PCSS
Providers' Clinical Support System

Monthly Update

September 2015

Inside

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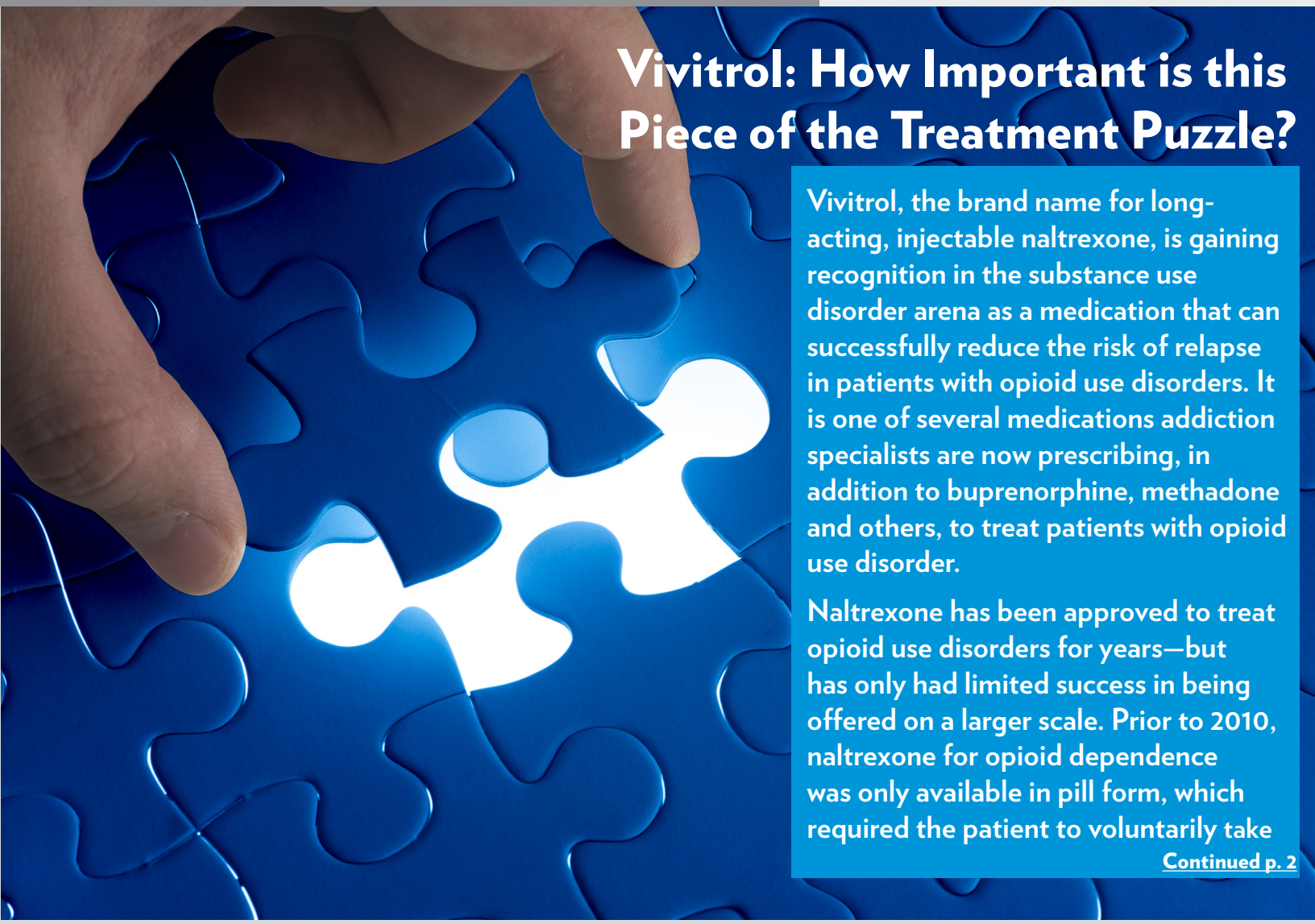

Vivitrol: How Important is this Piece of the Treatment Puzzle?

Vivitrol, the brand name for long-acting, injectable naltrexone, is gaining recognition in the substance use disorder arena as a medication that can successfully reduce the risk of relapse in patients with opioid use disorders. It is one of several medications addiction specialists are now prescribing, in addition to buprenorphine, methadone and others, to treat patients with opioid use disorder.

Naltrexone has been approved to treat opioid use disorders for years—but has only had limited success in being offered on a larger scale. Prior to 2010, naltrexone for opioid dependence was only available in pill form, which required the patient to voluntarily take

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Naltrexone SAMHSA Resources:

Incorporating Alcohol Pharmacotherapies Into Medical Practice

Naltrexone hydrochloride is a relatively pure and long-lasting opioid antagonist.
One study found that naltrexone significantly improved relapse rates during active treatment and a medication-free followup period.

