analysis from UK, USA & Australian studies, OD deaths were 3-8X greater in the 1st 2 wks vs. 3–12 wks post-release (Merrall et al., 2010)
- Elevated mortality persists thru wk 4 (Degenhardt et al., 2015)
- Imprisonment is associated with other harms:
  - Shared use of needles & syringes – *while imprisoned*
  - Elevated HIV transmission (Dolan et al., 2015)
  - Elevated hepatitis C transmission (Larney et al., 2013)
Returning Citizens

- **Opioid Agonist Therapy (OAT)** *in jail/prison* reduces:
  - IVDU
  - & needle sharing
    (Dolan et al., 2003; Larney et al., 2010)

- *Post-release*, with continued retention in the community, **OAT also significantly reduces**:
  - mortality  (Deghenhardt et al., 2014)
  - & re-arrest  (Larney et al., 2012)
Returning Citizens

- BUT, returning citizens are ambivalent RE OAT vs safety
- Over 1/3rd on in-jail OAT seek to withdraw prior to release
- Reasons: Concerns that community OAT could lead to drug use or offending, family opposition, inconvenience of clinic attendance, stigma
- Perception that prison is easier opportunity to withdraw
- Desire to ‘be clean’ and the long-term nature of OAT
  (Larney et al., 2017)
Returning Citizens

- In Rhode Island, in 2017, inmates entering jail/prison who were already on MAT were continued on it.
- Also, MAT was offered upon re-entry, statewide.
- OD death rates within 12 months of re-entry were over 60% lower (p< .01) in the year after MAT was widely introduced.
- Most deaths: Fentanyl.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart}
\caption{\% of OD Deaths Post Re-entry}
\end{figure}

(Green et al., 2018)
Extended-Release Naltrexone for Alcohol and Opioid Problems in Missouri Parolees and Probationers

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Alcohol

ABSTRACT

The purpose of this study was to compare the naturalistic outcomes of parolees and probationers with alcohol and/or opioid problems who were treated with extended-release naltrexone (XR-NTX) to those treated with other medication-assisted therapies or psychosocial treatment only. Methods consisted of using intake and discharge data collected as part of SAMHSA’s Treatment Episode Data Set (TEDS) assessments, controlling for group differences using propensity scores that were based on a range of intake variables. Results showed that patients receiving XR-NTX had longer durations of care (compared to oral naltrexone and psychosocial treatment only) and were more likely to become abstinent (compared to oral naltrexone, buprenorphine/naloxone, and psychosocial treatment only). Findings were similar for the total sample and those with opioid problems. These XR-NTX results were found in the absence of significant differences in rates of self-help participation. No differences were found in employment or arrests in this relatively short time frame. This study documents the real-world effectiveness study of current FDA-approved addiction medications in parolees/probationers and encourages the use of XR-NTX in such a criminal justice population.

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(Critos-Christoph et al., 2015)
XR-NTX in MO Probation & Parole

Naturalistic outpatient treatment, retrospectively analyzed; XR-NTX (N=156), Oral Naltrexone (N=45), Bup/Nal (N=168), No Meds (N=2513)
Returning Citizens

- MAT: Effective and is recommended for prisoners & parolees regardless of the length of sentence
- CJ OUD patients need MAT + psychosocial treatment
- ALL MAT should be used in CJ systems
- There is insufficient evidence to recommend any one treatment over any other for prisoners or parolees
- Pharmacotherapy should be initiated a minimum of 30 days before release from prison

(ASAM National Practice Guidelines, 2017)
U.S. State Jail/Prison MAT Offerings
(Vestal, 2018)
Multi-site Open Randomized Controlled Trial (RCT) in CJ: Relapse

Probability of Relapse-free Survival

Week

(N=308)

Lee JD et al. NEJM 2016;374:1232-42
Mortality Upon Re-entry from Prison

- MMT & BUP ↓ OD & death rates, BUT…rates are increasing
  XR-NTX has OD/death risk – due to loss of tolerance
- Re-entry in OUD: death rates ↑ 12-100X; MMT & BUP ↓ this

