Ethical Considerations Concerning Medication Assisted Treatment and Recovery

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ETSU, Department of Social Work

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AGENDA

• A FEW DEFINITIONS
• OVERVIEW OF OPIOID EPIDEMIC
• WHAT IS AN OPIOID USE DISORDER?
• HARM REDUCTION PHILOSOPHY
• MEDICATIONS FOR TREATMENT AND RECOVERY
• ETHICAL PRINCIPLES
• MYTHS & MISCONCEPTIONS
• Q & A PANEL
Opioid and prescription drug related deaths: Michael Jackson, Elvis, Prince, and

- Janis Joplin 27
- Heath Ledger 28
- Chris Farley 33
- Kurt Cobain
- Jimi Hendrix
- Billie Holiday
- River Phoenix
- Phillip Seymour Hoffman 46
- Whitney Huston

- Anna Nicole Smith
- Jim Morrison 27
- Jim Belushi 33
- Cory Monteith 31
- Dana Plato
- Syd Vicious
- Elvis 42
- Hank Williams
- And on, and on, and on, and on ......
A Few Definitions

• Opiate & Opioid:
  • Opiate - term classically used in pharmacology to mean a drug derived from the opium poppy
  • Opioid - substances, both natural and synthetic, that bind to opioid receptors
  • Effects:
    • CNS depressant, analgesic
    • Rush if injected, followed by pleasant, euphoric dreamy state

• Natural and semi-synthetic: derivative of the opium poppy
  • e. g., opium, morphine, and codeine
  • e. g., oxycodone, hydrocodone, heroin, oxymorphone, buprenorphine

• Synthetic: manufactured
  • e. g., meperidine (demerol), fentanyl, methadone
A Few Definitions: Addiction

• Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry.

• Dysfunction in these circuits leads to characteristic *biological, psychological, social and spiritual manifestations*.

• This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

ASAM, 2011
A Few Definitions: Addiction, cont.

• Addiction is characterized by
  • Inability to consistently abstain,
  • impairment in behavioral control,
  • craving,
  • diminished recognition of significant problems with one’s behaviors and interpersonal relationships,
  • and a dysfunctional emotional response.

• Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

(ASAM, 2011)
Reward/Reinforcement

- Reward/Reinforcement is in part controlled by mu receptors in the Reward Pathway:
  - Ventral Tegmental Area (VTA)
  - Nucleus Accumbens with projections to Prefrontal Cortex
  - Dopaminergic system
A Few Definitions:
Opioid Use Disorder

- A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe

1. Taking the opioid in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the opioid
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision. (APA, 2013)
Opioid Epidemic

• Drug overdose leading cause of accidental death
• 52,000 overdose deaths in 2015
• 63% related to prescription or illicit opioids
• 300,000+ opioid overdose deaths since 2000
• 10,574 heroin overdoses in 2014
  • fivefold increase of the heroin death rate from 2002 to 2014
• 91 Americans die every day from an opioid overdose.

(CDC, 2016)
Increase in opioid overdose death rates is driven in large part by illicit opioids

From 2014 to 2015:

- Death rates for synthetic opioids other than methadone increased 72.2%
- Heroin death rates increased 20.6%
- Synthetic opioid and heroin death rates increased across all groups 15 and older
- Methadone death rates declined 9.1%
- Natural opioids and semi-synthetic opioids involved in 12,700+ deaths in 2015

(CDC, 2016)
2010 - 2015: rate of drug overdose deaths in U.S. *increased* in 30 states and DC, remained stable in 19 states, and showed decreasing trends followed by increases in two states.

• From 2014-2015, 16 states had increases in synthetic opioid death rates
  - Greatest increases in death rates: New York (135.7%), Connecticut (125.9%) and Illinois (120%).

• 11 states had increases in heroin death rates
  - Greatest percent increases in death rates: South Carolina (57.1 %), **North Carolina** (46.4%) and Tennessee (43.5%).

• New Mexico, Oklahoma, **Virginia** decreases in rates of death involving natural/semi-synthetic opioids.

(CDC, 2016)
Number of Reported Law Enforcement Encounters Testing Positive for Fentanyl in the US: 2010 - 2015

Statistically significant drug overdose death rate increase from 2014 to 2015, US states
Closer to home

• Overdose deaths in 2015
  • Tennessee: 1457; 22.2 per 100,000
  • North Carolina: 1567; 15.8 deaths per 100,000
  • Virginia: 1039; 12.4 per 100,000
  • Kentucky: 1271; 29.9 per 100,000

• Heroin death rates in 2015
  • 11 states had increases in heroin death rates,
    1. South Carolina (57.1%),
    2. North Carolina (46.4 %)
    3. Tennessee (43.5 %)

Statistically significant changes in drug overdose death rates involving synthetic opioids (excluding methadone) by select states, United States, 2014 to 2015

