Welcome! Opioid Settlement Funds Strategic Planning Summit

May 24-25, 2023

Opioid Response Network

Opioid Response Network

Opioid Use Disorder Overview: Treatment

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May 24, 2023

Opioid Response Network

Working with communities.

- The SAMHSA-funded *Opioid Response Network (ORN)* assists states, organizations and individuals by providing the resources and technical assistance they need locally to address the opioid crisis and stimulant use.
- Technical assistance is available to support the evidence-based prevention, treatment and recovery of opioid use disorders and stimulant use disorders.

Working with communities.

- The *Opioid Response Network (ORN)* provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis and stimulant use.
- *ORN* accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Overall Mission

To provide training and technical assistance via local experts to enhance **prevention**, **treatment** (especially medications like buprenorphine, naltrexone and methadone) and **recovery** efforts across the country addressing state and local - specific needs.

Approach: To build on existing efforts, enhance, refine and fill in gaps when needed while avoiding duplication and not "re-creating the wheel."

Contact the Opioid Response Network

- To ask questions or submit a technical assistance request:
  - Visit www.OpioidResponseNetwork.org
  - Email orn@aaap.org
  - Call 401-270-5900

Substance Abuse and Mental Health Services Administration (SAMHSA)

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Positionality Statement

Today's Topics

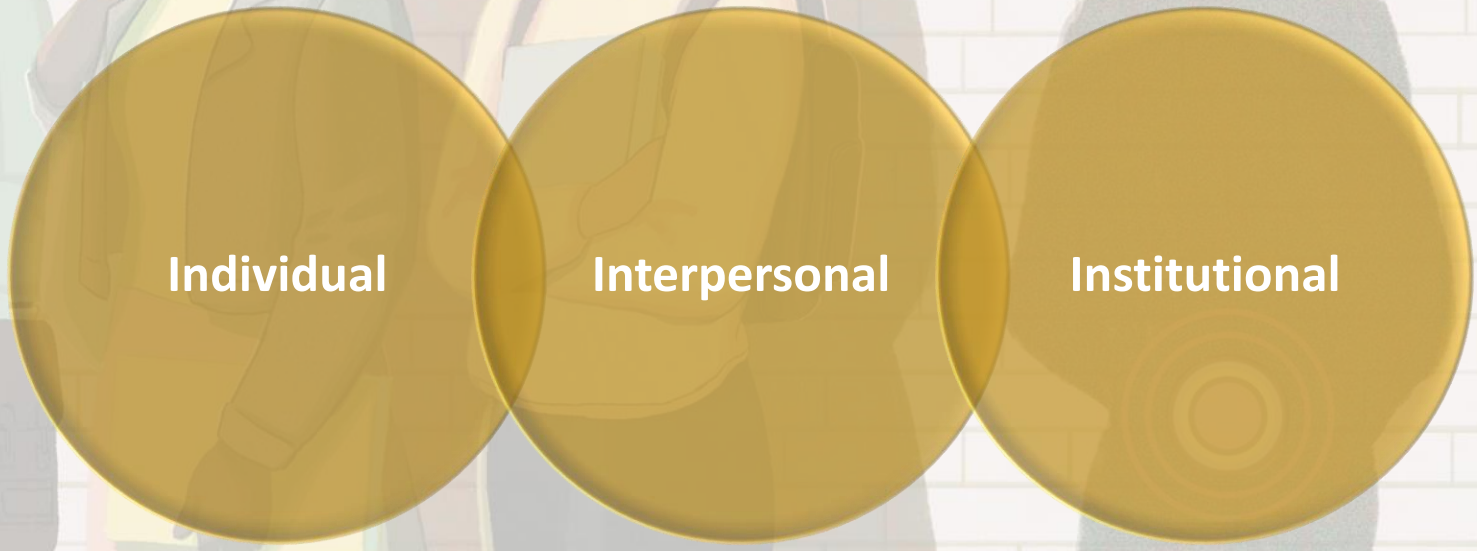
1. Stigma
2. Neurobiology of Addiction
3. MOUD Treatment
4. 2022 CDC Opioid Prescribing Guidelines
5. Perinatal OUD
6. Neonatal Withdrawal Syndromes
7. OUD in Incarcerated Populations
8. First-responders and OUD
9. Harm Reduction
10. How ORN can help (examples)

OUD = Opioid Use Disorder; CDC = Centers for Disease Control and Prevention; ORN = Opioid Response Network

Stigma

Stigma

"Dynamic process in which individuals and structures continuously engage in exchanges mediated by power, control, and domination."

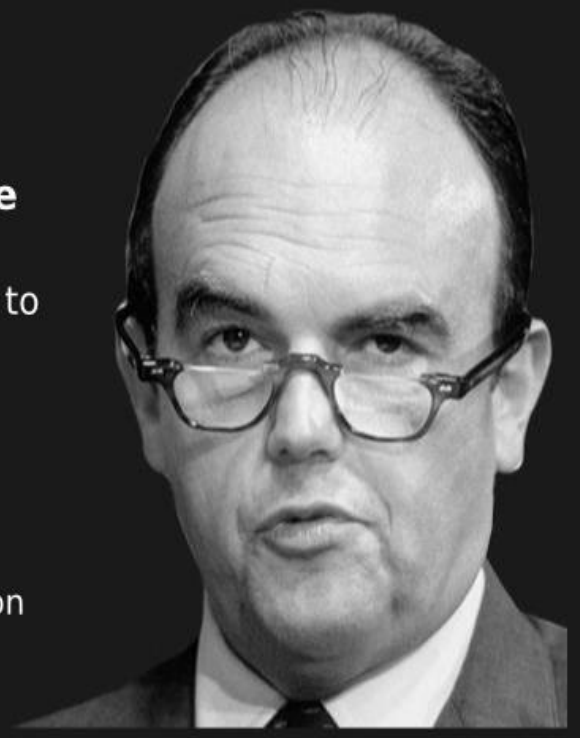


Weber et al. Sub Abuse Rehab 2021.

WHY THE WAR ON DRUG USERS?

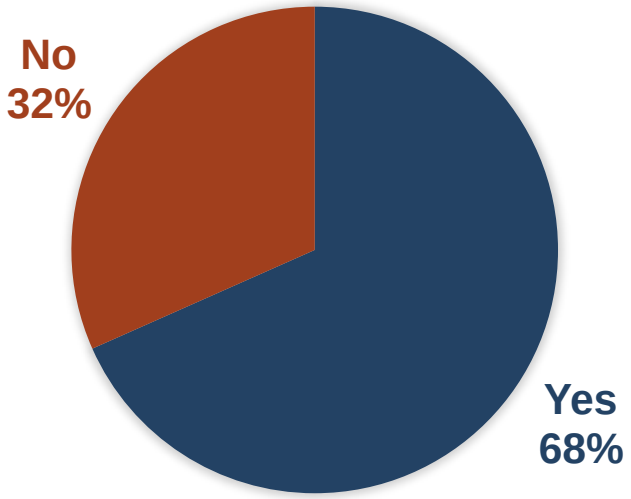
"You want to know what this was really all about? Nixon had two enemies: the antiwar Left, and black people. **We knew we couldn't make it illegal to be either against the war or black.** But by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. **Did we know we were lying about the drugs? Of course we did.**"

-- John Ehrlichman, Counsel and Assistant to US President Nixon

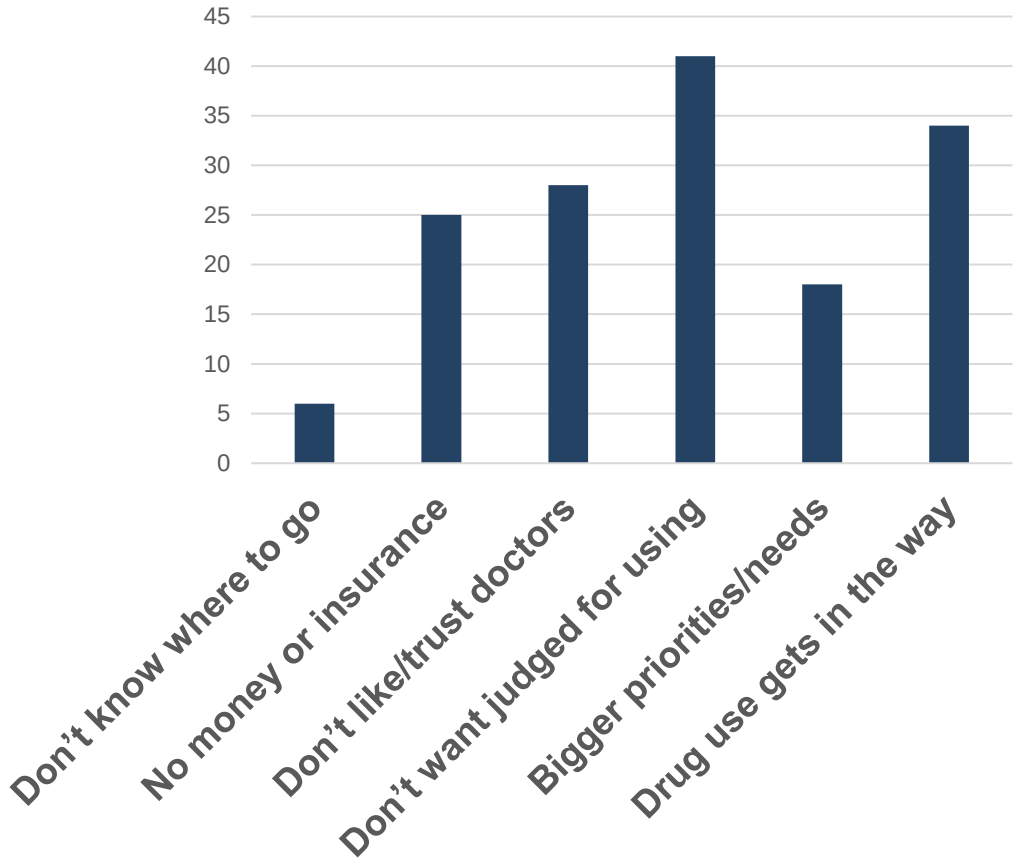


Interviewed in 1992. Full quote in "Truth, Lies, and Audiotape" (2012) by Dan Baum, journalist and author of *Smoke and Mirrors: The War on Drugs and the Politics of Failure*.

In the last 12 months, was there a time when you thought you should see a health care provider for a medical/physical issue, but you DID NOT go?



What were the main reasons you DID NOT see a health care provider?



Why?

"**The hospital is like cops…They say that there's a privacy of information and they say there's HIPPAA, but there isn't.** People look in your records and your PO or the cops are going to find out. The privacy of your information should apply to all government employees and all hospital employees and **only available to the doctor you see.**"

"I was told it's **not worth treating me because I wasn't gonna live anyway."**

“Didn't want a physician to find out about an abscess because then they'd know about drug use and would **get labeled a drug user**.”

"I've never had anybody come to me and tell me I could trust them."

“It’s **hard to get into mental health treatment and receive your medications** if they know about your drug use.”

Language Matters

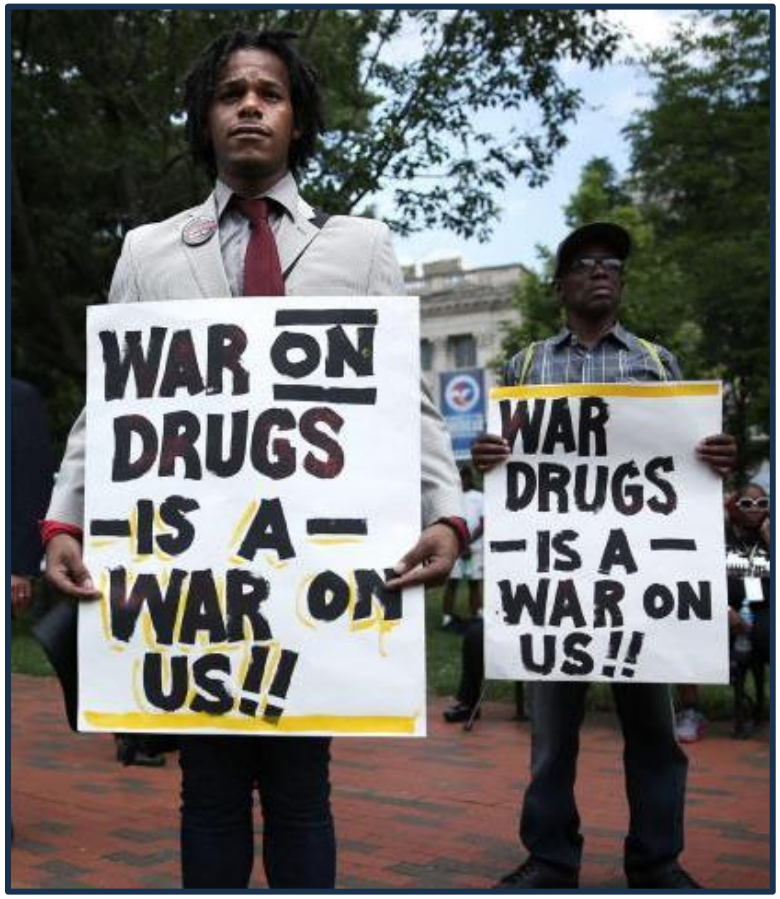
INSTEAD OF...	... USE THIS.
Narcotic	Substance
Abuse	Use disorder, Chaotic use
"Alcoholic", "Addict"	Person with a substance use disorder
Relapse	Return to use
Clean/dirty	Positive/negative
Staying clean	Maintaining recovery

Institutional Racism

- Historically marginalized populations have worse SUD outcomes:
  - Alcohol-related illness
  - Substance-related disability, premature death
  - Involvement in the carceral system
- Black population less likely to seek in or engage with treatment
  - Regardless of ACA

Acevedo et al. 2012; Satcher 2001; Schmidt and Mulia 2009; Galvan 2003; and Mojtabai R 2011. Watt TT. The race/ethnic age crossover effect in drug use and heavy drinking. J Ethn Subst Abuse 2008. Jordan, A. AAAP 2020.