3 XR-NTX RCTs in CJ:

- Coviello et al., Subst Abuse 2012 (N=61/2 mos.):
  0 OD deaths
- Lee et al., NEJM 2016 (N=308/18 mos.):
  XR-NTX=0 ODs vs. TAU (Treatment-as-Usual)=7
- Springer et al., pers. comm. (preliminary N=94/12 mos.):
  0 ODs/deaths; decreased HIV Viral Load

- Naloxone nasal spray or auto-injector: immediately reverses OD
  Should be supplied to ALL opioid users, families & 1st responders
  But – vital to then engage patient in follow-up & counseling
Returning Citizens – Patient Perspectives

- “I know when I get back outside that any little thing happens, any little thing could trigger me, you know, when I get back in addiction, where now I’ve been stable on the methadone, I find if I stay on that I’m sort of on the right track to staying clean”
  – 44-year-old man, currently in OAT

- “It just gives you something to do, like a routine”
  – 36-year-old man, currently in OAT

- “Some days I wake up and it’s sort of, yeah, I might see them about it [resuming OAT] and then the next day, no, no, you’re going so good.”
  – 44-year-old man, ceased OAT in custody

(Larney et al., 2017)
Returning Citizens – Patient Perspectives

- “I didn’t want to be on it anymore; I thought it was replacing one addiction with another”
  – 28-year-old woman, ceased OAT in custody
- “I won’t go to the methadone clinic. I don’t want to be around old acquaintances anymore. People that I’ve stole with, if they were going to offer me pills I’d take it”
  – 34-year-old woman, no OAT in custody.
- “I just wouldn’t want my family knowing [about being on methadone]. Bup, yeah…they know what methadone is for. Bup, you can tell them it’s an injury or something”
  – 25-year-old man, no OAT in custody
- Other concerns: Access, side-effects (e.g., constipation)

(Larney et al., 2017)
Returning Citizens – Patient Perspectives

- **JblazeTYC: Greenlighter  09-01-2015 20:23**
  I got it about an hr ago an shot up one bag, im kinda tight cause i really dont feel anything…
  so ima wait 2 more days try again, if nothing wait another 2 and so on til this shot i hate wears off, its really good if you seriously wanna stop which i did at first but i was forgetting what being high felt like so i had to do it ahha, anyway ill post when i first feel it good in a few days

- **cj  Moderator: Sober Living  09-01-2015 20:49**
  “Just goes to show that you can't force someone to quit.”

  (http://www.bluelight.org/vb/threads/745315-Vivitrol-information-for-those-forced-into-it-effects-and-timelines)
AGENDA:

9:00 AM  Introductions & Workshop Agenda
9:15 AM  Who: Epidemiology of the Opioid Epidemic
9:30 AM  Why: Biological & Clinical Parameters
10:00 AM Break
10:15 AM Why: MAT Specific Issues
11:00 AM How: Sub-populations
11:15 AM Returning Citizens
12:00 PM Lunch
AGENDA:

1:00 PM  Adolescents
1:20 PM  Pregnant Women
1:40 PM  Racial & Ethnic Minorities
2:00 PM  Break
2:15 PM  The Homeless
2:35 PM  Rural Americans
3:00 PM  Native Americans
3:15 PM  Veterans
3:30 PM  How: Delivering Collaborative Care
4:00 PM  Conclusion
Adolescents

- Drug use initiation peaks in adolescence (NIDA, 2017)
Adolescents

- OUD Risk: often starts in adolescents & young adults (Collectively: “youth”)
- 7.8% of high school seniors use nonmedical Rx opioids
- 2/3rds in OUD treatment state that 1st use was < age 25
- 1/3rd report that it was < age 18
- Early intervention: Critical to prevent harm & death
- Only 1 in 12 youth who need care receive it
- Black & Hispanic youth: even less likely to receive care
- FDA approved BUP for ≥ age 16 in 2003 and XR-NTX for ≥18 years in 2010

(Hadland et al., 2017)
Adolescents

- In a U.S. insurance sample (N= 9.7 million), 20,822 youth had OUD (0.2%). 82.2% were non-Hispanic White.
- Mean age was 21.0 years at 1st diagnosis.
- OUD increased 6-fold from 2001 – 2014.
- 26.8% received MAT within 6 months of diagnosis.
  - 89.2% → BUP; 10.8% → NTX.
- MAT increased ~10-fold (3.0% in 2002; 27.5% in 2014).
- Younger patients: less likely to receive MAT.
  - Females 20.3% vs. males 24.4% (P < .001)
  - non-Hispanic Blacks 14.8%
  - Hispanics 20.0%
  - non-Hispanic Whites 23.1% (P < .001)