- Did not meet inclusion criteria
- Increase > 70
- Increase 0 – 70
- Stable, not significant

<table>
<thead>
<tr>
<th>Location</th>
<th>% change 2014-2015</th>
<th>2014 #</th>
<th>2014 rate</th>
<th>2015 #</th>
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</thead>
<tbody>
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<td>300</td>
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<tr>
<td>Tennessee</td>
<td>90.5</td>
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<td>2.1</td>
<td>251</td>
<td>4</td>
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<tr>
<td>Virginia</td>
<td>57.1</td>
<td>176</td>
<td>2.1</td>
<td>270</td>
<td>3.3</td>
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</table>
Statistically significant changes in drug overdose death rates involving heroin by select states, United States, 2014 to 2015

<table>
<thead>
<tr>
<th>Location</th>
<th>% change 2014-2015</th>
<th>2014 #</th>
<th>2014 rate</th>
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<th>2015 rate</th>
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</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>46.4</td>
<td>266</td>
<td>2.8</td>
<td>393</td>
<td>4.1</td>
</tr>
<tr>
<td>Tennessee</td>
<td>43.5</td>
<td>148</td>
<td>2.3</td>
<td>205</td>
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<tr>
<td>Virginia</td>
<td>38.7</td>
<td>253</td>
<td>3.1</td>
<td>353</td>
<td>4.3</td>
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</tbody>
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(CDC, 2016)
In 2015, 15,000+ people died from overdoses involving prescription opioids.

- Most common drugs involved in prescription opioid overdose deaths include:
  - Methadone
  - Oxycodone (such as OxyContin®)
  - Hydrocodone (such as Vicodin®)

- Among those who died from prescription opioid overdose between 1999 and 2014:
  - Overdose rates highest among people aged 25 to 54.
  - Overdose rates higher among non-Hispanic whites and American Indian or Alaskan Natives, compared to non-Hispanic blacks and Hispanics.
  - Men more likely to die from overdose, but the mortality gap between men and women is closing
HARM REDUCTION PHILOSOPHY

• EMBEDDED IN PUBLIC HEALTH MODEL OF CARE
• GAINED RECOGNITION OUT OF AIDS EPIDEMIC
• HARM REDUCTION
  • UMBRELLA TERM USED TO DEFINE INTERVENTIONS, PROGRAMS, & POLICIES THAT SEEK TO REDUCE THE HEALTH, SOCIAL AND ECONOMIC HARMS OF SUBSTANCE USE TO INDIVIDUALS, COMMUNITIES AND SOCIETIES (RHEMS & FISCHER, 2010)
• A MOVEMENT FOR SOCIAL JUSTICE BUILT ON A BELIEF IN, AND RESPECT FOR, THE RIGHTS OF PEOPLE WHO USE DRUGS (HARMREDUCTION.ORG)
8 PRINCIPLES OF HARM REDUCTION

1. Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

2. Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.

3. Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.

4. Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

http://www.harmreduction.org
5. Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

6. Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

7. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.

8. Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.
MEDICATION-ASSISTED TREATMENT (MAT) AND RECOVERY FOR OUDS

- Reduces opioid use
- Protects against opioid-related overdoses
- Prevents injection behaviors
- Reduces criminal behavior
- Reduces drug use
  - Total amount used
  - Number of days/month used
  - Number of weeks with any drug use
MEDICATION-ASSISTED TREATMENT (MAT) AND RECOVERY FOR OUDS

• METHADONE (agonist)
• BUPRENORPHINE (partial agonist)
• NALOXONE & NALTREXONE (antagonists)
• Buprenorphine and methadone are “essential medicines” according to the WHO.
• Medications should be combined with behavioral counseling for a “whole patient” approach, known as Medication Assisted Treatment (MAT).

(NIDA, 2016)
MEDICATION-ASSISTED TREATMENT (MAT) AND RECOVERY FOR OUDS: METHADONE

• Schedule II
• Can be taken by mouth
• Slow onset of action
• No continuing increase in tolerance levels after optimal dose is reached; relatively constant dose over time
• Pt on stable dose rarely experiences euphoric or sedating effects; is able to perceive pain and have emotional reactions; can perform; can perform daily tasks normally and safely
• Long acting; prevents withdrawal for 24-36 hours (4x-6x as long as heroin), permitting once-a day-dosing
• At sufficient dosage, blocks euphoric effect of normal street doses of heroin
• Medically safe when used on long-term basis (10 years or more)

(Physician’s Guide: Opioid Agonist Medical Maintenance Treatment; CSAT 2000)
MEDICATION-ASSISTED TREATMENT (MAT) AND RECOVERY: Buprenorphine