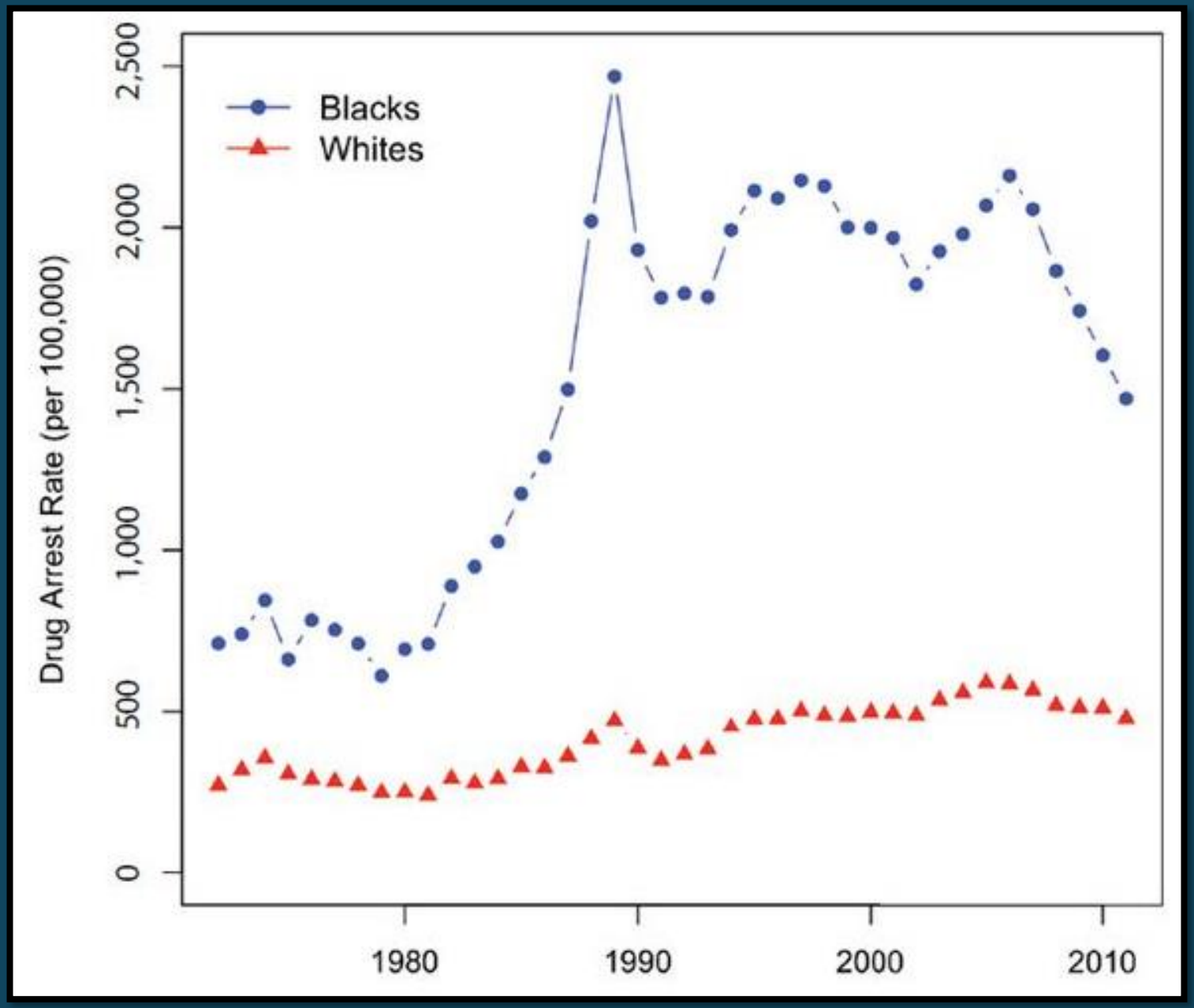
Institutional Racism



- Crack epidemic = War on Drugs
- Opioid epidemic = National Public Health Crisis

- Perpetuated in legislation:
  - "National security threat"
  - Mandatory minimum sentencing
  - Higher sentencing for forms of a substance more common in Black communities

Jordan, A. AAAP 2020.



Uniform Crime Reports race-specific arrest rates, 1980-2011 (BJS). Jordan, A. AAAP 2020

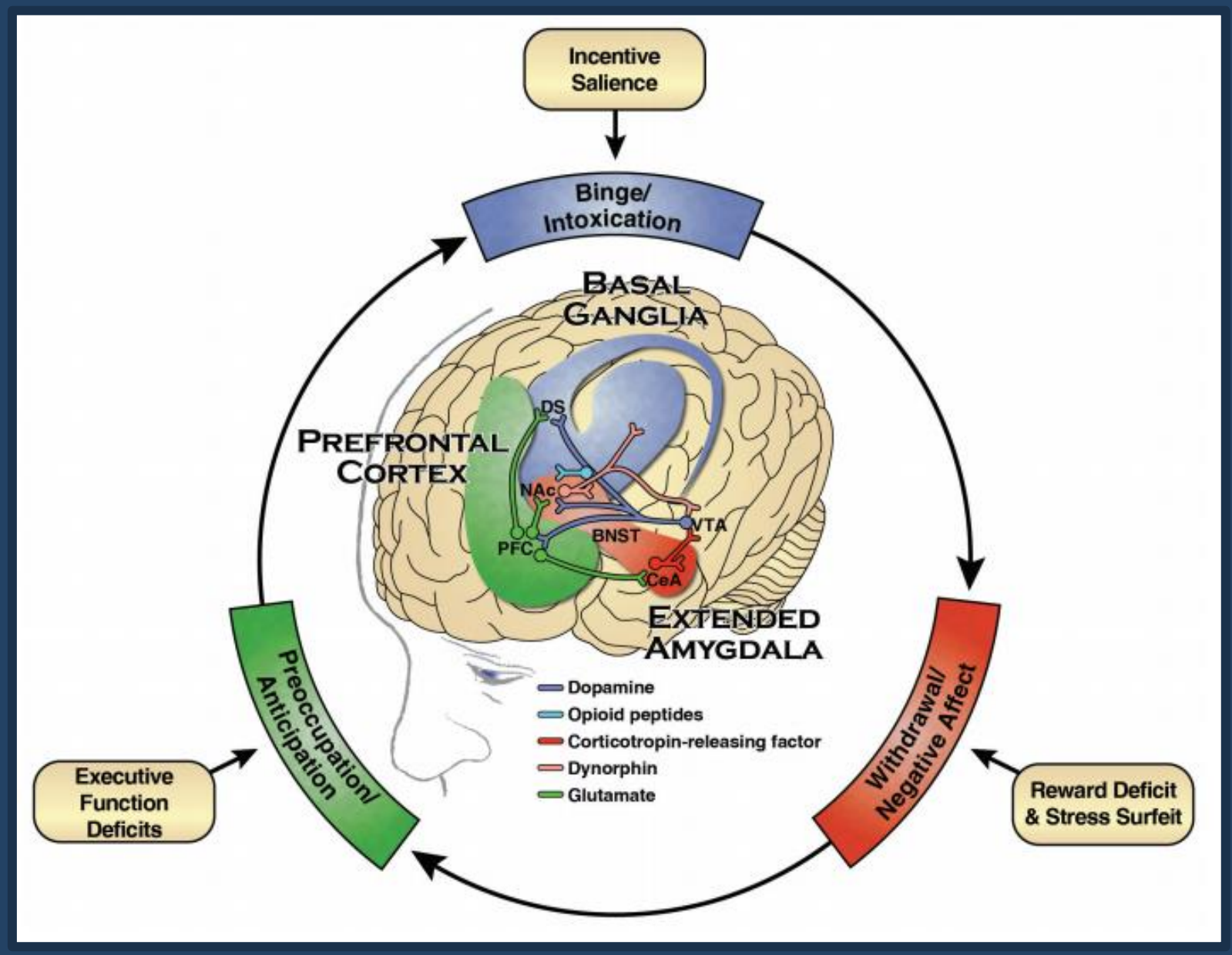
TAKE HOME POINTS

1. Stigma and racism continue to impact SUD treatment accessibility and outcomes.

2. Targeting individual bias is not enough.

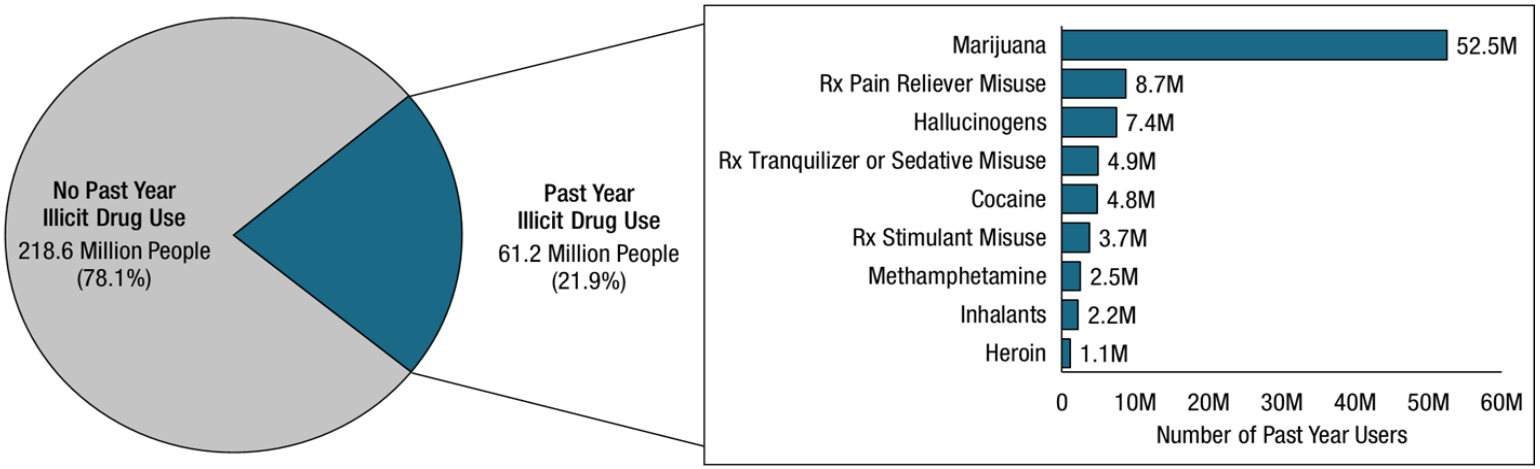
3. Re-evaluate policies that continue to increase inequity at every level in your organizations.

Neurobiology of Addiction

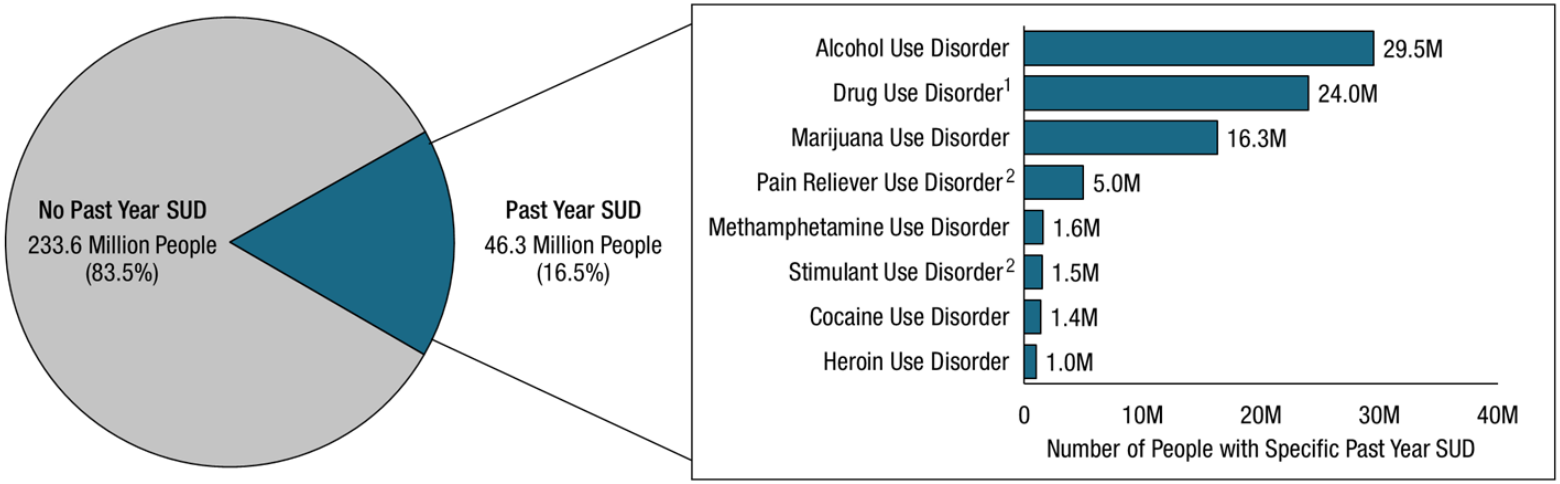


Volkow, et al. NEJM 2016. Koob, Volkow. Neuropsychopharmacology 2010. Nestler EJ. Nature Neuroscience 2005.

Any Use



Use Disorder



SAMHSA NSDUH Survey 2022.

Substance Use Disorder

2 or more within 12-month period:

1. Larger amounts or longer duration than intended
2. Persistent desire or unsuccessful attempt to cut down/control use
3. Significant time spent obtaining, using, or recovering*
4. Craving/strong desire/urge to use
5. Failure to fulfill major roles (work, home, school)*
6. Continued use despite ongoing social problems*
7. Important activities reduced/aborted
8. Recurrent use in hazardous environments*
9. Recurrent use despite physical/psychological problems
10. Tolerance
11. Withdrawal

Mild 2-3
Moderate 4-5
Severe 6 or 11

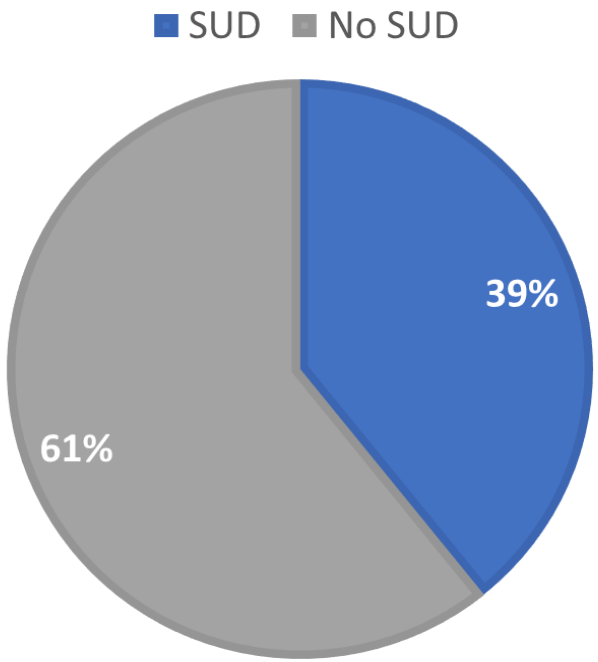
Substance Use Disorder

"...chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences."