(Hadland et al., 2017)
MAT in Youth, Ages 15-24
Naturalistic treatment data, Baltimore MD (N=92)

- Retrospective chart review, community specialty program
- Mean age 23.1, 70% male, 86% Caucasian, 82% IVDU
- Treated with BUP (77%) or XR-NTX (23%)
- Mean # of XR-NTX doses: 4.1 months
- Retention: 65% at 12 wks & 40% at 24 wks
- Opioid-negative urines: 50% at 12 wks, 39% at 24 wks
- No differences in retention or urine tests over 24 wks
- Males retained in treatment longer with more opioid-negative weeks vs. females

(Vo et al., 2016)
MAT group was retained longer than the group on no meds ($p < 0.01$) (Vo et al., 2016)
Adolescents

- Use the full range of MAT: MMT, BUP & XR-NTX
- Federal law & US FDA approvals are limited under 18 yrs
- BUP: FDA-approved for 16 years & above
- Psychosocial treatment is recommended
- Include concurrent sexual risk reduction interventions
- May benefit from treatment in specialized programs that provide multidimensional services

(ASAM National Practice Guideline, 2015)
Adolescents (SAMHSA, 2018)

- Family therapy: to address SUDs & other family problems (e.g., family conflict, unemployment, conduct disorders)
- Several forms of family therapy are effective with adolescents & can address family members’ MAT biases
- Discusses principles of SUDs in adolescents, summarizes evidence-based treatment approaches, and provides treatment referral resources
AGENDA:

1:00 PM Adolescents
1:20 PM Pregnant Women
1:40 PM Racial & Ethnic Minorities
2:00 PM Break
2:15 PM The Homeless
2:35 PM Rural Americans
3:00 PM Native Americans
3:15 PM Veterans
3:30 PM How: Delivering Collaborative Care
4:00 PM Conclusion
Pregnant Women

- Menstrual cycles may normalize once on MAT; birth control needed to avoid pregnancy (SAMHSA, 2018)
- 0.1% of pregnant women self-report illicit opioid use; prescription misuse has more than doubled, 1992–2008
- Prenatal opioid exposure, with complex environmental conditions, is associated with many adverse outcomes
- OUD Pregnant women: more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, or exhibit signs of withdrawal or intoxication
- Counsel/test for HIV. Test for hepatitis B/C & liver function
- Vaccinate for Hepatitis A & B if serology is negative

(ASAM National Practice Guideline, 2015)
Pregnant Women

- Pregnancy testing is important
- Patients should not start naltrexone during pregnancy.
- Am College of OB-GYNs & SAMHSA’s expert panel recommend MAT: either BUP or MMT (Am C1g OBGYN 2017)
- Providers should refer pregnant women to prenatal care or, if qualified, provide it themselves.

(SAMHSA, 2018)
Pregnant Women

- Withdrawal in pregnancy:
  Can cause premature labor, fetal distress & miscarriage
- OUD abstinence without MAT: generally not advised;
  Relapse can adversely affect both mother & fetus
- Laws penalizing women for +drug screens & treatment
decrease use of prenatal care & worsen outcomes
- MAT often yields neonatal abstinence syndrome (NAS),
  but this is treatable & not as harmful as ongoing drug use
- **Breastfeeding**: if mother stable on MAT: encouraged

(Jones et al., 2012; ASAM National Practice Guideline, 2015; SAMHSA, 2018)
Pregnant Women (SAMHSA, 2018)

- **MMT & BUP**: better maternal & infant outcomes than no treatment or medically supervised withdrawal
- Pregnancy can affect serum levels & clinical response: With MMT, measure levels, if drowsiness, craving or withdrawal symptoms occur in 3rd trimester
- **SMA-168 Exception Request**: daily take-home 1/2-doses (www.samhsa.gov/medication-assisted-treatment/opioid-treatmentprograms/submit-exception-request)
- **MMT & BUP**: not associated with birth defects & minimal long-term neurodevelopmental effect on infants
- **Neonatal Abstinence Syndrome (NAS)** can occur, which requires hospitalization, but rooming-in can work
- **XR-NTX**: Limited data in pregnancy (FDA Category C)
Pregnant Women

