Comprehensive Response to the Opioid Crisis

Monday, May 20, 2013
10:00-11:00 am

NAATP Annual Addiction Treatment Leadership Conference
A Comprehensive Response to the Opioid Crisis

Marvin D. Seppala, MD
Learning Objectives

1. To provide a description of our new program, with an explanation of how this works within a Twelve Step abstinence based treatment program

2. To provide a clear understanding for our decision to use medications for treatment of opioid dependence
 Disclosure Statement

- Nothing to disclose
- Four-fold increase in treatment admissions (U.S. 1998-2008)

- Overdose deaths have increased dramatically (3,000 in 1999 → 16,500 in 2011)

- Drug overdose is the No. 1 cause of accidental deaths, fueled by the increase in opioid overdoses

- Over 125,000 opioid overdose deaths have occurred in the U.S. in the past decade
Hazelden’s Experience

- Increased admissions for opioid dependence
- Problems with ASA discharges, treatment retention
- Unit milieu issues
- Use of opioids during treatment
- Increased incidence of death following treatment
Hazelden is Responsible

- To determine the best methods of treatment for our patients
- To use scientific evidence to improve treatment
- To be a leader in the Twelve Step addiction treatment field
Hazelden’s Response

- Alter the entire treatment of opioid dependence within our system: COR-12
- We added groups, education and individual sessions for opioid dependence
- We incorporated two evidence-based medications into treatment protocols for opioid dependence: naltrexone and buprenorphine
- We will study the results
- Our goal will be discontinuation of medication as patients become established in long-term recovery
Organizational Change Process

- Team Established
- Literature Review
- White Paper
- Plan for Organization
- Training Forums
- Communication
Vivitrol®: Extended Release Injectable Naltrexone

- Opioid receptor blocker (opioid antagonist)
- Administered by intramuscular injection, once a month
- Prevents binding of opioids to receptors, eliminating intoxication and reward
- Has been shown to reduce craving and relapse
- Has no abuse potential
Suboxone®: Buprenorphine/Naloxone

- A partial opioid agonist, a maintenance treatment
- Administered sublingually on a daily basis
- Binds to and activates opioid receptors, but not to the same degree as true opioid agonists
- Improves treatment retention, and reduces craving and relapse
- Illicit use and diversion are likely
## Injectable Extended Release Naltrexone

<table>
<thead>
<tr>
<th></th>
<th>Naltrexone</th>
<th>Placebo</th>
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<tbody>
<tr>
<td><strong>1. Weeks abstinent</strong></td>
<td>90%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>2. Opioid free days</strong></td>
<td>99.2%</td>
<td>60.4%</td>
</tr>
<tr>
<td><strong>3. Mean change in craving</strong></td>
<td>10.1%</td>
<td>0.7%</td>
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<tr>
<td><strong>4. Median retention</strong></td>
<td>168 days</td>
<td>96 days</td>
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</table>
2 phase study:
- 2 week Bup/Nal stabilization, 2 week taper, 8 week follow up
- 12 week Bup/Nal stabilization, 4 week taper, 8 week follow up

653 treatment seeking outpatients with opioid dependence

Randomized to:
- Standard medication management (SMM)
- SMM & opioid dependence counseling

All participants were referred to self-help groups

Buprenorphine-Naloxone

Results

Phase 1:

- Only 6.6% were successful
- No difference between SMM & SMM with opioid counseling

Phase 2:

- 49.2% successful while using bup-nal
- No difference between SMM & SMM with opioid counseling
- Success rates after completion: 8.6%

Compatibility with 12-Step Abstinence-based Model

- Extended release injectable naltrexone is already used for alcohol dependence
- Buprenorphine /naloxone can induce intoxication and is abused, but primarily for detox or to get by
- Twelve Step models tend to avoid buprenorphine
- Buprenorphine/Naloxone protocols will blur the line of abstinence-based programming, so our goal will always be discontinuation once long-term recovery is established
- Patients are coming in on buprenorphine/naloxone and asking for it
Initial Experience

- Acceptance by staff
- Support from Board
- Support from some treatment programs and professionals
- Bewilderment from others
- Patients seeking care
### Initial Experience (as of 05/01/13)

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
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<tbody>
<tr>
<td>Total number with opioid dependence</td>
<td>211</td>
</tr>
<tr>
<td>Unable to participate in COR-12</td>
<td>99</td>
</tr>
<tr>
<td>COR-12: No Medication</td>
<td>15</td>
</tr>
<tr>
<td>COR-12: Buprenorphine/Naloxone</td>
<td>17</td>
</tr>
<tr>
<td>COR-12: Extended Release Naltrexone</td>
<td>28</td>
</tr>
<tr>
<td>Undecided</td>
<td>52</td>
</tr>
</tbody>
</table>
COR-12 Clinical Implementation

Scott B. Hesseltine M.A., LADC
Clinical Perspective

- Discuss the team process leading to implementation
- Clinical Perspective/Role of Counseling Staff
- Role of Treatment Services
Medication Assisted Treatment Team

- Assembled to improve treatment of opioid dependence
- Quickly realized positive outcome was more than just expanded use of medication
- Expanded protocols needed to lead to engagement in Twelve Step recovery services
- Led MAT to COR-12; (Comprehensive Opiate Response with the 12 Steps)
Clinical Staff

- Experience increased complexity and acuity
- Increase in mortality rates
- Milieu management issues
- Atypical discharges
- Behavioral issues
- Revolving Door syndrome
- Readiness to Change issues
- Staff intensive demographic
Clinical Implementation

- Large segment of opioid dependent population were not effectively being reached.