NIH National Institute on Drug Abuse
Advancing Addiction Science

NIDA. 2020, July 13. Drug Misuse and Addiction.

Substance Use Disorders 2021*



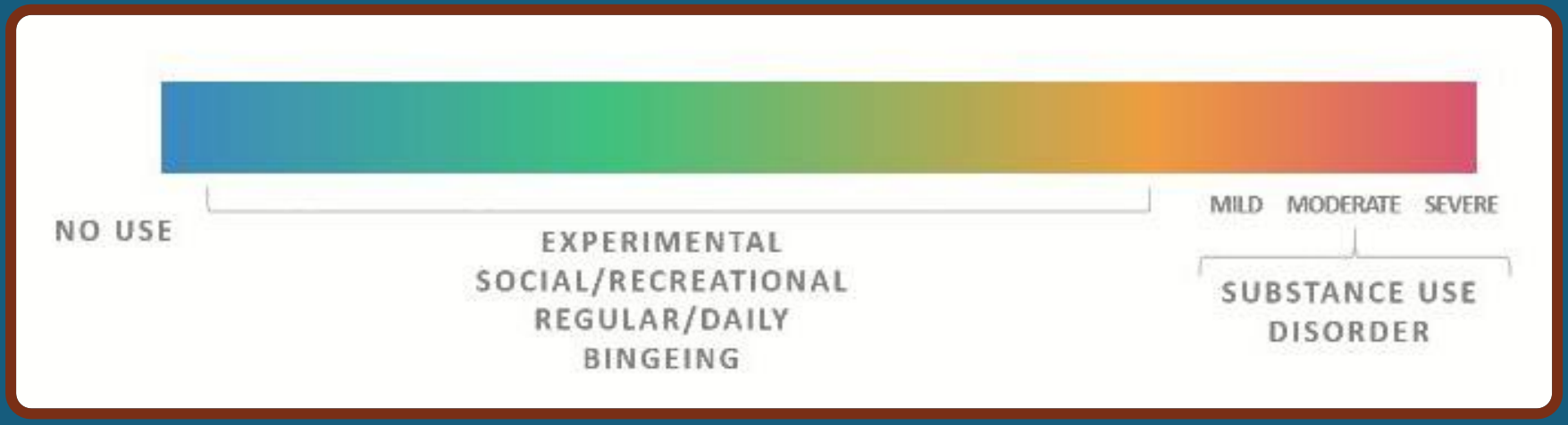
*DSM 5 criteria used since 2020

Most people who use drugs **DO NOT** develop substance use disorders (SUD).

- Trauma
- Genetic
- Age of onset
- Untreated mental illness
- Untreated physical illness
- Chronic, non-specific pain

SAMHSA NSDUH Survey 2022.

Continuum of Drug Use



TAKE HOME POINTS

1. Addiction is defined by a compulsion to engage in a behavior despite negative consequences.

2. Most people who use drugs do not have a SUD (and not all people with mild SUD need specialist treatment).

Medications for Opioid Use Disorders (MOUD)

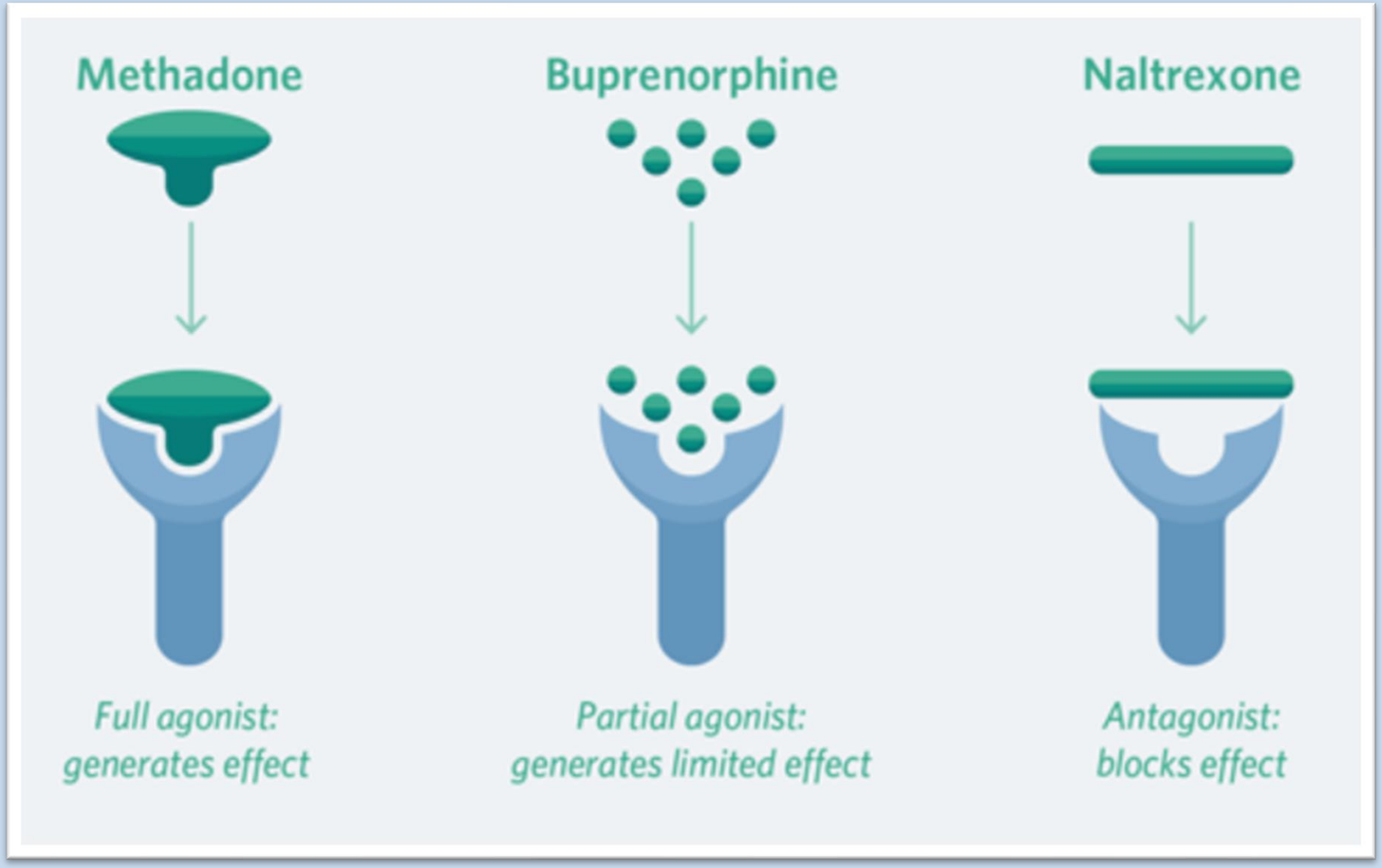
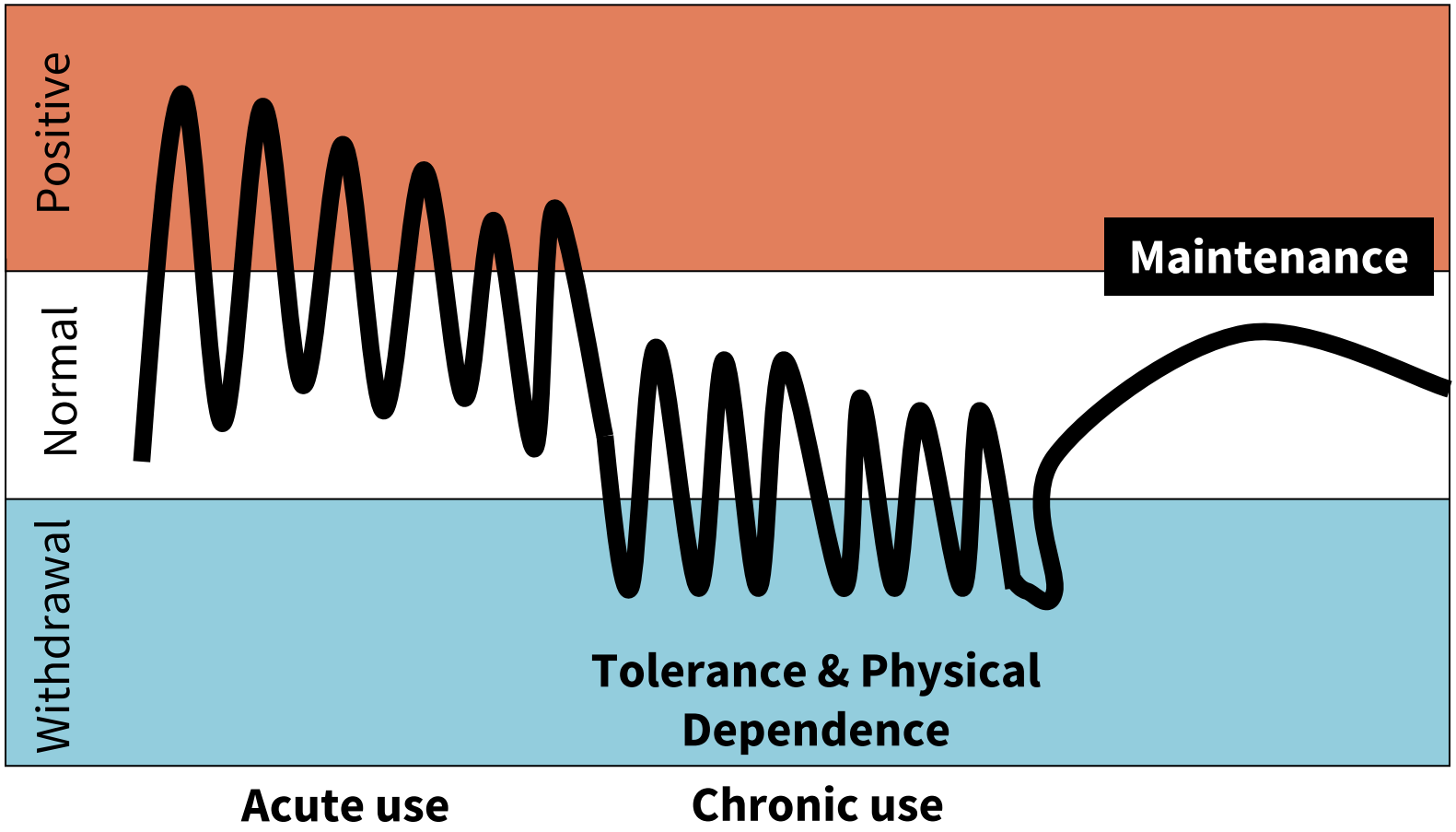


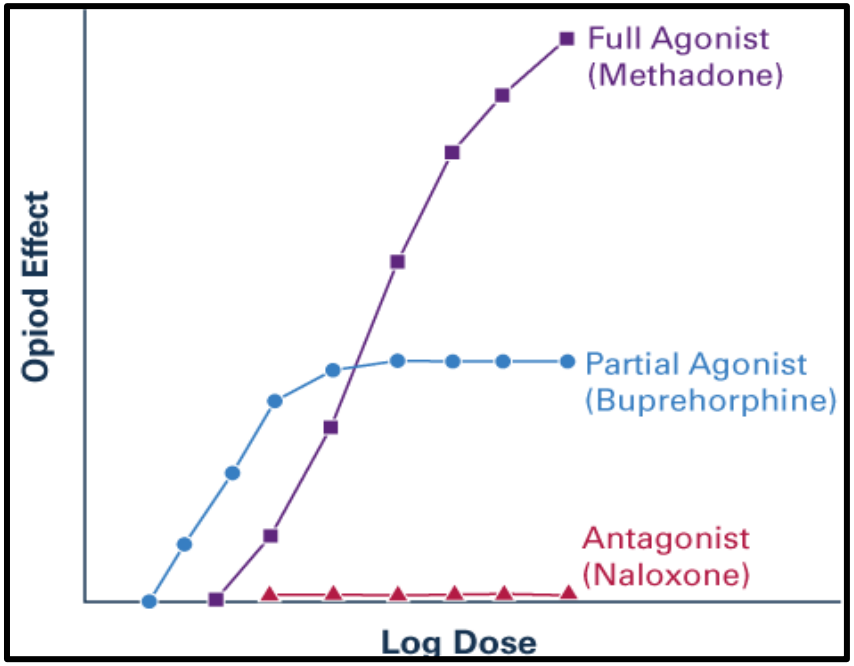
Image source: https://www.recoveringself.com/addiction/is-vivitrol-the-best-option-for-opioid-withdrawal

Methadone and Buprenorphine



Methadone and Buprenorphine

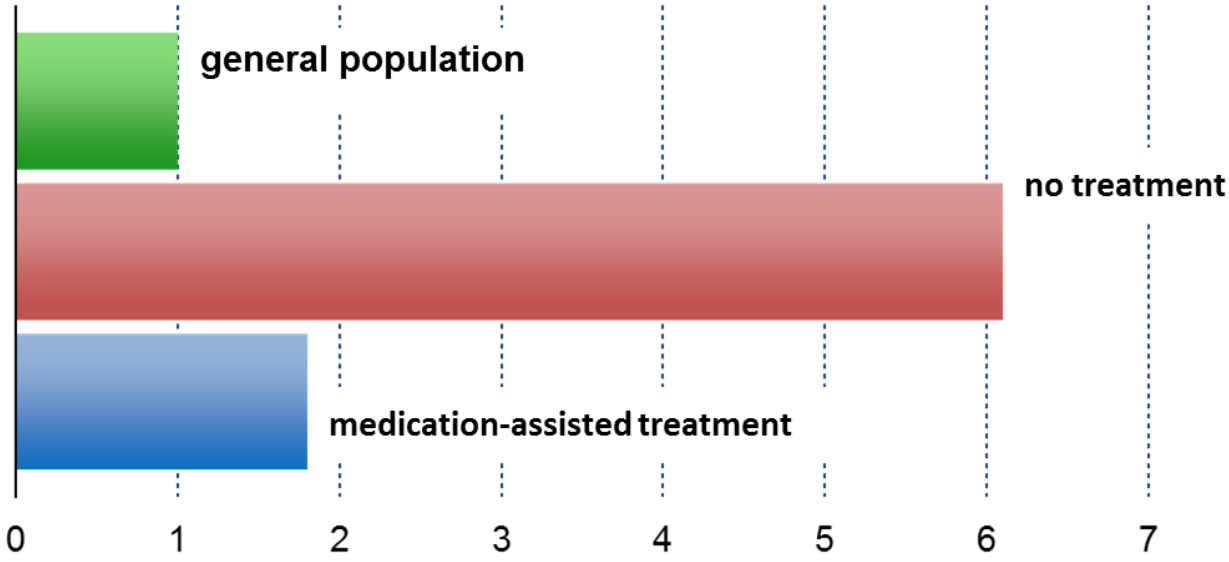
- Reduces blood-borne infection transmissions
- Less homelessness
- More financial independent
- Less carceral involvement
- Improved treatment retention



Dupouy et al. Ann Fam Med 2017; 15:355-58. Evans et al. Addiction 2015; 110:996-1005. Sordo et al. BMJ 2017; 357:j1550.
PCSS-MAT, MAT Waiver Eligibility Training 2018. Supported by SAMSHA.