- Consider starting MMT/BUP in hospital due to the potential for adverse events, especially in 3rd trimester
- **Inpatient**, Day 1: start MMT at 20–30 mg, up to 40 mg
- Incrementally dose 5–10mg every 3–6 hrs for withdrawal
- **After induction**, increase MMT dose by 5–10-mg/week
- **Goal**: use lowest dose that controls withdrawal/craving

(ASAM National Practice Guideline, 2015)
Pregnant Women  (SAMHSA, 2018)

- Don’t start XR-NTX in pregnancy, given the risk of precipitated withdrawal.
- Should a woman on XR-NTX remain on it during pregnancy? Expert panel could not agree
- Patients taking NTX before pregnancy: weigh the risks of unknown potential harm to the fetus vs. potential benefits of continuing XR-NTX
- If discontinues naltrexone & relapses: consider MMT or OBOT for rest of pregnancy
Pregnant Women (SAMHSA, 2018)

- NAS requires medical care for possible gastro-intestinal, respiratory, central nervous system, autonomic nervous system, breastfeeding dysfunction & prolonged hospitalization
- BUP (vs. methadone) NAS: needs less morphine & hosp.
- In animal studies with Sublocade’s excipient, N-Methyl-2-pyrrolidone, there were reported fetal adverse reactions. Advise women to use Sublocade in pregnancy only if benefits outweigh risks (Sublocade package insert)
- BUP monotherapy: preferred only because of risk to fetus of precipitated withdrawal if combo product is injected
- BUP is excreted at low levels in breast milk (Jones et al., 2012)
Pregnant Women (SAMHSA, 2018)

- **Fertility rises after withdrawal; note in patient contract:**
  “I have been educated about the increased chance of pregnancy when stopping illicit opioid use, about methods for preventing pregnancy, and about starting…
  - buprenorphine treatment”
  - naltrexone treatment”

“I have been informed that if I become pregnant during naltrexone treatment, I should inform my provider and have a discussion about the risks and benefits of continuing to take naltrexone.”
Pregnant Women (SAMHSA, 2018)

Assess & match multidimensional needs *for the right duration*:

- Dim 1: Withdrawal stabilization
- Dim 2: Treat general health & OB needs
- Dim 3: Treat MH needs; use trauma-informed care
- Dim 4: Examine & address readiness thru stages of change
- Dim 5: Structure treatment to meet relapse potential risks
- Dim 6:
  - Meet housing, transport’n, job, legal & education barriers
  - Assist w/child care, parenting training, relational supports
  - Address family – incl. parenting/lifeskills/communication
  - Treat the children
  - Assess & address cultural values & traditions
Sample Standard Consent to Opioid Maintenance Treatment Form for OTPs

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of these medications at any time. If I choose this option, I understand I will be offered medically supervised withdrawal.

For women of childbearing age: Pregnant women treated with methadone or sublingual or buccal buprenorphine have better outcomes than pregnant women not in treatment who continue to use opioid drugs. Newborns of mothers who are receiving methadone or buprenorphine treatment may have opioid withdrawal symptoms (known as neonatal abstinence syndrome). The delivery hospital may require babies who are exposed to opioids before birth to spend a number of days in the hospital for monitoring of withdrawal symptoms. Some babies may also need medication to stop withdrawal. If I am or become pregnant, I understand that I should tell the medical staff of the OTP right away so I can receive or be referred to prenatal care. I understand that there are ways to maximize the healthy course of my pregnancy while I am taking methadone or buprenorphine.

Signature of Patient: ___________________________ Date of Birth: ___________ Date ___________
Witness: ___________________________
AGENDA:

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2:35 PM  Rural Americans
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3:15 PM  Veterans
3:30 PM  How: Delivering Collaborative Care
4:00 PM  Conclusion
Racial & Ethnic Minorities (Guerrero, et al., 2013)

- **Latinos:**
  - Fastest growing population in SUD treatment
  - Treatment outcome: Depends on acculturation, English proficiency, national origin, rural/urban status