Clinical Use of Extended Release Injectable Natrexone in the Treatment of Opioid Use Disorder: A Brief Guide

Clinical trials of extended release injectable naltrexone showed a consistent pattern of clinical efficacy for maintaining abstinence, achieving medication adherence, maintaining retention, protecting against reestablishment of opioid physical dependence, and may reduce craving for opioids for some individuals, while showing good safety and tolerability.

The Facts about Naltrexone for Treatment of Opioid Addiction

A resource for physicians to give their patients.

Vivitrol cont.

a pill daily for it to be effective, and compliance was sporadic at best, especially among populations with less stable social circumstances. Vivitrol is an injectable version of naltrexone that is considered by many addiction specialists as a good option in the treatment of opioid use disorders and one that should be considered in consultation with the patient. An antagonist medication such as naltrexone/Vivitrol, works differently than agonists such as buprenorphine and methadone, and creates an option that can leave motivated patients free of chemical dependence. Here's how it works: Antagonists like naltrexone block the *mu*-opioid receptors in the brain preventing the normal euphoric response that opiates cause, whereas agonists like methadone and buprenorphine mimic the effects of neurotransmitters naturally found in the human brain. When used to treat opioid use disorders, these medications essentially replace the substances abused for intoxication with longer acting forms, preventing aversive withdrawal symptoms. Vivtrol can also lower cravings, making it a viable alternative to buprenorphine for some patients.

Freedom from Intoxication

When used by a highly motivated patient, Vivitrol can reduce cravings by providing a freedom from intoxication even if an opiate is used, breaking the cycle of use by reducing the reward of misuse. Should the person drink alcohol or take opioids while on the drug, he or she feels less or no effects—a change in the reinforcement process that is key to aiding a patient's ability to stop use. Physicians and the treatment community increasingly are embracing Vivitrol because it is long-acting—one injection is effective for 30 days—and when patients discontinue naltrexone they do not suffer withdrawal symptoms typical for discontinuance of agonists.

A study published this year in *Addiction* followed 34 inmates, half of whom were given Vivitrol and counseling and half who received no treatment. After eight weeks, 88 percent of inmates with no treatment relapsed; 62 percent treated with Vivitrol and counseling were sober. A larger clinical study is expected out soon.

Vivitrol is still a relatively new option for medically assisted opioid treatment protocols—the injection was approved by the Federal Drug Administration in October, 2010. For this reason, evidence-based guidelines for its use have not yet been fully developed and implemented, noted Adam Bisaga, MD, co-chair, PCSS-MAT Clinical Experts and Professor of Psychiatry

at Columbia University Medical Center and Research Scientist at the New York State Psychiatric Institute. Dr. Bisaga said initial findings, however, are extremely promising.

"Most clinicians have very limited experience with Vivitrol," Dr. Bisaga said, adding that buprenorphine and methadone are currently the treatment of choice in most settings in the recovery industry. "It's not surprising that they think buprenorphine is the better choice because the majority of providers who use medications are familiar with it." It's important for clinicians to know alternatives to agonists and that for motivated patients, naltrexone may work well.

According to Dr. Bisaga, it is not an issue of buprenorphine versus Vivitrol, but rather a matter of complementing protocols to a patient's specific needs in medication assisted treatment. The only incorrect treatment is no treatment. All patients will do better with treatment and clinical contact with professionals, and more importantly have far less chance of overdose. While both Vivitrol and buprenorphine carry the risk that the patient could ultimately overdose, "the biggest risk of overdosing is with people who aren't on anything," Dr. Bisaga stressed.

Positive Results

William Roberts, MD, PhD, an anesthesiologist who is also board certified in addiction medicine, said he has seen positive results with prescribing Vivitrol for his patients and has used it for those who are completely committed to sobriety and as an alternative to buprenorphine when patients are struggling but not making progress. In his practice, Dr. Roberts most often administers Vivitrol to patients who have already undergone treatment using other MATs agents, such as burprenorphine. The key is the transition from agonist to antagonist as patients must be off buprenorphine for five to seven days before beginning Vivitrol or they may be subject to precipitated withdrawal.

Continued p. 4

Two Projects. One Mission.

Helping to end the opioid use disorder epidemic

Providers' Clinical Support System for Medication Assisted Therapies (PCSS-MAT) focuses on the most effective medication-assisted treatments for opioid use disorders.

Providers' Clinical Support System for Opioid Therapies (PCSS-O) provides educational resources on the treatment of pain and opioid use disorders.

Programs provide evidence-based trainings and resources for health professionals including:

- Clinical mentoring programs
- Small group discussions
- Monthly newsletter
- Online modules
- Live and archived webinars
- Buprenorphine waiver training
- Clinical tools
- Case vignettes
- And more!

All are provided at no cost. Most trainings offer CME credit.

PCSS O TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Opioid Therapies

www.pcss-o.org

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PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

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Upcoming Meetings of Interest

American Society for Pain Management Nursing (ASPMN), Sept. 16-19, 2015. Atlanta Marriott Marquis. Atlanta, GA.