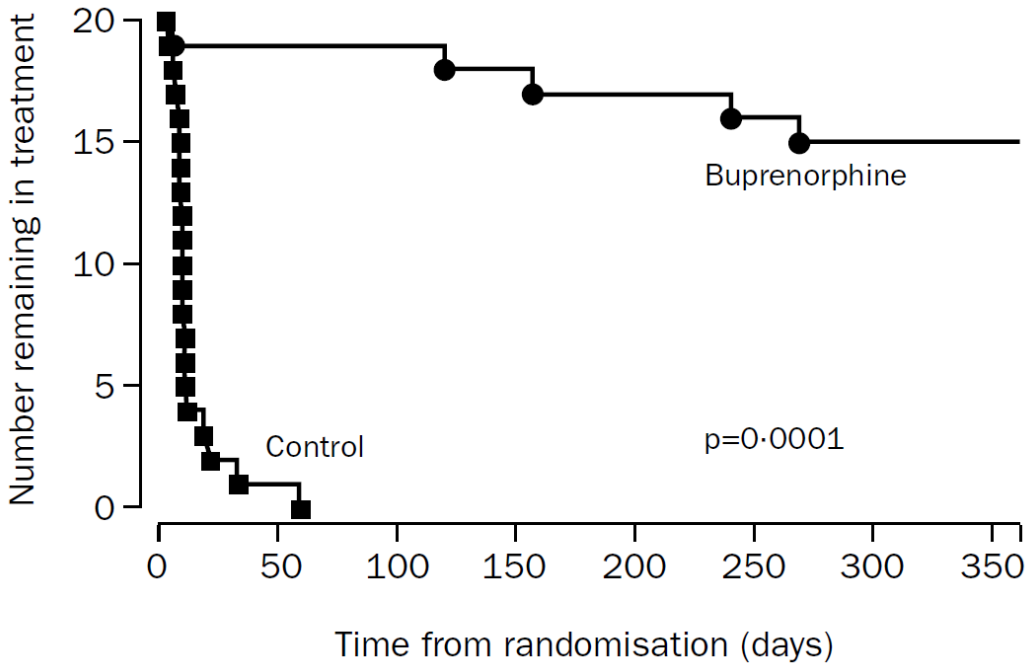
Reduces Mortality

Death rates:



Dupouy et al. Ann Fam Med 2017; 15:355-58. Evans et al. Addiction 2015; 110:996-1005. Sordo et al. BMJ 2017; 357:j1550.
PCSS-MAT, MAT Waiver Eligibility Training 2018. Supported by SAMSHA.

Buprenorphine Taper vs. Maintenance



Completed 52-week trial:

- taper 0%
- maintenance 75%

Mean % urine negative:

- maintenance 75%

Mortality:

- taper 20%

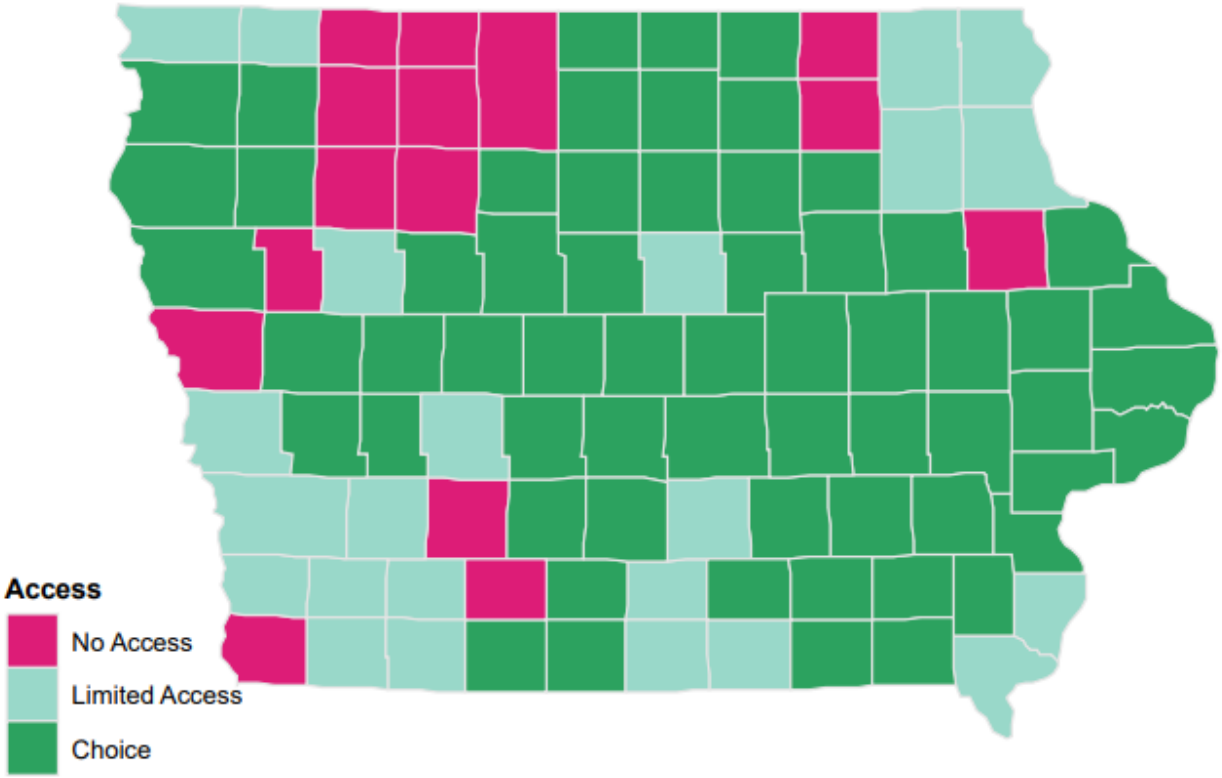
Kakko J et al. Lancet 2003.

Treatment Duration

Continue maintenance treatment as long as benefitting:

- Decreased substance use
- Employment
- Education
- Relationships
- Stable housing

Access Barriers



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- Insurance?
- Taking new patients?
- Require counseling?
- Complete abstinence?
- Mental health treatment?
- Rule out conditions?

Arndt, Stephan & Hedden, Suzy. (2019). Iowa Access to Medication-Assisted Treatment for Opioid Use Disorder by County. 10.13140/RG.2.2.30432.12803.

Low-barrier MOUD Care

Same-day treatment

- Medications on the day of visit
- Unobserved initiation

Harm reduction approach

- Reduction in illicit opioid is acceptable goal
- Use of other substances does NOT result in stopping MOUD

Flexibility in treatment structure

- Visit frequency based on clinical stability
- Counseling offered, but not required

Jakubowski, Fox. J Addict Med. 2019.

Where can this happen?

- Community organizations
- Crisis Centers
- Medical Clinics
- ERs
- Hospitals
- SUD treatment facilities
- Jails/Prisons

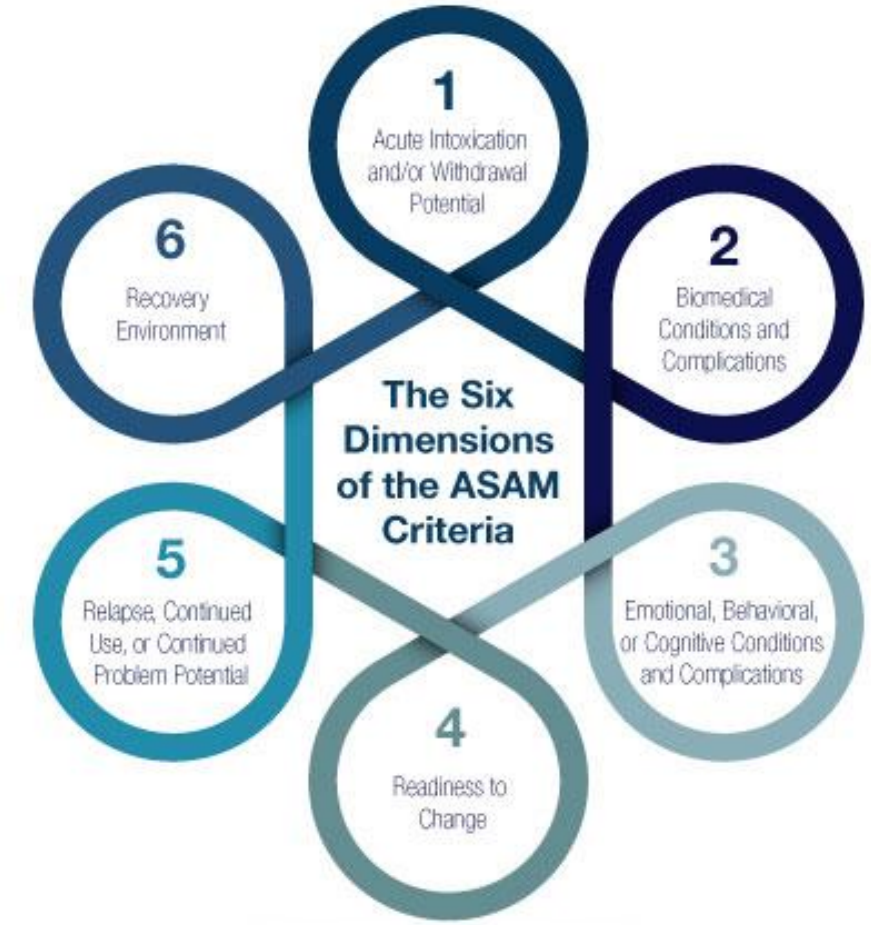
Insurance Barriers

- Prior authorizations
- Dose and duration restrictions
- Naloxone restrictions
- OTC naloxone available – cost? coverage?

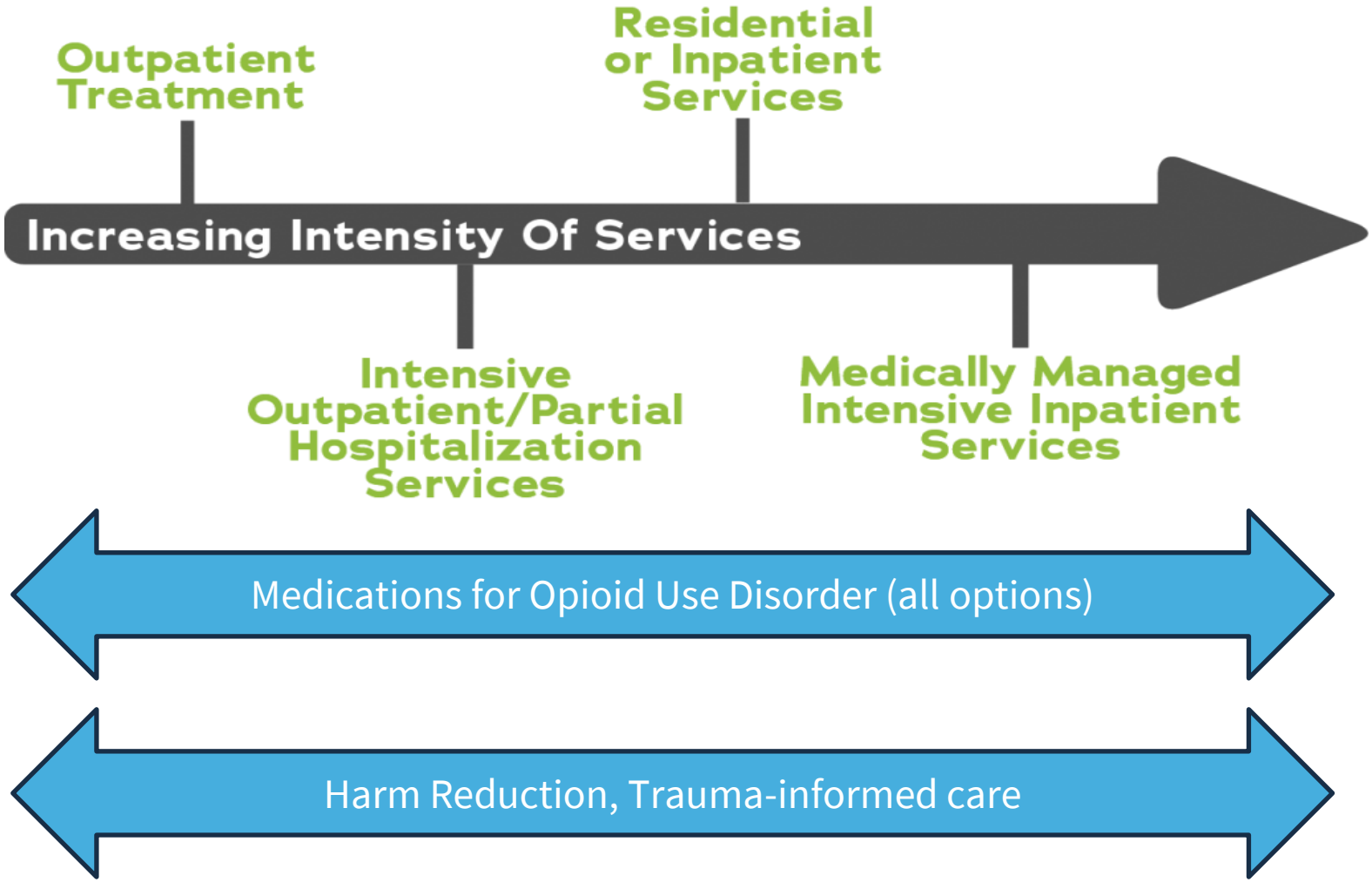
Pharmacy Barriers

- Do not carry naloxone OR buprenorphine
- Take 24-48 hours to order in prescription
- Stigma, misinformation

