Suboxone Programs: Treating Opioid Dependence in CHCs
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Educational Objectives:
- Review epidemiology of opioid addiction in the U.S.
- Discuss the history of opioid replacement therapies.
- Review some of the recent research that reinforces the model of addiction as a chronic brain disease.
- Discuss considerations for CHCs looking to establish suboxone programs.

Epidemiology of Opioid Abuse
2006 National Survey on Drug Use and Health:
- 1.6 Million regularly abusing or addicted to prescription opioids
- 323,000 additional with heroin abuse or dependence
- Currently only ~260,000 are involved in licensed opioid maintenance treatment (methadone clinics, some also offering buprenorphine)
epidemiology, continued

- Note that overdose accounts for only ~½ of the deaths observed in heroin users.
- So, in spite of an enormous demonstrated need, access to care for opioid abuse and dependence remains severely limited.

History

- Harrison Narcotic Act of 1914, restricted the use of opioids in addicted patients.
- New York City Health Department treats ~8,000 heroin addicts with prescribed heroin during the first “heroin epidemic” after WWI.
- 1919, U.S. Supreme Court rules specifically that the Harrison Act forbids the prescription of narcotics for “maintenance”.

history, continued

- Addicts convicted under narcotics laws flood the federal prison system which lead to the founding of “The Lexington Narcotics Farm”, a federal prison/USPHS hospital. This institution under various names ran from 1935 – 1971.
- Here at the Addictions Research Center basic research was conducted, including early studies in the use of methadone for heroin addiction.
Early OMT, Drs. Dole and Nyswander

- Numerous articles published (1967 – 1988) establishing the benefits of methadone therapy for heroin addiction and postulating heroin addiction as a “metabolic disease”.
- “The treatment is corrective but not curative for severely addicted persons. A major challenge for future research is to identify the specific defect in receptor function and to repair it. Meanwhile, methadone maintenance provides a safe and effective way to normalize the function of otherwise intractable opiate addicts.” - Dole, VP., JAMA 1988

Dr. E.L. Gardner, 1992

- “Is it possible then that some substance abusers have a defect in their ability to capture reward and pleasure from everyday experience as postulated by some physicians? If this be so, then our goals are really two-fold: To rescue addicts from the clutch of their addiction and, second, to restore their rewards systems to a level of functionality that will allow them to “get off” on the real world.”

The “Reward System”, Dopamine and “Hedonic Tone”

- There is a growing body of evidence that alteration of dopamine levels in the median forebrain bundle is the final common pathway for most addicting substances.
- Opioids can cause a sudden increase in the dopamine levels in this area, creating an intense sense of well-being/euphoria.
Once this has occurred, the drive to find and ingest opiates can take precedence over finding pleasure from food, sex, exercise or personal achievement. In this way the opioids are said to have “hijacked” the part of our limbic system that allows us to feel pleasure.

Much of the energy that would normally be directed to these “normal activities” is now directed toward obtaining more opiates.

Animal models support the idea that low basal levels of dopamine in the median forebrain bundle are associated with an increased risk of addiction. It can take as little as 3 generations to see markedly lower dopamine level in this area. Clinically, many patients report that the first time they used opiates is the first time they felt “normal” and continued use allows them to interact more comfortably with their environment.
Impact of Environment

- Rhesus monkey experiments relating basal dopamine level changes to social ranking.
- The discovery of genes relating to “resilience” and the effect of early trauma and resulting in a decreased effect of dopamine at the N.A.
- Dopamine affects learning, particularly the “salience” of certain experiences. This may be related to the phenomenon of “triggering”.

Addiction as a Brain Disease

- Given the evidence for addiction as a medical illness, why is the medical model not more widely accepted?
  - Stigma, shame of addictions
  - Criminalization
  - Lack of proper training of medical staff.
  - Lack of knowledge about medical aspects of addiction in the general population.

Chronic Disease Model

- Just as we have done for diabetes and depression, we need to develop a chronic disease model for addictions.
- As with these diseases we need to develop a program that includes case management, behavioral health care, intensive patient education.
- Just as with insulin for a diabetic, opioid replacement will not “cure” a patient. It can provide them a way to return to normal function and rebuild their lives.
**SSTAR: Stanley Street Treatment and Resources**

Nearly an ideal environment for developing this model with on campus:
- In-patient detox/ATS and dual diagnosis/EATS units
- "SOAP"/Step-Down Units
- Ambulatory Behavioral Health, including I.O.P.
- Family Health Care Center
And "Lifeline", a MMT Program offered off-site.

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**What is the minimum needed to start?**

- Federal requirements are very minimal under the DATA 2000 (21 U.S.C. 823 (g) (2)):
  - "The physician must be qualified under DATA 2000." (Certification, obtaining DEA “X” number)
  - "The physician must certify to his or her capacity to refer patients for appropriate counseling and other appropriate ancillary services."
  - "The physician must certify that the total number of patients at any one time does not exceed the applicable number."

