

Recovery Oriented Medication Assisted Treatment (MAT)

John Emmel, MD, FASAM

Department of Alcohol and Other Drug Abuse Services (DAODAS)

jemmel@charlestoncounty.org

Objectives

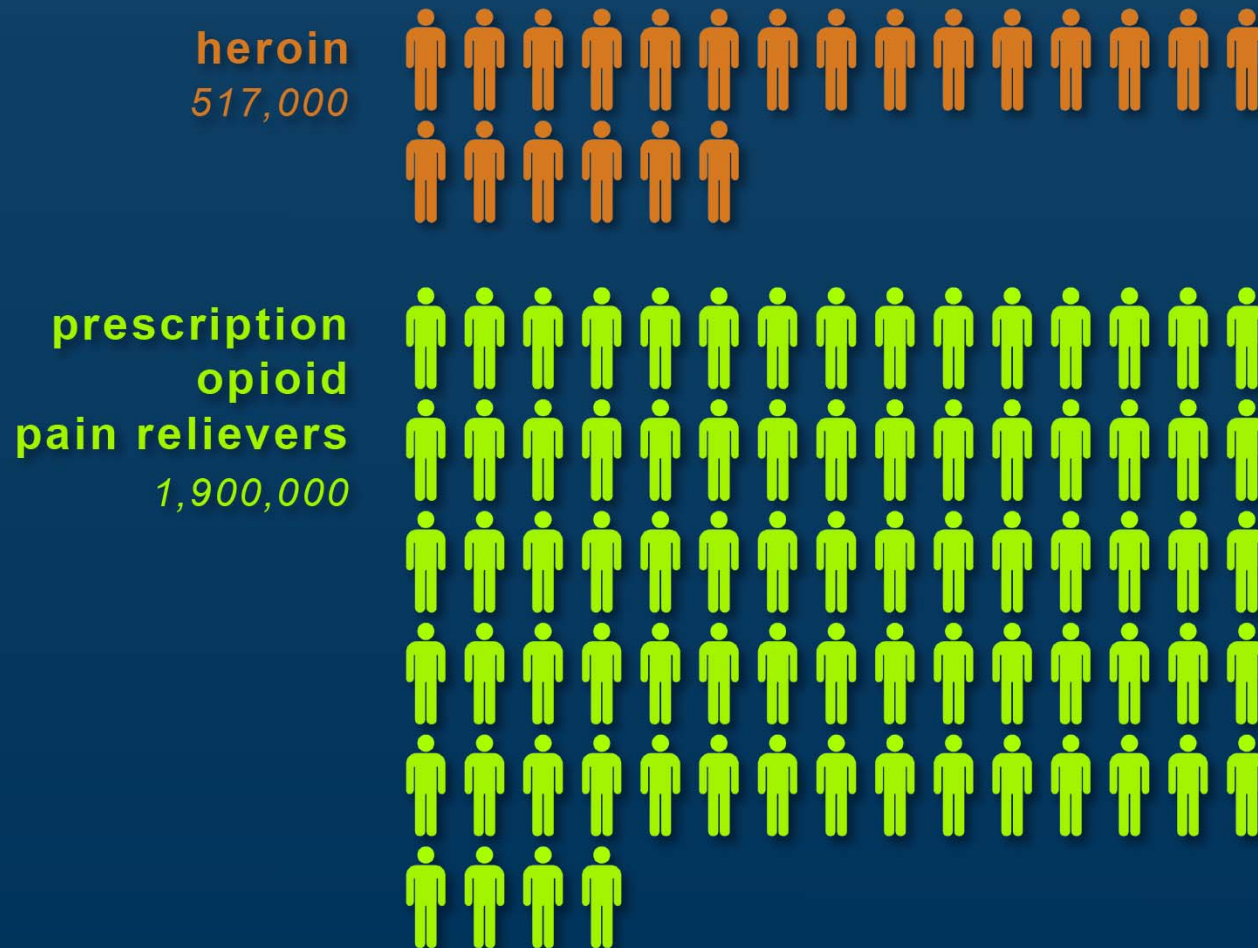
- Understand opioid use disorder (OUD) as a chronic disease comparable to other “medical” chronic diseases
- Understand the concept of Medication Assisted Treatment (MAT)
- Identify medications available and their use in treating OUD

INTRODUCTION

- Today's subject: opioid use disorder
- Opioid drugs used for thousands of years
- Medicine has used them for hundreds of years
- Prescription of opioids regulated since Harrison Narcotic Act
- People have "misused" opioids for as long as they've been around
- But in the last 15 years: epidemic of opioid addiction