Dimensions of ASAM Criteria



ASAM Levels of Care



Treatment Barriers

- Treatment centers are not required to offer or continue MOUD
- Actively turn away clients on medications
- “Goal of treatment” to taper to discontinuation
- “Not in recovery” per 12-step programming
- Don’t accept insurance for medication treatment
- Disease vs. behavior model

TAKE HOME POINTS

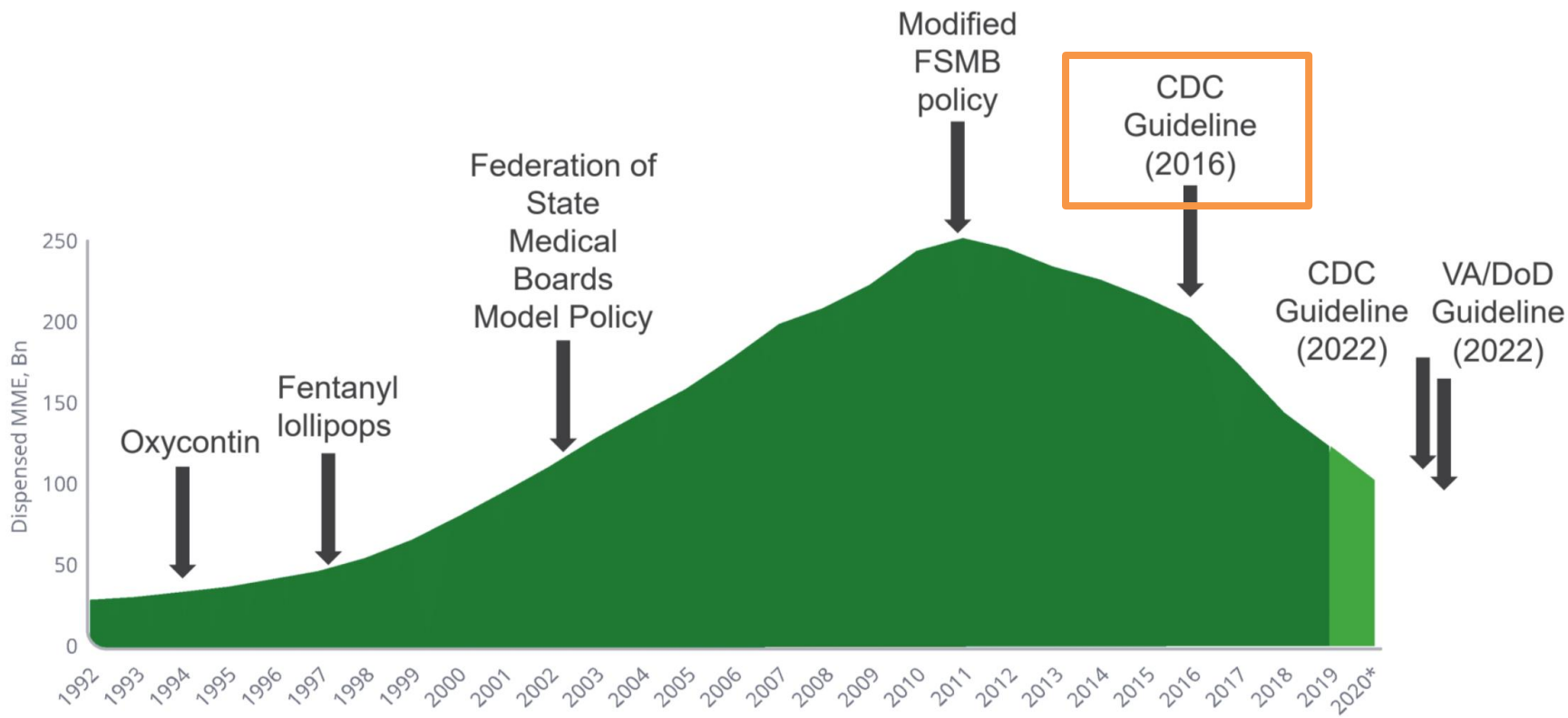
Increase access to MOUD:

- remove prior authorizations
- increase reimbursement to PCPs
- mandate substance use treatment programs accept and offer MOUD
- normalize long-term MOUD treatment

Increase step-down, recovery housing

2022 CDC Opioid Prescribing Guidelines: An Update

Epidemiology of Opioid Prescribing



IQVA Xponent, Mar 2020; IQVIA National Prescription Audi; IQVIA Institute, Nov 2020. Starrel, J. ASAM Conference 2023.

2016 CDC Guidelines

When to prescribe opioids for chronic pain:

- Non-pharmacologic and non-opioid therapies are preferred
- Establish functional treatment goals
- Shared-decision making

How to prescribe opioids for chronic pain:

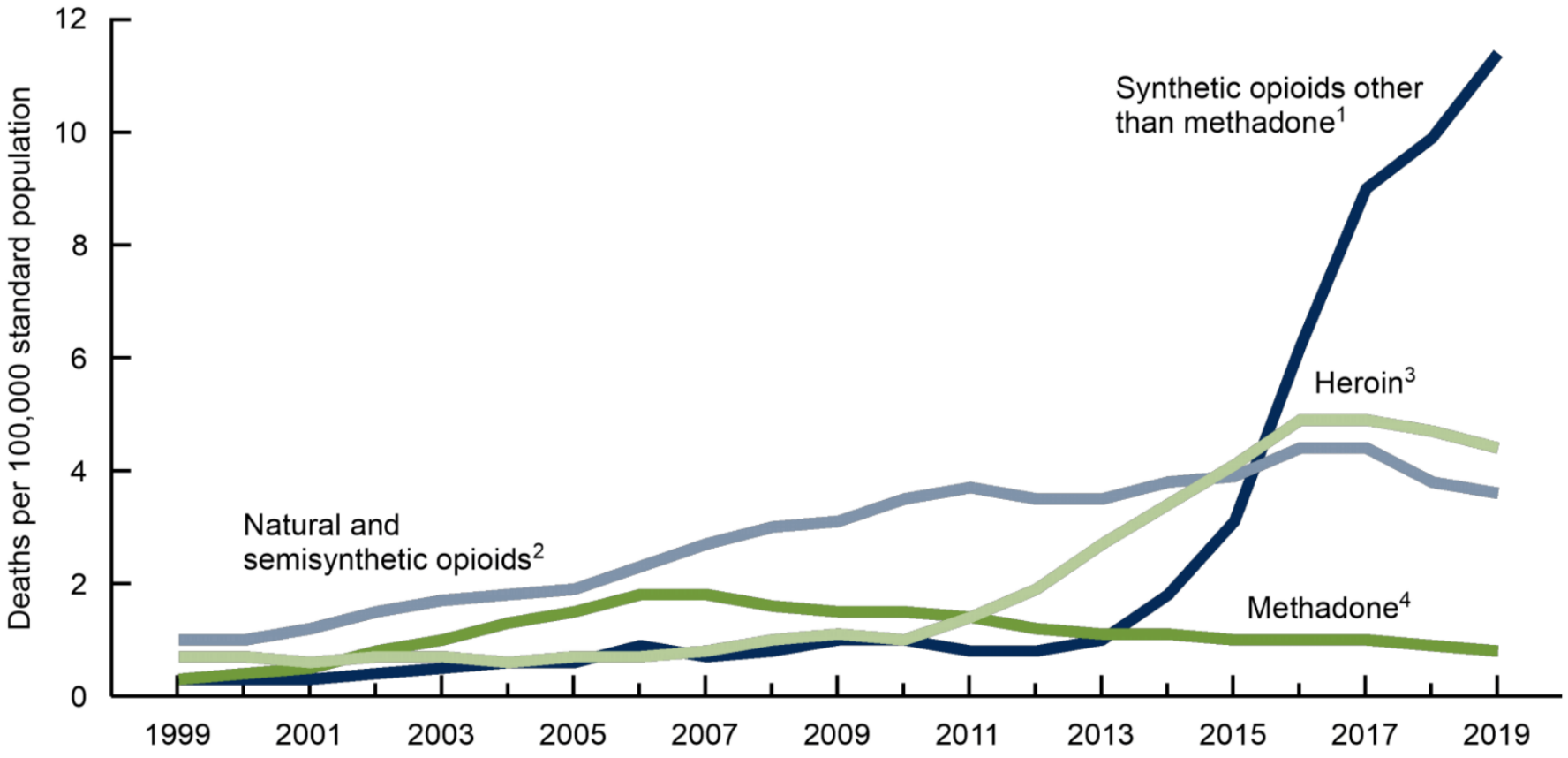
- Start with short-acting versions
- Prescribe lowest effective dose (avoid and justify >90 MME)
- For acute pain, not more than 3 to 7 days' supply
- Regularly reassess; taper if pain and functional benefits do not outweigh risks

Assess and mitigate risks and harms

- Use the prescription drug monitoring program, urine drug testing, give naloxone
- Avoid concurrent benzodiazepine use when possible
- If OUD, provide or refer for OUD treatment

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA. 2016 Apr 19;315(15):1624-45. doi: 10.1001/jama.2016.1464. PMID: 26977696; PMCID: PMC6390846.

…Yet, Overdose Deaths Rise



National Center for Health Statistics, National Vital Statistics System, Mortality

Unintended Consequences

- 43% of doctors unwilling to prescribe to someone on long-term opioids
- Inequities expanded
  - Non-white, non-male patients less likely to receive opioids for pain, more likely to be tapered

Lagisetty P et al. Assessing reasons for decreased primary care access. Pain (2021).

Harms of Involuntary Tapers

- Opioid withdrawal
- Exacerbation of pain
- Psychological distress
- Termination of chronic medical care
- Illicit opioid use
- Opioid-related hospital/ED visits
- Overdose and overdose death
- Deaths by suicide

Demidenko MI et al., Genl Hosp Psych (2017); Oliva EM et al., BMJ (2020); Perez HE et al., JGIM (2019); Binswanger IA et al., DAD (2020), Coffin PO et al., Plos One (2020); Mark TL et al., JSAT (2019); James JR et al., JGIM (2019), Glanz JM et al., JAMA Network Open (2019

2022 CDC Guidelines

"Misapplication [of the 2016 guideline] including inflexible application of the recommended dosage and duration thresholds, contributed to patient harms… These experiences underlined the need for an updated guideline reinforcing the important of flexible, individualized, patient-centered care."

Dowell D et al. NEJM (2022), CDC website.

2022 CDC Guidelines

- Maximize nonpharmacologic and nonopioid phar macologic treatments for acute pain
- Non-opioid therapies preferred for chronic pain and now subacute pain as well
- Still, prescribe the lowest effective dose of opioid s for chronic pain
- If benefits do not exceed risks, work closely with patients to gradually taper or lower doses...

Dowell D et al. NEJM (2022), CDC website.

TAKE HOME POINTS

1. Use of long-term opioids for chronic pain is a decision between patients and prescribers.

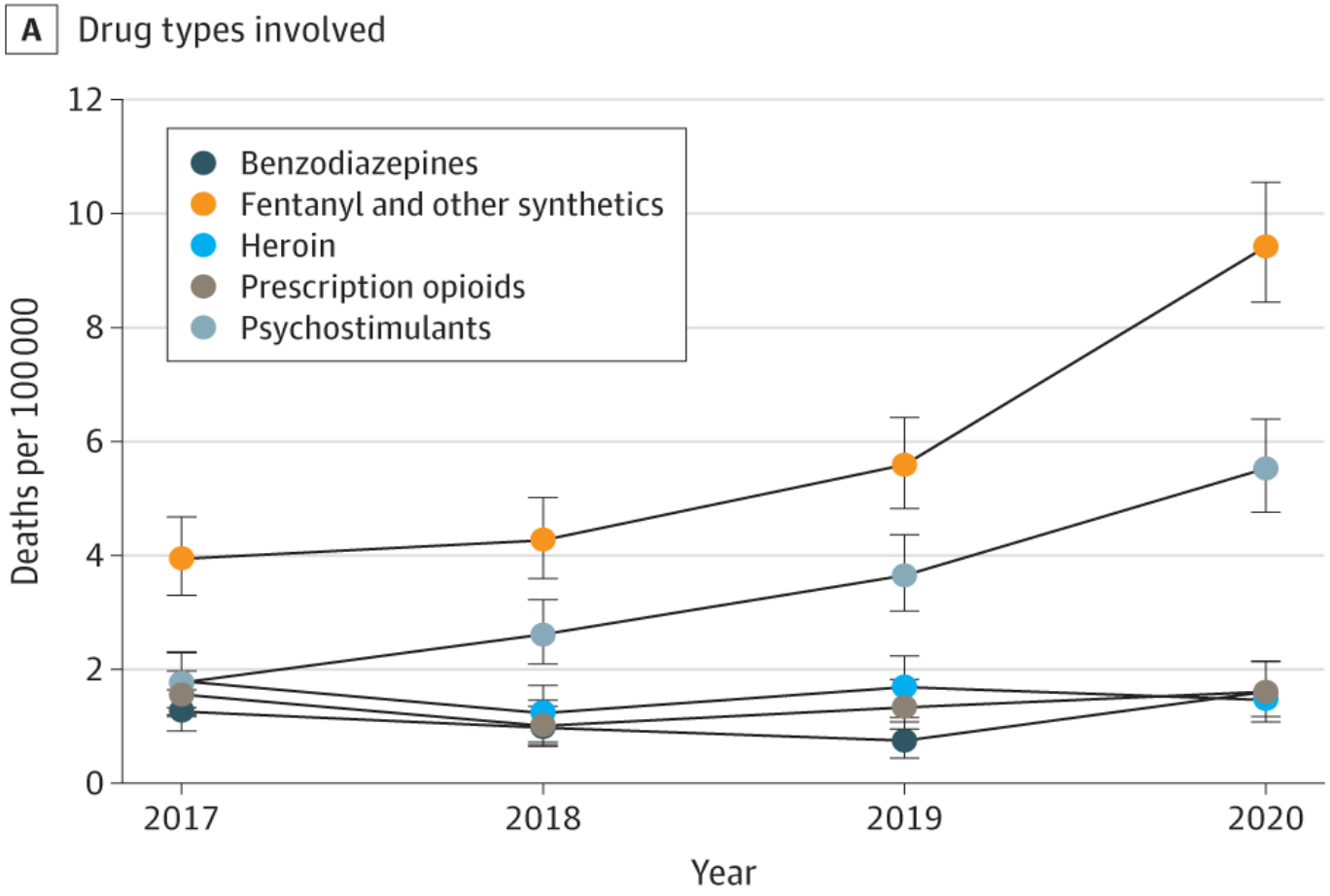
2. Rapid tapers and involuntarily discontinuations increase mortality.