- New protocols needed to be introduced along with purposeful clinical practices.

- Opportunity to provide a means for this high risk population to have a better chance at engaging Twelve Step Recovery.
Clinical Concerns

- Creating well defined and consistent rationale for participation in extended medication assisted treatment pathway.
- Developing purposeful means of discontinuation.
- Are we inviting further milieu management issues or will this reduce some of the associated dysfunction?
  - En Masse Discharges
  - Drugs on Campus
  - Sentinel Events
Program Development

- Clinical Practice Protocols
- Addition of Education and Support Groups
- Stigma Management Initiatives
- Use of continuum of care to enhance engagement in Twelve Step Recovery
- Will require consistent and accurate messaging along with engaged recovery support
Recovery Management

- Use of MORE and full continuum of care
- Treating Chronic Disease over an extended period of time.
- Ability to utilize Recovery Management tools to assist with discontinuation.
- Increase treatment retention through additional support over an extended period of time.
Clinical Implementation

Program Development Clinical Practice Protocols *(November 15)*

- Pre-Entry
- Nursing/Medical
- Clinical Staff
- Continuing Care

- Clinical Trainings *(December 15)*

- Go Live in Center City *(December 31)*
Summary

- New clinical protocols have been developed and introduced in a limited scope.
- Experienced benefits to opioid dependent patients.
- Patients are beginning to move through the continuum of care.
The COR-12 Program

Fred Holmquist, BA
Anecdotal Review of Hazelden’s Ever-Evolving Twelve-Step/Abstinence-Based Treatment Model
2006 - White-Paper on Acuity/Complexity

- **Acuity**- the patient-issue side of treatment process challenges

- **Complexity**- the system-issue side of treatment process challenges

2009 - Staff Training Team for Implementing the use of Naltrexone and Vivitrol as anti-craving agents for selected alcoholic patients

- **Alcoholics Anonymous Co-Founder’s craving reference**
January 10th, 1949 - Hazelden founded as a “charitable hospital for functioning alcoholics”. An unstructured, 12-Step rest-farm model for men with efforts to follow-up with former patients- foreshadows statistical research and recovery management.


1953/1954- Opening of a men’s half-way-house, Fellowship Club in St Paul from which the “24 Hours a Day” meditation book was published, foreshadowing step-down residential services and expanded bibliotherapy.
1956- Developing a women’s stand-alone treatment unit, Dia Linn in Dellwood, Minnesota where in response to the greater acuity of alcoholic women’s needs, a more comprehensive, multi-disciplinary team model of treatment developed, foreshadowing special-population sensitivity and the “Minnesota Model”.

1966- Not only expanding men’s treatment capacity and moving the Dia Linn women’s unit to the Center City campus, but incorporating it’s comprehensive treatment methodologies campus-wide, replacing the yet existing “rest farm” tradition for treating men.
Risk Factors

- Out-dated Innovation- “old ideas”
  - 1966- Center City expansions
  - 1970’s- Use of Niacin/Vitamin B3
  - 1980’s/90’s- “Co-Dependency”
  - 1990’s- New Yorker “Caffeine Wars”
- Program Complexity
- Staff Engaging Client Resistance
- Polarized Attitudes
  - Wet/dry
  - Abstinence/maintenance

Resiliency Factors

- Mission
  - Dignity and respect
  - Multi-disciplinary team
  - 12-step/abstinence-based philosophy
  - Continuum of care
  - Research and evaluation
- Margin
  - Publishing Business Unit
- Early Adapters
Risk Factors

• Out-dated Innovation- “old ideas”
  • 12X12 p 139 Trad. 3- “In our early time, nothing seemed so fragile, so easily breakable as an AA group.”

• Program Complexity
  • 12X12 p 139 Trad. 3- “many membership rules” p 140- “list of protective regulations” “So beggars, tramps, asylum inmates prisoners, queers, plain crackpots, and fallen women were definitely out.”

• Staff Engaging Client Resistance
• Polarized Attitudes

Resiliency Factors

• Mission
  • 12X12 p 139 Trad. 3- “We just want to be sure that you get the same great chance for sobriety that we’ve had.”
  • 12X12 p 107 Step 12- “What they have received is a free gift,” “in some small part, have made themselves ready to receive it” “in the practice of the Twelve Steps”.

• Early Adapters
  • 12X12 p 140 Trad. 3- “How could we know that thousands of these sometimes frightening people were to make astonishing recoveries…”
“At last, experience taught us that to take away any alcoholic’s full chance was sometimes to pronounce his death sentence, and often to condemn him to endless misery. Who dared to be judge, jury, and executioner of his own sick brother.”
Heroin/et al., generates a state-of-mind perhaps paralleled only by the highest of spiritual experiences while simultaneously disallowing any tolerance for even the slightest discomfort. This complicates many patient’s ability to remain in treatment or to be available for developing new relationships and acquiring new information.
Extended, adjunctive withdrawal protocols significantly long to allow more patients to remain in treatment and to be available for new relationships and information. And…..

Borrowing directly from the models of intensified Twelve Step practices, structured in the fellowships like OA and SAA/SLAA in which members continue to use non-craving triggering forms of their drugs of no choice.