Heroin vs. Prescription Opioids

Drug dependence or abuse in the past year 2013*



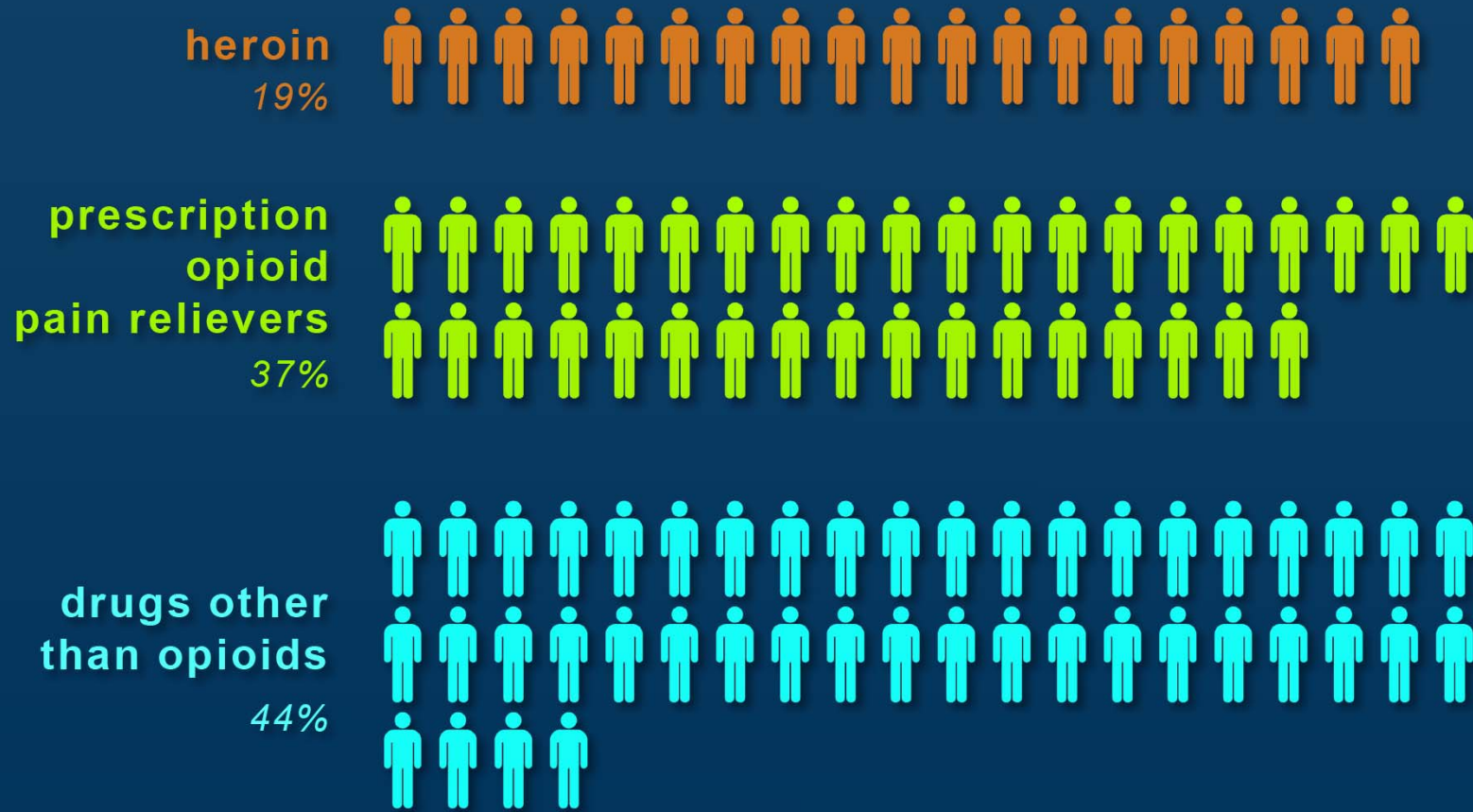
* Note that the terms dependence and abuse as used in the NSDUH are based on the diagnostic categories used in DSM-IV; in the DSM-V, those categories have been replaced by a single Substance Use Disorder spectrum.

Source: National Survey on Drug Use and Health (NSDUH)