3. Increase access and payment for multimodal chronic pain management.

BREAK

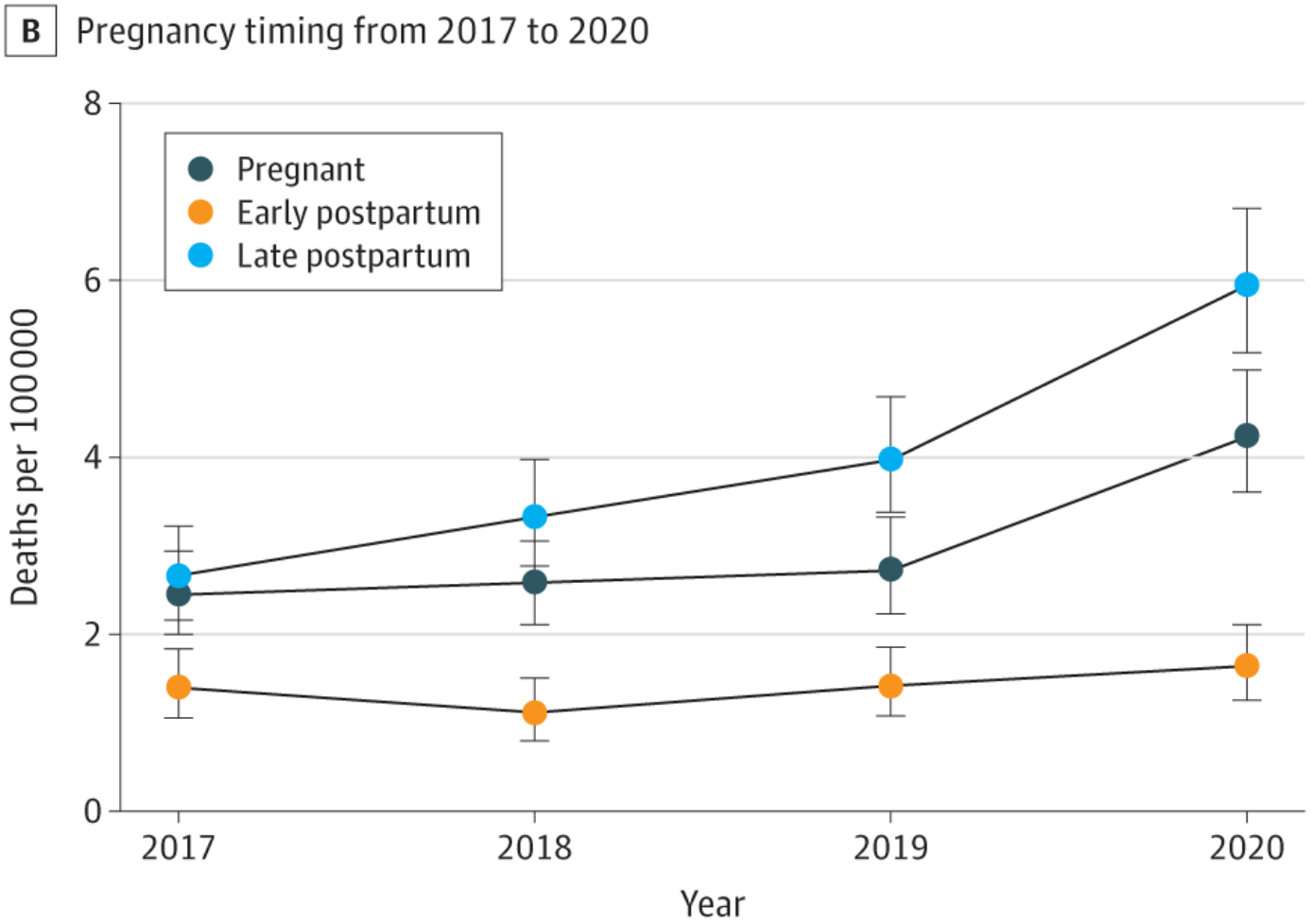
Perinatal Opioid Use Disorder

Pregnancy-Associated Drug Overdose Mortality



Bruzelius E, Martins SS. US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020. *JAMA.* 2022;328(21):2159–2161. doi:10.1001/jama.2022.17045

Pregnancy-Associated Drug Overdose Mortality



Bruzelius E, Martins SS. US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020. *JAMA.* 2022;328(21):2159–2161. doi:10.1001/jama.2022.17045

Pregnancy-Related Mortality

- Drug overdose mortality increased 81%
- Over 80% are preventable
- Mental health conditions were the most common

Among pregnancy-related deaths with information on timing,

53% occurred 7–365 days postpartum.

Bruzelius E, Martins SS. *JAMA.* 2022; CDC MMR: Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. 2022

Postpartum

- Standard-of-care pain management not received during labor/delivery
- MOUD not offered or continued
- Decreased incidence of rooming-in
- Decreased lactation coaching/consults
- Re-traumatization reduces follow-up

Jones et al. Am J Drug Alcohol Abuse 2009. MacVicar, Kelly. Birth 2019. SAMHSA 2018.

Postpartum

- May start again after birth
- **Overdose rates highest 7-12 months after having a baby**
- May return to using more chaotically
- Support systems may change
- Insurance coverage changes may remove supports

National Harm Reduction Coalition. Pregnancy and Substance Use: A Harm Reduction Toolkit. Accessed Jan 2022.

Neonatal Withdrawal Syndrome (NWS)

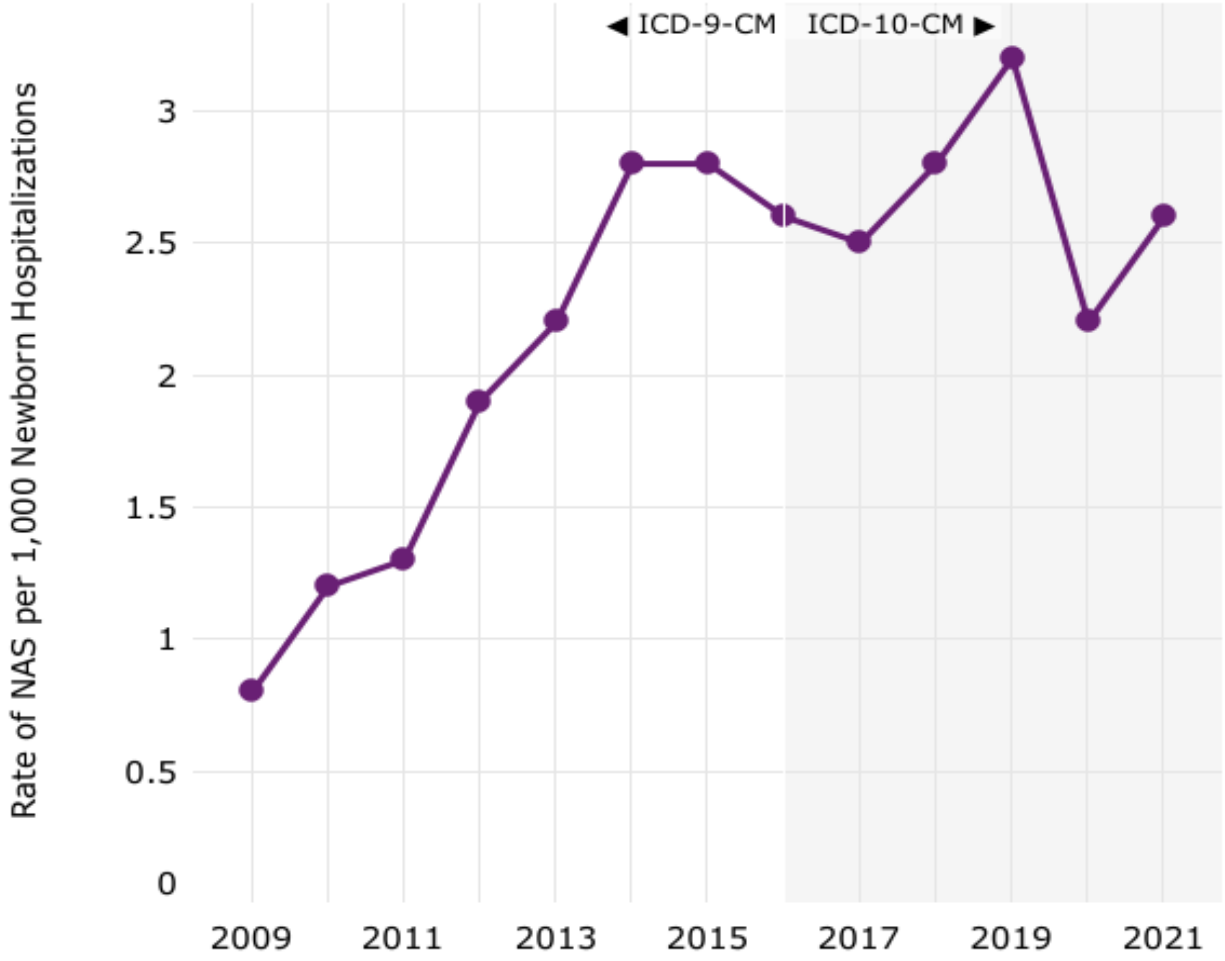
- Symptoms:
  - Irritability, fever, diarrhea, hyperreflexia, seizure
  - Begins 24-72 hours of birth, with peak symptoms at 3-4 days, and continues for up to one week

- **Higher risk with UNTREATED parental OUD**

- No known long-term consequences
  - Studies lacking overall

Kakko et al., 2008. Patrick at al., 2015. Smith et al., 2017

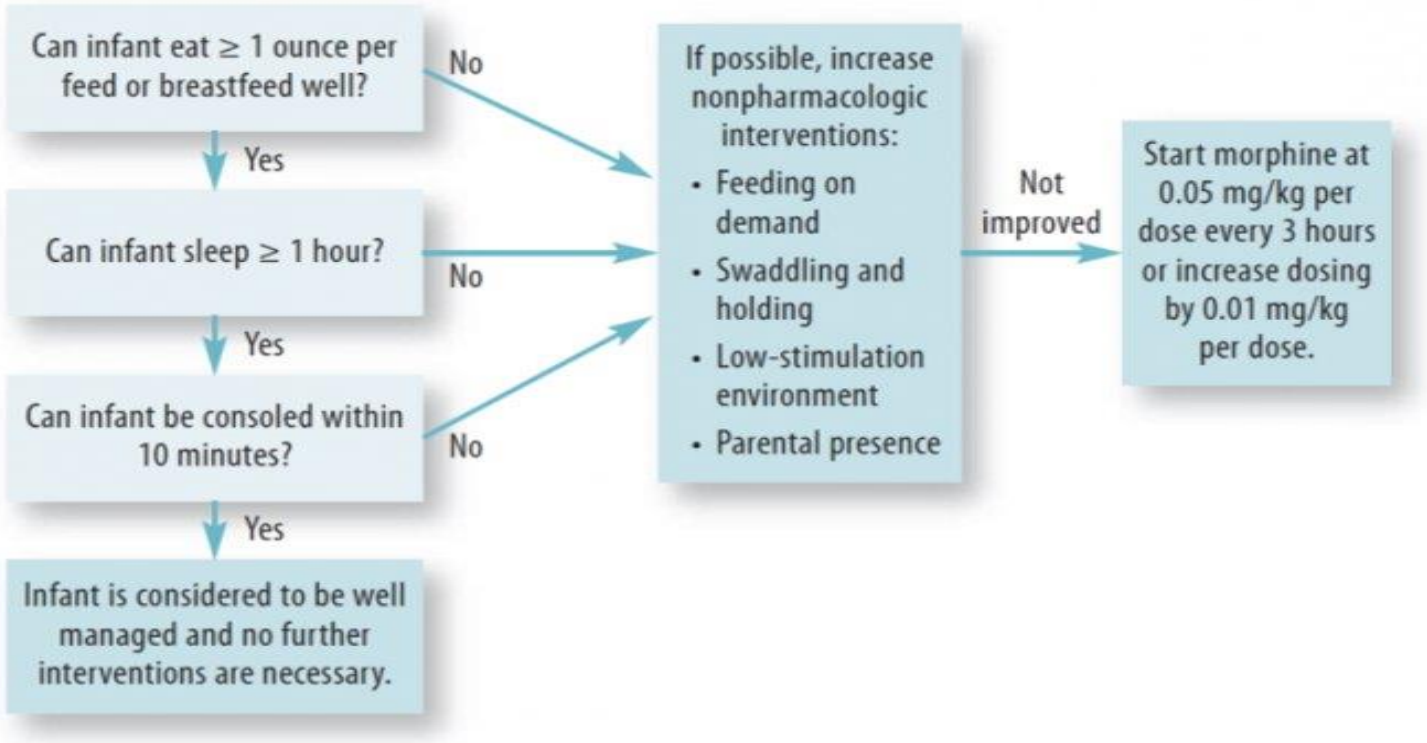
NWS: Iowa 2009-2021



Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and utilization Project (HCUP), State Inpatient Databases (SID) 2009 to 2021 (all available data as of 10/18/2022)

NWS: Treatment

- "Eat, Sleep, Console"
- Rooming in results in a reduction in NWS length of stay and cost



Holmes et al., 2016; Hudak et al., 2012; Slowiczek L, 2018; Grossman et al 2018 (image)