National Association for Alcoholism and Drug Abuse Counseling, (NAADAC) Oct. 10-12, 2015, Washington, D.C.

American Osteopathic Academy of Addiction Medicine (AOAAM), Oct. 17-21, 2015, Orlando, FL

American Academy of Pediatrics, Oct. 24-27, 2015, Washington, D.C.

Association for Medicine Education and Research in Substance Abuse (AMERSA), Nov. 5-9, 2015, Washington, D.C.

American Dental Association (ADA), Nov. 5-10, 2015, Washington, D.C.

American Academy of Addiction Psychiatry (AAAP), Dec. 3-6, 2015, Huntington Beach, CA

Safe Opioid Prescribing Highlighted

Erik Gunderson, MD, an addiction specialist and PCSS-MAT mentor, spoke before a group of clinicians in August on safe opioid prescribing practices. Rappahannock Rapidan Community Services organized the event.

Vivitrol cont. from page 2

Drs. Bisaga and Roberts are mentors for PCSS-MAT and prescribe Vivitrol to patients who are good candidates or to patients who specifically request they be prescribed the medication. They note patients should always be treated individually to identify which treatment approach works best. Some patients do extremely well on buprenorphine and some on Vivitrol, Dr. Roberts said.

Percy Menzies, president of the Assisted Recovery Centers of America in Missouri, is a passionate advocate for Vivitrol and has been puzzled by the reluctance of the recovery community to embrace it.

Menzies states, "I see a complete disconnect with the recovery community and the medical community," although views are changing. For years major recovery centers, including the Hazleden/Betty Ford Clinic rejected the use of pharmaceuticals to aid in recovery, relying instead on abstinence and 12-step programs. The clinic now uses pharmaceutical treatments in conjunction with counseling, a move that was not initially accepted by proponents of abstinence-based treatment. Complete acceptance of antagonists is still an uphill climb, Menzies said, as is acceptance of naltrexone over methadone—the most well-known opioid use disorder treatment.

Menzies has had a long history with treating patients with naltrexone; in the past he advocated for prescribing the medications to physicians and clinics as an alternative to methadone. Methadone for years had a stronghold in the opioid treatment programs community, which resisted adding naltrexone to the mix. "I was in the trenches with them; the hostility (against naltrexone) was unbelievable," Menzies said. The benefits of Vivitrol, Menzies said, are many. He says that with counseling, a patient can eventually be drug-free; it has far less stigma than methadone; it is nonaddictive; and it can be administered once per month in an office setting.
One barrier, noted by all of the clinicians cited above, is that a patient must be drug-free for a period of time to begin Vivitrol. Each patient is different, but generally five to seven days is ideal for these transition protocols.

Like most medications, Vivitrol does have some downsides and some unpleasant side effects for some patients. These may include nausea, dizziness, muscle cramps, and joint pain, injection side effects and complications among others. Another concern is that patients on Vivitrol who do relapse face a high risk of overdose because the drug greatly reduces tolerance to opioids.

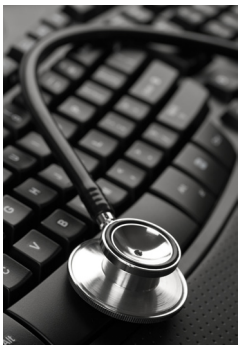
A special focus group will discuss naltrexone as part of the American Academy of Addiction Psychiatry's 26th Annual Meeting and Scientific Symposium.
Learn more about antagonist-based relapse prevention in this module. ■

Trainings

PCSS-O Upcoming Webinars
PCSS-O Archived Webinars
PCSS-O Online Modules

PCSS-MAT Upcoming Webinars
PCSS-MAT Archived Webinars
PCSS-MAT Online Modules

Upcoming Buprenorphine Waiver Trainings



Small Group Discussions

PCSS-MAT

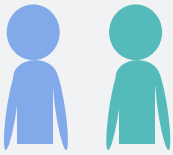
Managing Buprenorphine Patients – the Basics
Thursday, September 17, 2015, 12:00 - 1:00 pm ET
Michael Shore, MD

Note: These programs are designed as a coaching session on clinical issues. Invitations are sent to those already enrolled in PCSS-MAT Mentor or PCSS-O Colleague Support programs at least three weeks prior to the event. Learn more by emailing Seth (PCSS-MAT) or Justina (PCSS-O).

Case Study: What would you do?

A 30-year-old veteran, twice divorced, states he is seeking treatment for his substance abuse disorder. He describes a history consistent with PTSD, chronic (combat); Opiate Use Disorder, severe; and Tobacco Use Disorder. He denies a family history of psychiatric illness and substance use disorder (SUD). The veteran states he began to use narcotic pain medication, including Oxycodone, six years ago when he was prescribed these medications for chronic pain stemming from injuries incurred during an explosion. He has built up a tolerance and experiences withdrawal systems when not taking.

Read the case study and answer questions by completing this module.



PCSS-MAT Steering Committee Members

PCSS-O Steering Committee Members

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