- **African Americans & Latinos:**
  - Enter treatment with more health, mental health, & social problems than Whites
  - Disproportionally represented in the justice system
  - Lower odds of completing treatment than Whites:
    While national studies of clients attending all care levels found a 45% treatment completion rate, in LA County, Blacks & Latinos had a 12% rate
Racial & Ethnic Minorities & HIV/AIDS (NIDA)

https://www.drugabuse.gov/sites/default/files/addictionscience.ppt
Racial & Ethnic Minorities (Marsh et al., 2009)

- Minority groups are heterogeneous – genetically, socially, historically & culturally
- Less human capital (education, employment) vs. Whites
- African Americans & Latinos:
  - Report more SUD & MH problems vs. Whites
  - Unmet SUD needs – regions vary: Mostly, underserved (Marsh et al., 2009; Mulvaney-Day et al., 2012)
  - More report their SUD & MH needs are not met:
    - Whites - 12.5%
    - African Americans - 25.4%
    - Latinos - 22.6%
  - Also receive lower quality of services
Racial & Ethnic Minorities (Shiels et al., 2018)

- Historically: underserved in general
- Shorter durations of services than Whites (Marsh et al., 2009)
- Less satisfaction with treatment (Marsh et al., 2009)
- Blacks less likely to receive opioids for pain
- Older Black men in recovery from 1970s heroin are now relapsing to fentanyl
- Middle-aged, urban Blacks: greatest ↑ in OD deaths
- Black youth 12-17: more likely than Whites to use opioids
- Systemic challenges: unemployment, incarceration cycle, neglect, trauma
Racial & Ethnic Minorities (Shiels et al., 2018)

- Native-born Hispanics: more SUD than foreign-born Hispanics (Turner & Gil, 2002)
- Latinos: enter treatment younger than Blacks or Whites (Marsh et al., 2009)
- MMT: More in Blacks/Hispanics v. Whites (Krawczyk et al., 2017)
- Early on, Whites were more likely to get OBOT, but with improved access, disparities have lessened (Mitchell et al., 2012)
Racial & Ethnic Minorities  (Marsh et al., 2009)

Nat’l Treatment Improvement Evaluation Study (NTIES):
- Latinos with SUD: younger, fewer have HS education, job vs. Whites or African-Americans
- Latinos & Blacks: More likely pregnant or have a child
- More Pre-Tx Substance Use: Latinos > Blacks > Whites
- Less Prior SUD Treatment: Latinos & Blacks < Whites
- Less time in Treatment: Latinos & Blacks 20% < Whites
- Less receipt of matched services: Minorities < Whites
- Latinos: Providers offer least number of on-site services & more minimal counseling schedules
- Post-treatment Subst. Use: Latinos & Blacks > Whites
Racial & Ethnic Minorities (Marsh et al., 2009)

Nat’l Treatment Improvement Evaluation Study (NTIES):
- Less time-in-treatment: Latinos & Blacks 20% < Whites
- BUT, time-in-treatment is critical for reducing drug use, & more so for Black & Latino patients than for Whites
Racial & Ethnic Minorities (Marsh et al., 2009)

- Address housing, job, legal & education barriers to care
- Provide access – transportation & child care
- Treat co-occurring health, trauma MH problems
- Manage pregnancy & childcare needs
- Address family – incl. parenting/lifeskills/communication
- Treat the children
- Extend treatment duration: important outcome predictor
- Assess & address cultural values & traditions
- Overall, assess & match services to client needs
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The Homeless

- >2 million homeless annually in US
- 20% - 59% lifetime prevalence of drug use disorders
- Drug-related deaths: 8-17x worse than general population
  (Baggett et al., 2015)

Massachusetts Homeless Deaths by Substance

- Non-substance: 42.8%
- Tobacco: 7.8%
- Tob. + Alc.: 13.1%
- Alcohol: 8.1%
- Alc. + Drugs: 0.1%
- Drugs ± Alcohol: 28.1%
The Homeless

- >2 million homeless annually in US
- 20% - 59% lifetime prevalence of drug use disorders
- Drug-related deaths: 8-17x worse than general population (Baggett et al., 2015)

**MEN** (20-34 yrs; 35-49; 50-64)
- □ Homeless
- □ MA General Population

**WOMEN** (Baggett et al., 2015)
The Homeless

- Traditional approaches typically fail
- **ASAM Criteria**: *Integrate care along all 6 Dimensions*
- **Dim 1**: Daily Intoxication even following withdrawal
- **Dim 2/3**: Physical, Cognitive & MH impairments: common
- **Dim 4**: Readiness – challenging, w/o supportive housing
- **Dim 5**: Long-term supports key: e.g., mutual-help groups
- **Dim 6**: Social supports at high intensity:
  - Stabilize income
  - Counteract social isolation
  - Manage co-occurring psych illness
- **ASAM**: Fixed time frames are inappropriate – individualize!