Lactation and Chestfeeding

Chestfeeding is safe while using MOUD

- Improved bonding
- Favorable effects on NWS

Transferred amounts of MOUD unable to prevent NWS

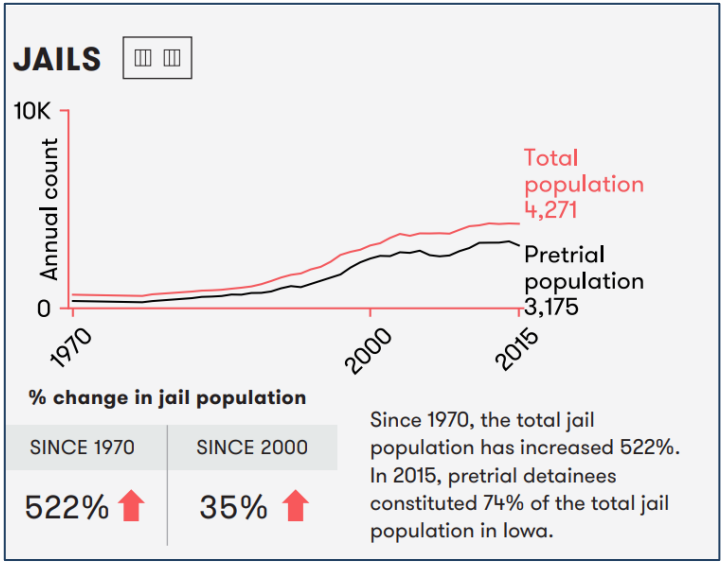
Sachs et al., 2013

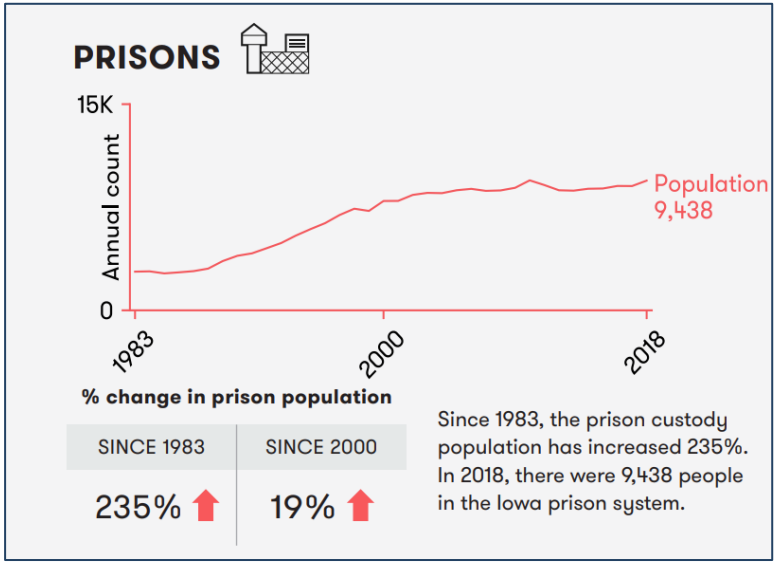
TAKE HOME POINTS

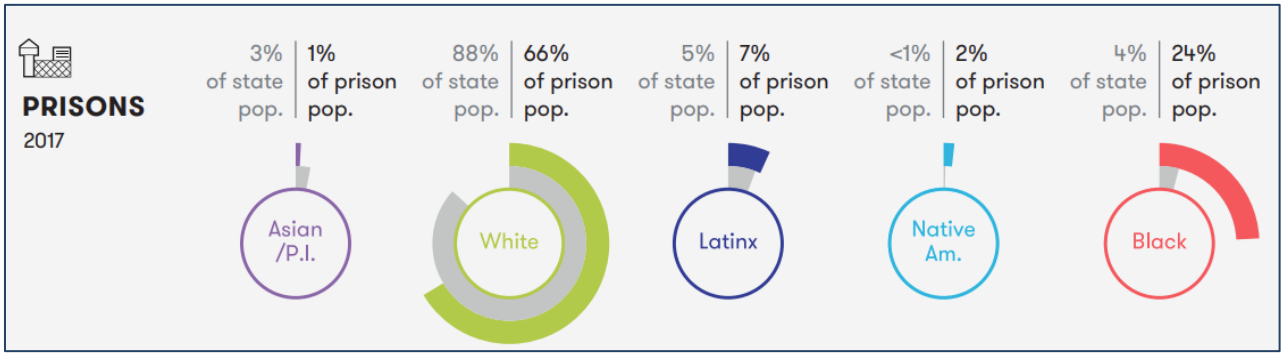
1. Increase MOUD access in pregnancy
2. Destigmatize use of MOUD
3. Do not criminalize parental SUD
4. Encourage bonding post-partum
5. Encourage chestfeeding to all interested while continuing MOUD

OUD in Incarcerated Populations

Incarcerated Population

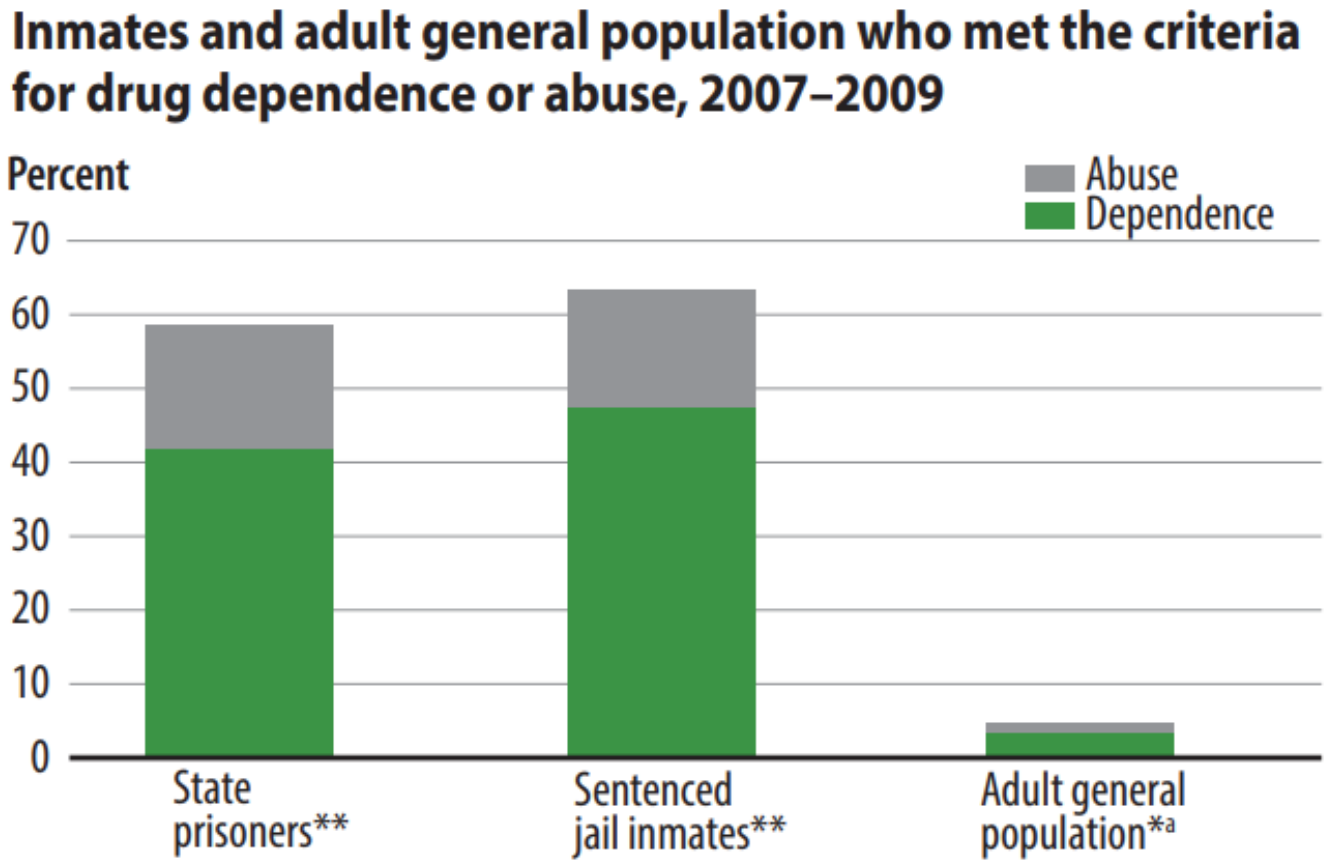






https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-iowa.pdf

High Rates of SUD



https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf

MOUD while Incarcerated

- Most MOUD are stopped or never started while incarcerated
- 12.7x higher rate of death leaving incarceration

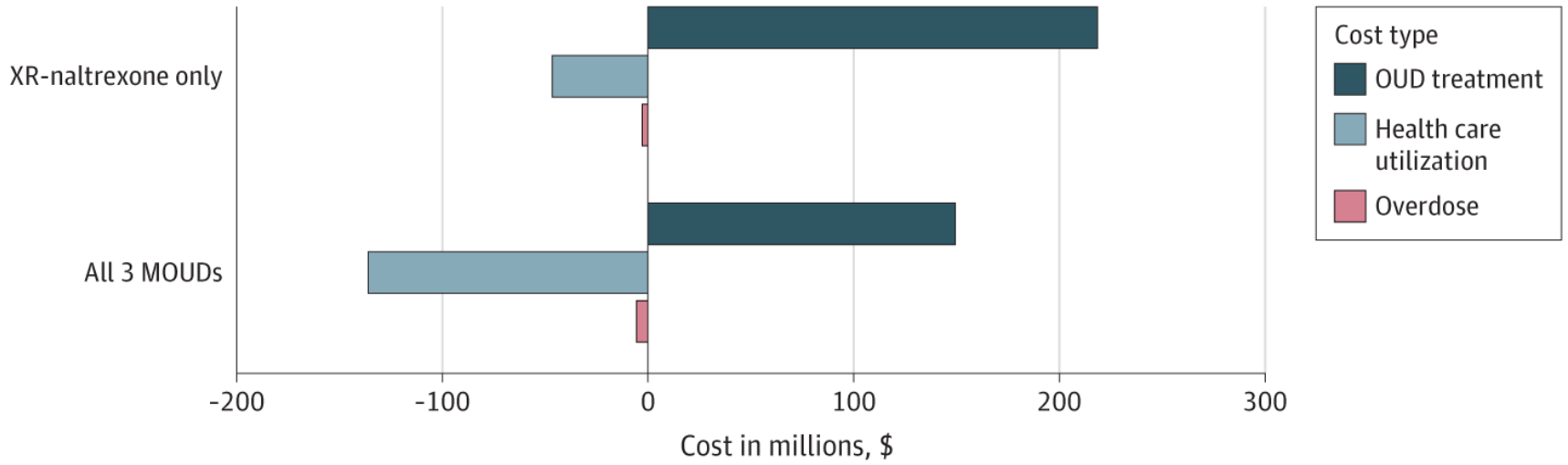
Iowa:

- No universal policy for county jails.
- Prison limits treatment initiation timeline.

Binswanger IA. Opioid use disorder and incarceration—hope for ensuring the continuity of treatment. NEJM 2019.
Binswanger IA, et al. Release from prison—a high risk of death for former inmates. NEJM 2007.

MOUD while Incarcerated

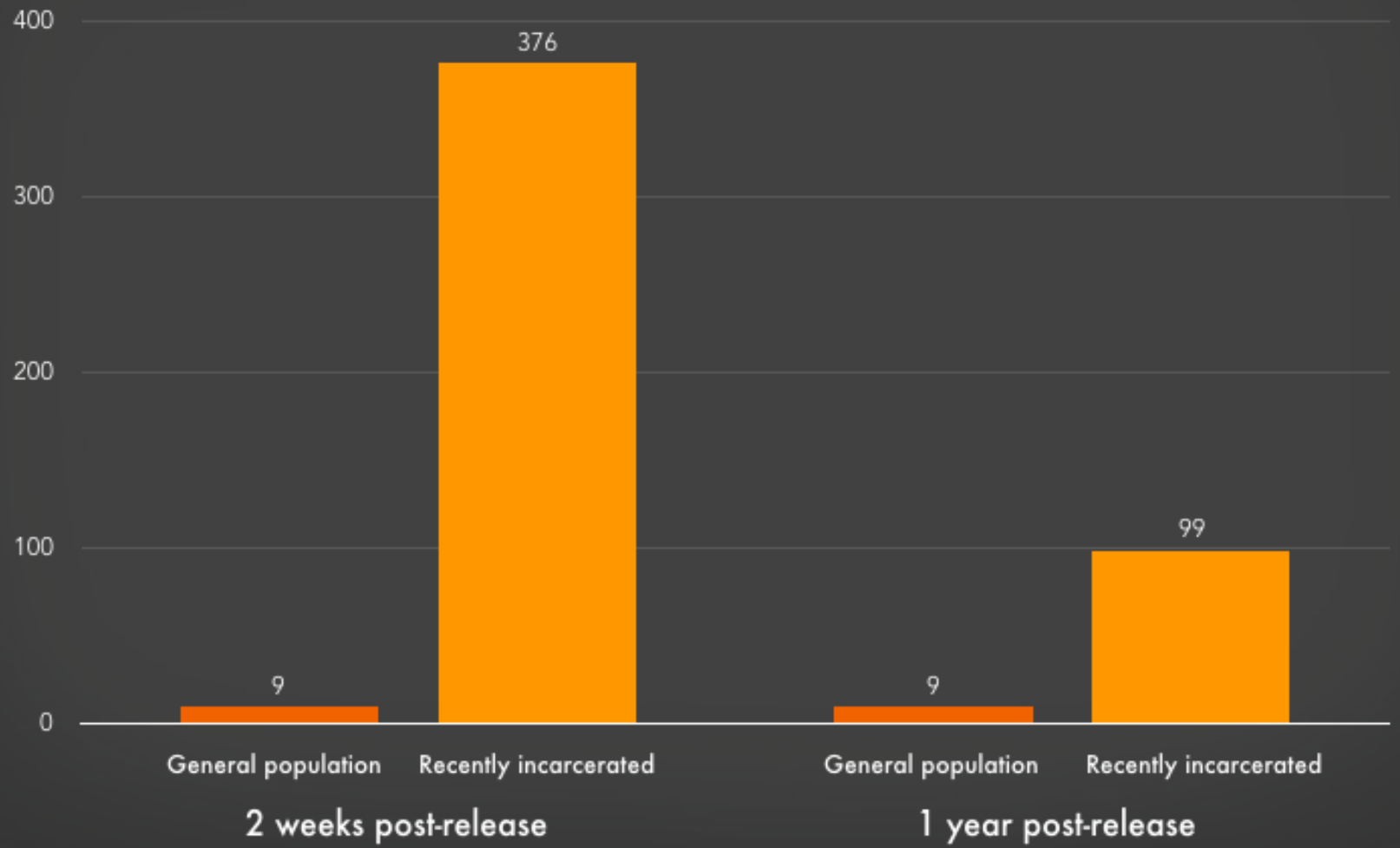
MOUD decreased overdose and was more cost-effective than XR-naltrexone only.