- Two, schedule III, sublingual buprenorphine tablet formulations (2 mg and 8 mg) approved for US use:
  - Subutex® (buprenorphine alone)
  - Suboxone® (buprenorphine + naloxone)
- Modest μ agonist activity with ceiling
- Long half life
- Precipitated withdrawal if taken after full agonist
- Decreased risk of respiratory, CNS depression
- Sublingual route of administration
- “Combo” tablet with naloxone limits abuse by injection
MEDICATION-ASSISTED TREATMENT (MAT) AND RECOVERY: NALTREXONE

• Revia
• Vivitrol
MEDICATION-ASSISTED TREATMENT (MAT) AND RECOVERY: NALOXONE

• Reverses opioid-related sedation and respiratory depression = pure opioid antagonist
  • Not psychoactive, no abuse potential
  • May cause withdrawal symptoms
• May be administered IM, IV, SC, IN
• Acts within 2 to 8 minutes
• Lasts 30 to 90 minutes, overdose may return
• May be repeated
• Narcan® = naloxone
  • naloxone ≠ Suboxone ≠ naltrexone
Medication Assisted Treatment (MAT) and Recovery

• MAT DECREASES opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission.
  • After buprenorphine became available in Baltimore, heroin overdose deaths decreased by 37%.

• MAT INCREASES social functioning and retention in treatment.
  • Patients treated with medication were more likely to remain in therapy compared to patients receiving treatment that did not include medication.

• Pregnant women w/OUDs treated with methadone or buprenorphine IMPROVES OUTCOMES for their babies;
  • MAT reduces symptoms of neonatal abstinence syndrome and length of hospital stay.

NIDA, 2016
The ethical delivery of psychosocially-assisted pharmacological treatment of opioid dependence is achieved by respecting the following ten basic principles:
1: Human rights of opioid dependent individuals should be respected

• The human rights of people who are dependent on opioids should be respected by ensuring that they have access to appropriate and effective medical treatment and psychosocial support.

• Individuals should not be stigmatized or discriminated against by virtue of their condition, nor should the legal status, gender, age, lifestyle, race, political, religious or other beliefs, social, financial, sexual, criminal or other status, or physical of mental capabilities, bar them from accessing safe and effective treatment.
2: Treatment decisions should be based on the best available evidence

- To ensure that treatment is safe and effective, rigorous evidence should be used to guide treatment decisions.

- Existing treatment programs must operate in accordance with the obligation to evaluate treatment safety, effectiveness and acceptability to their clients and patients.
3: Treatment decisions should be based on standard principles of medical care ethics

- It is important that treatment decisions be based on objective measures of what will provide the most effective medical care and the best health care outcomes.
- Treatment that accords with the ethics of personal medical care should also be the most successful in meeting the aims of a public health care program because good individual treatment will ensure good program retention and maximum benefits to the individual and the community that funds treatment.
- Treatment programs should be separate from law enforcement agencies.
4: Equitable access should be provided to treatment and psychosocial support that best meets the needs of the individual patient

- Treatment should be individualized and flexible.
- Patients should be able to choose from a variety of forms of treatment that are shown to be safe and effective, including detoxification, relapse prevention and maintenance programs with good quality psychosocial care to address the many personal and social problems experienced by opioid dependent individuals.
Treatment should respect and validate the autonomy of the individual

- Treatment staff and programs need to respect and validate the autonomy of the client by involving them in the process and evolution of the treatment.
- Programs should emphasize the importance of the client-helper relationship in providing ethically adequate treatment that respects the autonomy of patients, and protects their privacy and the confidentiality of information that they provide.
- The primary goal of treatment, both pharmacological and psychotherapeutic, should be to increase the autonomy of individuals by facilitating improvements in decision-making abilities.
- Respecting autonomy also includes respecting a decision not to receive treatment.
6: Patients should be fully informed about the risks and benefits of treatment choices

- Clients should be fully informed of the risks, benefits, likely outcomes, costs, requirements and punishments associated with the treatment program in which they are participating.
- Also be informed of other treatment options and their relative risks and benefits.
- The risks include: fatal overdose, the low chance of achieving abstinence in the short to medium term; and the high likelihood of relapse after detoxification in the absence of other pharmacological or psychosocial treatments that support abstinence.
- Enough information should be provided to clients to allow an informed choice of treatment and its safe and effective delivery.
7: Programs should create supportive environments and treatment relationships to facilitate treatment

• Punitive policies & attitudes in treatment represent a failure to provide ethical treatment and an impediment to successful treatment outcome.