(adapted from Lehman & Dixon, 2016)
The Homeless  (Padgett et al., 2006)

- **U.S. Homelessness**: A demographic tragedy resulting from deinstitutionalization & the 1980s housing “famine”
- **Deinstitutionalization** offered Mentally Ill (MI) independent living but patients with schizophrenia & bipolar disorder needed an array of support services:
  - Medication management, Psychological Counseling
  - Education, Job training
- **Substances**: Used by >50% - 70% of MI homeless
- Public sector MH services segregated from SUD services
- Clinicians recommend supervised congregate housing but homeless with Co-Occurring Mental Health Disorders prefer independent living
The Homeless (Padgett et al., 2006)

- **Critical dilemma** for Homeless w/SUD + MH problems: *Treatment 1st vs. Housing 1st philosophies*

- **Treatment 1st**: Conventional model:
  - Clients submit to rules requiring treatment compliance, abstinence, curfews, limited visitation, loss of privacy
  - Rule-breaking leads to return to the streets

- **Housing 1st**: Harm reduction model
  - Consumer-driven
  - Scatter-site housing without on-site staff supervision
  - Immediate permanent housing (even if hospitalized) with integrated Assertive Community Treatment (ACT) without requiring treatment compliance or abstinence
The Homeless (Padgett et al., 2006)

- Randomized Controlled Trial (RCT) of 225 homeless MI in NYC: Tx 1st vs. Housing 1st

Figure 1: Heavy Drug Use, Baseline to 48 Months
The Homeless (Padgett et al., 2006)

- RCT of 225 homeless MI in NYC: Tx 1\textsuperscript{st} vs. Housing 1\textsuperscript{st}

Figure 3: Substance Treatment Service Utilization, Baseline to 48 Months
The Homeless (Padgett et al., 2006)

- RCT of 225 homeless MI in NYC: Tx 1ˢᵗ vs. Housing 1ˢᵗ
- After 48 months:
  - Tx 1ˢᵗ Group: more likely to use treatment services BUT, continued to use substances
  - Overall, no group differences were found in subst. use
  - Housing Stability during final 6 months:
    Tx 1ˢᵗ = 50% of the time; Housing 1ˢᵗ = 75% of the time
- CONCLUSION:
  - “Co-Occurring” adults can remain stably housed without increasing their substance use
  - Assumption that MI & and homelessness cannot be addressed until client is abstinent – is invalid
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Rural Americans

- Pain Reliever Misuse, Past Year, Individuals 12 or Older (SAMHSA, 2017)
Rural Americans

- Pain Reliever Misuse, Past Year, Youths 12 – 17 yrs
  (SAMHSA, 2017)
ASAM recommends that Opioid Treatment Programs (OTP) & OBOTs be sensitive to treatment barriers such as lack of public transportation to visits, which may be particularly challenging for patients in rural areas.

**Geographic Solution:** A parent OTP may use a distributed methadone unit to provide methadone or buprenorphine administration, dispensing capacity, and urine drug testing, but not counseling.

The parent clinic must provide counseling and other required services. Such arrangements can lessen the amount of time required to drive to a parent OTP location in large states with rural populations.

(ASAM National Practice Guidelines, 2015)
Rural Americans

- **Mobile MMT Vans**: have served rural areas since 1990s
- **DEA** stopped licensing MMT vans in 2007; “diversion”
- **AATOD**: no security breach ever reported in a MMT van
- **CT, MD, NJ, NY & WA**: All now seeking more MMT vans
- **Critical Need**: Puerto Rico; due to Hurricane Maria’s destruction of transportation & medical infrastructure

(Vestal, Mar 23, 2018)
Rural Americans

- Use **Telehealth** for rural populations
- **Online mutual-help groups**: Before recommending an online group, check its content and tone RE MAT.
- **Internet Mutual Help**: Growing in popularity (real-time chat rooms or post & wait discussion boards). Especially valuable for rural areas.
- Range of Online Groups: From general meetings for people with particular SUDs (e.g., online AA meetings) to very specific ones (e.g., Moms on Methadone).
- **Moderated groups**: Preferable to unmoderated groups.