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**What Should You Actually Have in Place For a Suboxone Program?**

- From our experience at SSTAR we have found the need for 3 major categories of staff:
  - Medical Staff
  - Nurse Case Managers
  - Behavioral Health Personnel
Medical Staff

- Physicians: licensed and trained for OBOT
  - Beyond the mandatory 8 hours of training required for an “X” number, additional training in addictions medicine including behavioral approaches such as “motivational interviewing” and “trans-theoretical model of change” are advised.
  - Advanced training in psychopharmacology and pain management also helpful.

RN/Case Managers

- Vital role in managing care for these patients who can be very demanding.
  - Need a background in substance abuse, preferably experience in the acute detox setting.
  - Experience with a psychiatric population as many patients will have other Axis I and II diagnoses.
  - General medical background to deal with the co-occurring medical diagnoses, especially hepatitis C and HIV.

Behavioral Health Staff

- Group therapy leaders for suboxone psycho-ed, relapse prevention groups.
  - C.D.A.C.
- Therapists for 1:1 counseling are frequently needed as patients sort out substance abuse and co-occurring mental health issues.
  - LMHC/LICSW/Psychologist
- Psychopharmacology consultants for patients who will require an intensive level of med. management.
  - Clinical Nurse Specialist/Psychiatrist
Communication

- It is essential to proper coordination of care that providers be able to communicate with each other about a patient.
- Providing time for regular team meetings is important. At SSTAR these meetings include physicians, counselors, the nurse case managers and often a psychiatrist. Giving providers this time is expensive but pays off in the long run.
- Be prepared for a wide variety of opinions about how to handle certain issues, especially relapses.
- Put some thought into your program philosophy, especially “Harm Reduction” vs “Abstinence Only”.

Controversies:

- We found a wide range of opinions within the treatment team. Some members were very judgmental, giving meetings a para-judicial feeling. Others took the “Mother Theresa” approach and would have collected patients like stray cats without questions and kept them in the program no matter what they did.
- SSTAR’s program is evolving from a “3 strikes and you’re out” system to individualized, assessment-driven treatment. Our goal is to address relapses and failures to comply the treatment plan by attempting to modify treatment according to the patient’s needs. This may involve mandating 1:1 counseling, psychiatric consult or IOP attendance for example.

Discharges from OBOT

- Discharges are an unfortunate fact of life and roughly 50% of the patients who start OBOT will not be able to stay on the program.
- If, after adequate attempts have been made to modify the treatment plan, the patient is not able to work within the parameters of the program they are discharged. Some patients are tapered off suboxone and many referred to MMT.
Who are the “Right” Patients for OBOT?

ASAM Criteria – Treatment Continuum: Level 0.5: Early Intervention, Level I: Outpatient Services, Level II: Intensive Outpatient/Partial Hospitalization, Level III: Residential/Inpatient Services, Level IV: Medically managed intensive inpatient services

- Patients will often tell you that you are their “last chance”. The “customer” in not always right.

Know Your Patient’s Needs

- Is the patient stable enough to do an outpatient induction?
  - Thorough assessment must be done BEFORE the patient is told that they will be taken on to your suboxone program. Medical, social, psychiatric factors must all be considered.
- Would they be better served with an in-patient detox?

Outpatient Tx: Methadone vs Suboxone

- Predictive factors for success include: level of drug use, co-occurring psychiatric illness, degree of social support present, h/o previous treatment.
- Some patients are clearly more likely to fail on a suboxone program. Many of these will benefit from daily dosed MMT. Others may require even more structure, eg. residential treatment.
- Many patients will prefer OBOT vs MMT but may not be appropriate for this less structured setting.
- One study involved a stepped approach where all new patients were started on a suboxone program. Of these 46% were successful on suboxone and others were eventually transferred to MMT.
Continued...

- Patients who have been stable on MMT for some time may become reasonable candidates for OBOT.
- There appears to be little to support taking patients who have failed MMT and trying them on suboxone. Patients with a h/o previous failures on suboxone are also often a poor risk.
- In the end: “This is a judgment call, based on the patient’s past adherence to treatment for addiction or other medical conditions, comorbid psychiatric conditions, psychosocial stability, comorbid substance use disorders, and other factors”, SAMHSA, TIP # 40.

Conclusions:

- Opioid Addiction is a chronic, relapsing brain disease that demands an integrated approach.
- Opioid Replacement Therapy has a long history, strong scientific basis and documented success.
- CHCs, with their experience in team management of chronic diseases, are an ideal setting for the care of these patients.
- We all deal with addicted patients everyday. Why not learn how to address their needs?

References:

- TIP 43: Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, DHHS Publication # (SMA) 05–4048, 2005.
References, continued

- Neurobiology of Addictions, Eliot L. Gardner, Ph.D., Presentation, ASAM Review Course in Addiction Medicine, October 26, 2008.

Questions?

For example: How do we get paid for this?