• People don’t get better in response to making them feel bad about themselves! ~ William Miller

• Attitudes of staff towards clients and their relationship with clients are critical factors in determining success of treatment. This involves:
  • affirmation & validation of client;
  • building trust;
  • and, ensuring flexibility in treatment delivery to meet individuals’ needs.
8: There should be coordinated treatment of comorbid mental and physical disorders and social factors

- Many people who seek or require treatment for OUD also suffer from
  - co-morbid psychiatric d/o
  - concomitant social and personal difficulties
9: Programs should include participation of community and other stakeholders

• Garnering community support for and involvement in the treatment of OUDs is vital in preventing the cycles of drug use within vulnerable populations

• A complete understanding of the causes and outcomes of drug use and treatment programs is important in overcoming stigmatized views of people suffering from OUD, and preventing the discriminatory attitudes and policies that hinder adequate and effective treatment and the reintegration of people with OUDs into the community.

• Broader community support for education and employment programs also needed.
10: The use of legal coercion into treatment for OUD should respect basic ethical and legal principles.

• Coerced treatment is ethically justified if and only if:
  1. the rights of the individuals are protected by "due process" (in accordance with human rights principles)
  2. effective and humane treatment is provided.

• Drug dependent offenders should be allowed two "constrained choices":
  1. whether they participate in drug treatment or not; and
  2. if they agree to participate in drug treatment, a choice of the type of treatment that they receive.
NASW Code of Ethics: Preamble

• The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of **all people**, with particular attention to the needs and empowerment of people who are **vulnerable, oppressed, and living in poverty**. A historic and defining feature of social work is the profession’s focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

• Social workers promote **social justice** and social change with and on behalf of clients. [...]. Social workers are sensitive to cultural and ethnic diversity and strive to **end discrimination, oppression, poverty, and other forms of social injustice**. [...]. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals’ needs and social problems.

• These core values, embraced by social workers throughout the profession’s history, are the foundation of social work’s unique purpose and perspective:
  • service
  • social justice
  • dignity and worth of the person
  • importance of human relationships
  • integrity
  • competence.
CONCLUSION: MYTHS & FACTS

• MYTH #1
  • Medication–assisted treatment “substitutes one addiction for another.”

• FACT #1
  • When properly prescribed, MAT stabilizes brain chemistry, reduces drug cravings and prevents relapse, blocks euphoric effects of opioids & normalizes body functions
CONCLUSION: MYTHS & FACTS

• MYTH #2
  • Addiction medications are a “crutch” that prevents “true recovery.”

• FACT #2
  • Individuals stabilized on MAT can achieve “true recovery,” according to leading addiction professionals and researchers.
Is MAT “Recovery?”

• Recovery status is best defined by factors other than medication status. Neither medication-assisted treatment of opioid addiction nor the cessation of such treatment by itself constitutes recovery. Recovery status instead hinges on broader achievements in health and social functioning—with or without medication support. *Thomas McLellan and William White*

SAMHSA, 2016

http://store.samhsa.gov/shin/content/SMA16-4938/SMA16-4938.pdf
CONCLUSION: MYTHS & FACTS

• MYTH #3
  • MAT should not be long term.

• FACT #3
  • There is no one-size-fits-all duration for MAT.
  • For some patients, MAT could be indefinite. NIDA describes addiction medications as an “essential component of an ongoing treatment plan” to enable individuals to “take control of their health and their lives.” For methadone maintenance, NIDA states that “12 months of treatment is the minimum.”
CONCLUSION: MYTHS & FACTS

• MYTH #4
  • Requiring people to taper off MAT helps them get healthy faster.

• FACT #4
  • Requiring people to stop taking their addiction medications is counter-productive and increases the risk of relapse.
CONCLUSION: MYTHS & FACTS

• MYTH #5
  • Courts are in a better position than doctors to decide appropriate drug treatment.

• FACT #5
  • Deciding the appropriate treatment for a person with opioid addiction is a matter of physician discretion, taking into consideration the relevant medical standards and the characteristics of the individual patient.
CONCLUSION: MYTHS & FACTS

• MYTH #6
  • Methadone is responsible for many deaths due to overdose

• FACT #6
  • Methadone used in MAT is highly regulated and results in little diversion and few deaths. Methadone prescribed for pain, rather than for MAT, has been shown to be the cause of the increase in overdoses from methadone
CONCLUSION: MYTHS & FACTS

• MYTH #7
  • Pregnant women should come off of opioids and MAT

• FACT #7
  • Rarely is withdrawal from opioids recommended for pregnant women
  • Pregnant women w/OUDs treated with methadone or buprenorphine have improved outcomes for their babies
  • MAT reduces symptoms of neonatal abstinence syndrome and length of hospital stay.
RESOURCES

WEBSITES

• CDC: https://www.cdc.gov/drugoverdose/data/index.html
• NIDA: https://www.drugabuse.gov/

FREE PUBLICATION

Medication-Assisted Treatment For Opioid Addiction in Opioid Treatment Programs
A Treatment Improvement Protocol TIP 43
SAMHSA
References


• Center for Substance Abuse Treatment. (2000).


• World Health Organization
Thank You!

PANEL DISCUSSION AND Q & A