(SAMHSA TIP 60, 2015)
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Native Americans

- Nationwide: $\geq 2x$ rate of addiction as general population
- 3x as likely to die of OD – highest demographic group
- Heroin & OxyContin by Native American 12th-graders: ~double the national average
- 38.7% of Natives age 12-17 have lifetime illicit drug use
- Native adolescents: highest rates of nonmedical pain Rxs
- Legacy of loss of ancestral lands, forced relocations, childhood separations, deep poverty, cultural identity loss
- Multigenerational adverse childhood experience, alcoholism, drug abuse, domestic violence, neglect, incarceration, physical/sexual trauma

(Vestal, 2016)
Native Americans

Yet, most of the 2.9 Native Americans on & off reservations have little to no access to health care, mental health or SUD care

With casino & other business income, some tribes, mostly near major cities, have built world-class health care systems on reservations, including addiction treatment

32 states expanded Medicaid to provide coverage

Intense needs:
- recovery housing, mother + child housing
- support services & parenting skills training
- needle exchange, naloxone
- nutritional counseling

(Vestal, 2016)
Native Americans

- Native Americans may be reluctant to discuss problems
- Excess counseling pressure may drive patients away
- Chaotic lifestyle, high caffeine & sugar/fat intake, smoking
- Allow MAT to establish stability x2-3 months
- Work on resolving homelessness
- Then work on attendance at regular counseling
- Include attention to parenting skills & supports

(Vestal, 2016)
Native Americans

- Role of *indigenous traditional knowledge (ITK)*
- Unlike scientific method, ITK is *personal & experiential*
- Treatment-seeking Obstacles: Mistrust, fear of researcher exploitation & negative attitudes towards EBTs
- Strong beliefs that recovery, healing, & wellness in SUD require a holistic approach: “*our culture is our treatment*”
- AI/AN tribes routinely incorporate ceremonial practices as important in recovery & healing
- Benefits are frequently described as *plainly apparent* by community advocates & providers

(Gone, 2012)
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Veterans

- **Multiple Veterans Eras:**
  Vietnam, 1\textsuperscript{st} Iraq War, 2\textsuperscript{nd} Afghanistan/Iraq Wars
- Vets’ SES: Slightly lower than U.S. general population
- Vets’ Drug Risks: Slightly higher than gen’l pop’n for OUD
- Vets’ Mortality Risk: Elevated rates of premature death
- Integrated care for PTSD + SUD: Essential

(Price et al., 2001)
Veterans

- Vietnam Vets:
  - >35% used opioids in Vietnam; >10% returned drug +
  - 90% quit Heroin without treatment
  - Now aging; much co-occurring Alcohol Use Dis.

(Price et al., 2001)
Veterans

- 20 veterans die by suicide each day – much higher than the general population
- In a recent study of more than 4.4 million veterans...
- Veterans with SUD have double to quadruple the suicide risk of their fellow vets
- Among women, OUD elevates this risk to 5X
- This suicide risk is particularly high if they also have depression, schizophrenia, bipolar disorder, PTSD or anxiety
- 2/3rds of the suicides involve firearms; 1/4 poisoning

(Bohnert et al., 2017)
Veterans: Markedly Elevated Suicide Rates

- Suicides per 100,000 person-years, based on 4.4 million Vets treated in the VA over 6 years
- Overall U.S. suicide rate: 13.0 per 100,000
- Women Vets who misuse opioids: 98.6 per 100,000
  (Bohnert et al., 2017)
Veterans

- Iraq/Afghanistan Vets:
  - Higher rates of PTSD co-occurring w/SUD
  - PTSD + SUD is associated with increased mortality
  - Especially pronounced for young Vets
  - Combat exposure: Raises SUD risk
  - Of those with SUD, 55-75% also had PTSD or depression

(VA/DoD, 2015)
Veterans

VA/DoD recommendations:

- BUP/NAL in office-based setting
- MMT in an OTP
- Military personnel are not deployed if they are on MMT
- XR-NTX if refusing/completing/off agonists, or on active duty, or in safety-sensitive roles
- BUP should be initiated with a psychosocial intervention
  - Medical Management, e.g., in primary care
  - More intensive counseling models with concurrent alcohol, benzodiazepine or cocaine use disorder or if psychiatrically unstable, e.g., PTSD or depression

(VA/DoD, 2015)
## Veterans

<table>
<thead>
<tr>
<th>Criteria</th>
<th>OBOT</th>
<th>OTP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can an office-based setting provide needed resources for the patient?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patient’s psychosocial supports</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>Previous failed treatment attempts with opioid maintenance</td>
<td>None/Few</td>
<td>Many</td>
</tr>
<tr>
<td>Difficulty accessing OTP (distance, DoD mobility requirements, etc.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pain condition that requires ongoing or recurrent treatment with short-acting opioids</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(VA/DoD, 2015)
Veterans

- High rates of PTSD, Traumatic Brain Injury (TBI), suicide
- Therefore, evidence-based practices (EBPs) highlight essential roles of:
  - Screening
  - Assessment: Baseline & Ongoing
  - Safety planning
- Provide Crisis Support Information Resources: [https://www.veteranscrisisline.net/depression](https://www.veteranscrisisline.net/depression)
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Public Health Model of an Epidemic

Addiction:

**Promoters**
- Agent: receptor affinity,
  - purity,
  - faster routes
  - of administration
- Environment: access, lower cost,
  - prescribing

**Responses**
- Agent: blockade, catabolism
- Environment: culture change,
  - neighborhood policing, sanctions

**Host**
- Agent: genetic, congenital &
  - acquired vulnerability,
  - comorbidity
- Environment: resilience, coping
# ASAM Criteria

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Levels:</th>
<th>Outpatient</th>
<th>Opioid Treatment Program</th>
<th>Day Treatment Partial Hosp.</th>
<th>Residential Rehabilitation</th>
<th>Hospital (Medically Managed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intox/WD</td>
<td>0.5</td>
<td>1</td>
<td>OTP</td>
<td>2.1, 2.5</td>
<td>3.1, 3.3, 3.5, 3.7</td>
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<tr>
<td>2. Biomedical</td>
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<td>3. Emot'I/Behav'I</td>
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<td>4. Readiness</td>
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<td>5. Relapse Potential</td>
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<td>6. Environment</td>
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**Sub-levels:**
- Withdrawal Management (L-1, 2, 3.2, 3.7, 4)
- Biomedical Enhanced (L-3.7)
- Co-Occurring Disorders Capable (L-2, 3)
- Co-Occurring Disorders Enhanced (L-2, 3)
ASAM Criteria

An individualized treatment plan,
which includes problem formulation
and articulation of short-term, measurable treatment goals
and activities designed to achieve those goals.

The plan is developed in collaboration with the patient
and reflects the patient's personal goals,
while considering the capabilities and resources available
to achieve the patient's personal goals.
ASAM’s Level Of Care (LOC) Specifications: Six Domains

1. **Setting**: Structural component(s)
2. **Support Systems**: Services & provider entities
3. **Staff**: The care team, credentials & specific roles
4. **Therapies**: The types of care being delivered
5. **Assessment**: For initial & ongoing treatment planning process
6. **Documentation**: The process of care communication
The Phases of Treatment

- **Withdrawal Management** – Medical Detoxification
- **Post-Withdrawal Anti-Craving Medication**
  - Stabilizing brain chemistry; *Use ALL MATs*
- **Counseling** – for the real *work* of recovery
  - Accept the disease
  - Know one’s vulnerabilities
  - Anticipate risk factors
  - Insulate from re-encountering the drug of abuse, even under stress
  - Master new coping behaviors
  - Construct healthy relationships
  - Find purpose in life/spiritual grounding
AGENDA:

1:00 PM  Adolescents
1:20 PM  Pregnant Women
1:40 PM  Racial & Ethnic Minorities
2:00 PM  Break
2:15 PM  The Homeless
2:35 PM  Rural Americans
3:00 PM  Native Americans
3:15 PM  Veterans
3:30 PM  How: Delivering Collaborative Care
4:00 PM  Conclusion
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