Chatterjee A, et al. Estimated Costs and Outcomes Associated With Use and Nonuse of Medications for Opioid Use Disorder During Incarceration and at Release in Massachusetts. JAMA Netw Open. 2023

Recently incarcerated people are over 40 times more likely to die from an opioid overdose

Number of opioid overdose deaths per 100,000 recently incarcerated people in North Carolina compared to rate among the general population in North Carolina



Data Source: "Opioid Overdose Mortality Among Former North Caroline Inmates: 2000-2015" Table 1

PRISON POLICY INITIATIVE

Naloxone EVERYWHERE

Overdose Prevention and Education for everyone

Free naloxone distribution

Unsure how to do this? Partner with community organizations!

https://www.cdc.gov/drugoverdose/featured-topics/evidence-based-strategies.html

Policy Recommendations:

- Universal screening for OUD
- Offer MOUD and counseling to everyone
- Overdose education and naloxone
- Ensure continuity of treatment between facilities and community partners
- Immediately activate state insurance upon release
- Work with partners and state to help track outcomes to quality improvement

https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons

OUD and First-Responders

The Facts

- Leading cause of accidental death since 2011
  - 60% involve opioids
- 5.5% 1-year mortality rate after a non-fatal overdose
  - 20% die within the first month
  - **30% saw EMS within the past year**

IEMSA
IOWA EMERGENCY MEDICAL SERVICES

Novel EMS-Driven Programs

OUD Support and Bridge Programs:

- OD patients contacted within 24 hours
- Education about MOUD
- Dosing of buprenorphine provided daily until clinic connection
- Naloxone

Incidental Fentanyl Exposure

Incidental fentanyl exposure on the skin CANNOT cause an overdose.

ACMT | American College of Medical Toxicology

No credible reports of "emergency responders developing signs or symptoms consistent with opioid toxicity from incidental contact with opioids."

Winograd et al. 2019; Moss et al. 2017; McKenzie, M. 2022

Fentanyl Test Strips

What They Do	What They DON'T Do
▪ Easy to use ▪ Cheap ▪ Reduce substance use ▪ Increase safe practices ▪ Utilize only drug residue	▪ Increase substance use ▪ Increase risk of incidental exposure ▪ Increase substance amounts purchased and/or left for testing

Winograd et al. 2019; Moss et al. 2017; McKenzie, M. 2022

Iowa's Good Samaritan Laws

- **Protects "overdose reporters" if they:**
  - are the first person to seek medical assistance for the overdose victim
  - provide their contact information to emergency personnel
  - remain on the scene until assistance is provided
  - cooperate with medical and law enforcement personnel

- **DOES NOT** protect against arrest for open warrants and other crimes
- Link to Law

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Overdose Prevention and Education for everyone

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TAKE HOME POINTS

1. EMS contact with people after non-fatal overdose can be an opportunity to connect to resources

2. Incidental fentanyl exposure cannot cause overdose using current EMS PPE.

3. Encourage cheap (free) distribution of naloxone

Harm Reduction

Harm Reduction

Goal:

Help people make informed decisions regarding use and empower them to reduce potential harm from ongoing use.

IRON LAW OF PROHIBITION

THE HARDER THE ENFORCEMENT, THE HARDER THE DRUGS

INCREASING LAW ENFORCEMENT

INCREASING COST OF ILLEGALITY

INCREASING POTENCY OF THE SUBSTANCE

Need to Avoid Detection
(Less Weight and Volume, Easier to Hide, Store and Transport)

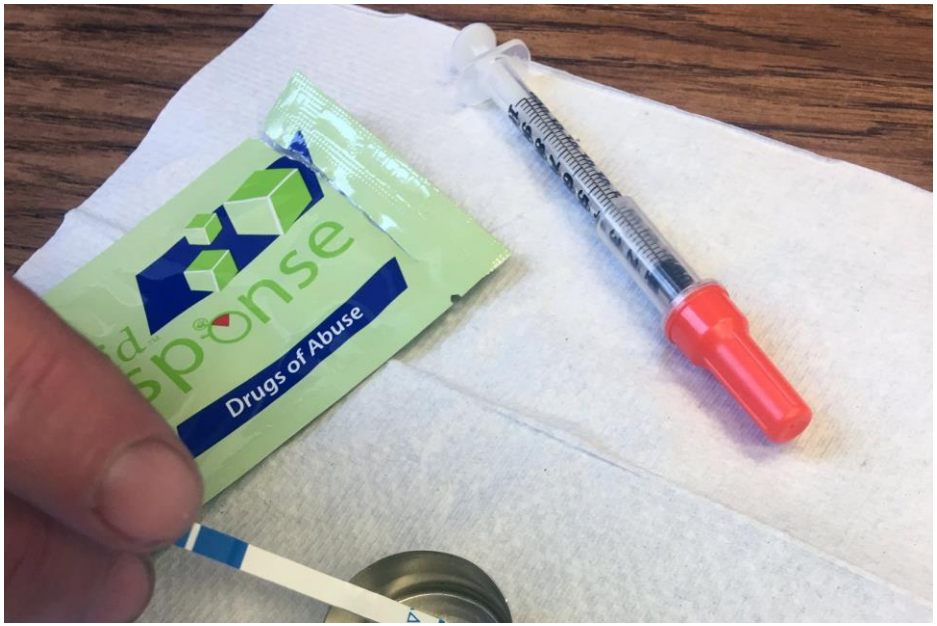
Beer and Wine	Spirits	Moonshine
Cannabis	High THC Cannabis	Synthetic Cannabinoids
Coca Leaf/Tea	Powder Cocaine	Crack/Paco/Basuco
Opium	Heroin	Fentanyl/Carfentanyl
Ephedra	Amphetamine	Ice/Methamphetamine

Image source: https://www.drugfoundation.org.nz/matters-of-substance/archive/november-2018/global-leaders-call-to-regulate-drugs/

Contaminated Supply

Advertisement	Reality
Heroin	Fentanyl analogue +/- diphenhydramine +/- benzodiazepine
Prescription pill	Null product preservatives +/- benzodiazepines +/-fentanyl analogue +/- diphenhydramine

Drug Testing



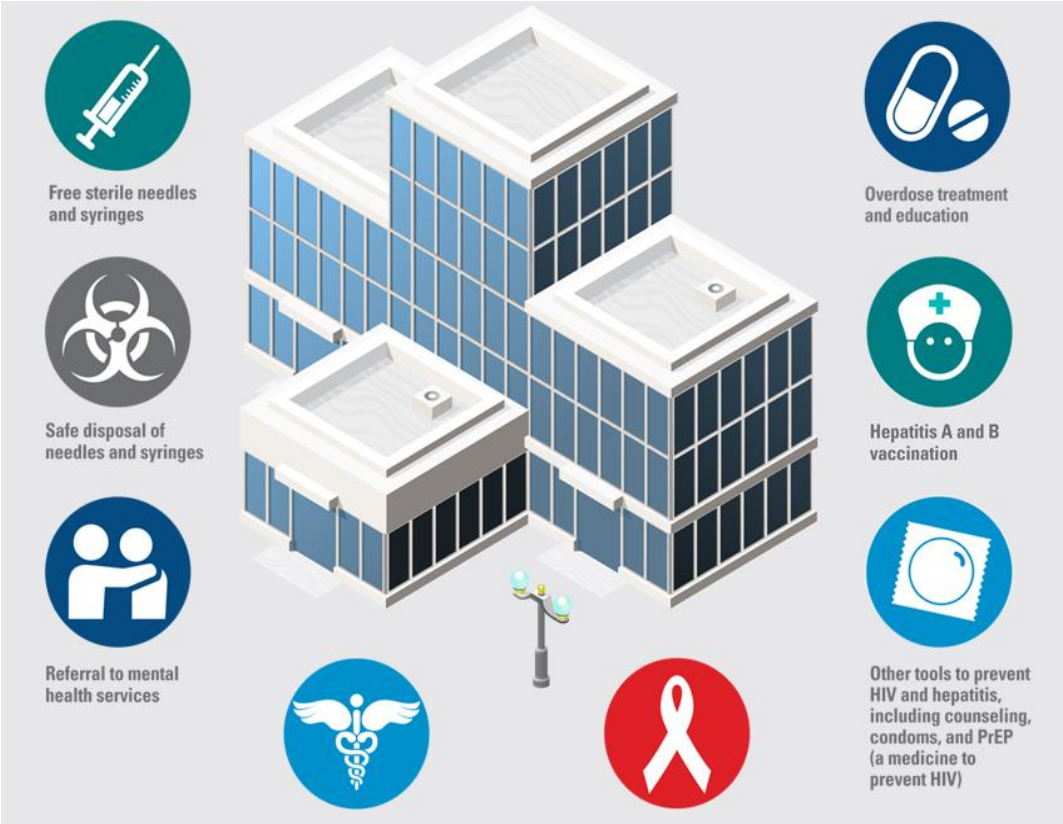
- Fentanyl strips
- Mobile GC-MS machines

Increase Naloxone Access

- **Increase access to people who use drugs**

- Current Iowa access:
  - Covered by Medicaid (nasal spray)
  - IDPH standing order
  - UIHC TeleNaloxone program:
    - www.naloxoneiowa.org
  - Iowa Harm Reduction Coalition
  - OTC Narcan nasal spray?

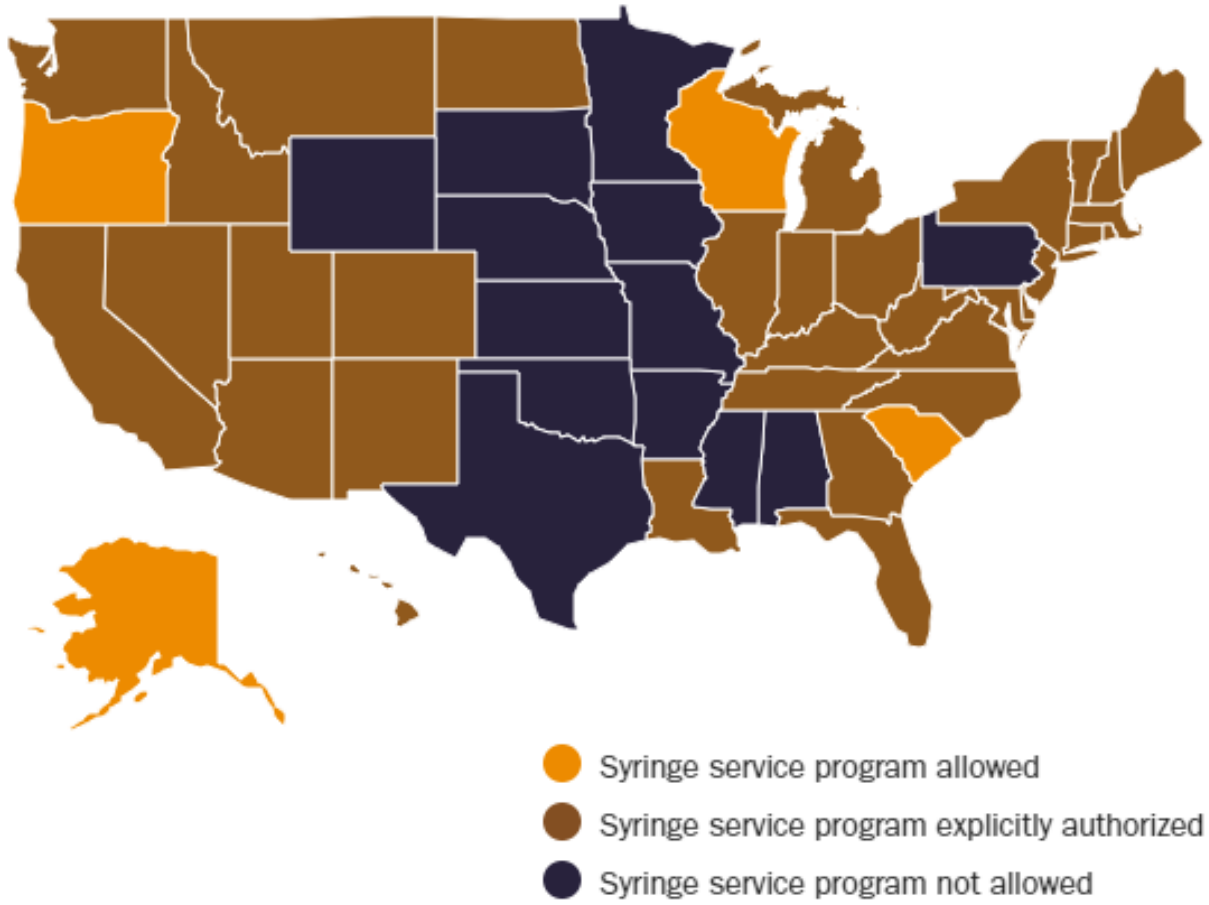
Syringe Services Programs



- Reduce overdose
- Increase treatment entry
- Reduce substance use
- Prevent disease
- Reduce legal involvement

National Association of Counties (NACo). Syringe Service Programs. January 2023. Link: https://www.naco.org/resources/opioid-solutions/approved-strategies/ssps

Syringe Services Programs



National Association of Counties (NACo). Syringe Service Programs. January 2023. Link: https://www.naco.org/resources/opioid-solutions/approved-strategies/ssps

How to Support SSPs

- Secure funding
- Support needs-based policies
- Empower SSP led by people with lived experience
- **FIGHT STIGMA**
- **ADVOCATE FOR LEGALIZATION**

National Association of Counties (NACo). Syringe Service Programs. January 2023. Link: https://www.naco.org/resources/opioid-solutions/approved-strategies/ssps

TAKE HOME POINTS

1. Harm reduction practices and SSPs are more likely to:
    - Reduce overdose
    - Decrease substance use
    - Decrease health consequences

2. SSPs are cost-effective ways to mitigate opioid-related harm

3. Advocate for legalization of SSPs and fentanyl test strip access.

Today's Topics

1. Stigma
2. Neurobiology of Addiction
3. MOUD Treatment
4. 2022 CDC Opioid Prescribing Guidelines
5. Perinatal OUD
6. Neonatal Withdrawal Syndromes
7. OUD in Incarcerated Populations
8. First-responders and OUD
9. Harm Reduction
10. How ORN can help (examples)

OUD = Opioid Use Disorder; CDC = Centers for Disease Control and Prevention; ORN = Opioid Response Network

Final Thoughts

- Medications for OUD are life-saving → make them as easy as possible to get.

- Pregnant and incarcerated populations are high-risk for overdose deaths → make MOUD and naloxone access easier.