ASAM The Value of Addiction Medicine
American Society of Addiction Medicine

2013 Overdose Deaths in the U.S.



43,982 deaths from all drug overdoses in 2013

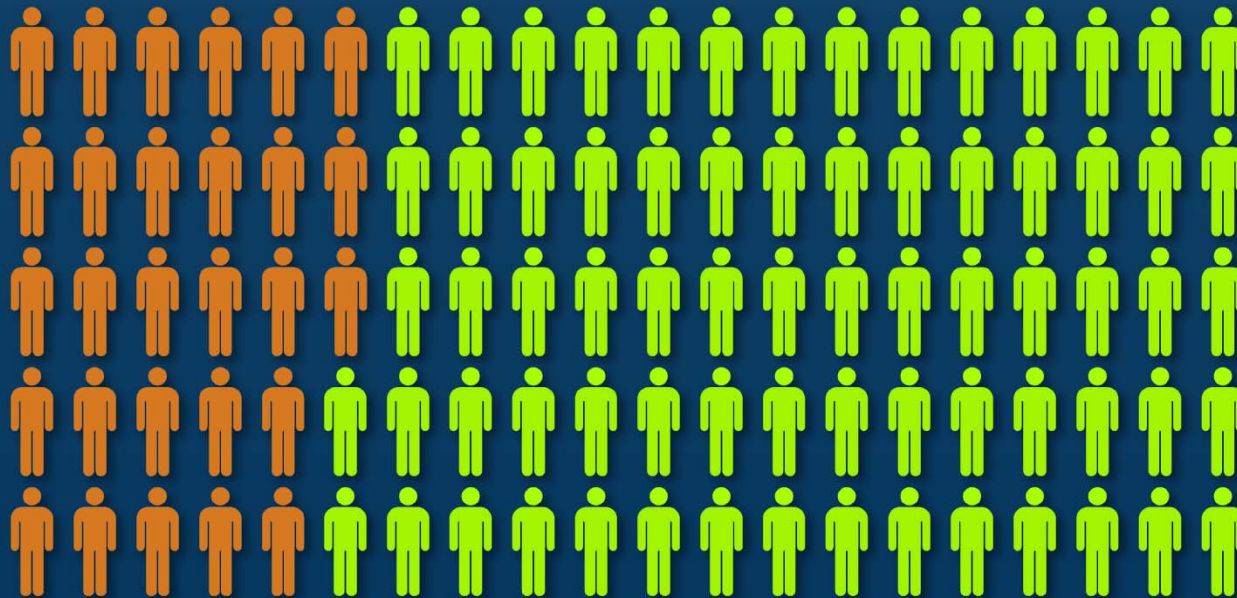
source: National Center for Health Statistics at the CDC



ASAM The Value of Addiction Medicine
American Society of Addiction Medicine

Treatment Gap

Use of pain relievers or heroin in the past month 2012



28% \approx 1.5 million
opioid and heroin patients
receiving medications *



72% \approx 3.7 million
no treatment received

5,197,000 total users surveyed

**Number of individuals receiving buprenorphine or naltrexone from IMS plus number of patients receiving methadone from NSSATS. Source: IMS Total Patient Tracker, September 2014 and SAMHSANSSATS. Buprenorphine data exclude forms indicated for pain. Oral naltrexone factored for opioid dependence use. Methadone patients from SAMHSA, N-SSATS 2012.*



ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

Contributors to the epidemic

Human “nature” /genetics

Availability of Rx opioids, at least partially due to the “enlightening” of physicians in the 1990s about our inadequate treatment of pain, accompanied by unprecedented pharmaceutical company marketing of opioids

Availability of purer heroin, making intranasal use an effective route of use, which vastly increased the number of willing users

Nomenclature

- DSM-I through IV: opioid use, misuse, abuse, dependence
- Addiction
- DSM 5
- Opioid use disorder
- The “disease” debate
- Lawyers and doctors agreed publically in the 1950s that alcoholism is a disease

Addiction the Disease

- A disease OF the brain
- Chronic
- Treatable
- Not curable
- Sometimes fatal

Alan Leshner, Ph. D. 1998, then Director of NIDA

- The brain of someone addicted to drugs is a changed brain; it is qualitatively different from that of a normal person in fundamental ways, including gene expression and responsiveness to environmental clues

Leshner (cont)

- Just as depression is more than a lot of sadness, drug addiction is more than a lot of drug use. The addict cannot voluntarily move back and forth between abuse and addiction because the addicted brain is, in fact, different in its neurobiology from the nonaddicted brain.

How do you “come down with” a chronic disease?

- Host
- Agent
- Environment
- Analogy to infectious disease paradigm

Chronic Disease

- Once you have it, you've got it
- "Disease" implies there is a "medical" component
- Causes are usually multifactorial
- Treatments must usually be multi-modal
- Response rates are variable and depend on the patient, the treatment itself, and outside factors

Chronic Disease Comparison

Diabetes

- Genetic predisposition
- Lifestyle choices are a factor in development of the disease
- Severity is variable
- There are diagnostic criteria
- Once diagnosed, you've got it

Addiction

- Genetic predisposition
- Lifestyle choices are a factor in development of the disease
- Severity is variable
- There are diagnostic criteria
- Once diagnosed, you've got it

Disease Comparison (cont.)

Diabetes

- Primary treatment is lifestyle modification
- Small percentage of patients comply with same
- Medications can help
- Patients often don't comply with medical regimen

Addiction

- Primary treatment is lifestyle modification
- Small percentage of patients comply with same
- Medications can help
- Patients often don't comply with medical regimen

Drug Dependence, a Chronic Medical Illness

- Title of an article in JAMA, Oct 4, 2000, Vol. 284, no. 13, pp 1689-1695
- Compares drug dependence to type 2 diabetes, hypertension, and asthma
- Genetic heritability, personal choice, and environmental factors are comparably involved
- Medication adherence and relapse rates similar across these illnesses

Disease Comparison (cont.)

Diabetes

- Patients who are partially compliant are the rule, and outcomes are better than those who do not get treatment
- Support systems improve outcomes

Addiction

- Patients who are partially compliant are the rule, and outcomes are better than those who do not get treatment
- Support systems improve outcomes

Disease Comparison (cont.)

Diabetes

- Since suboptimal patient compliance is expected, medication use is titrated to maximize outcome

Addiction

- Since suboptimal patient compliance is expected.....blame them for lack of motivation? withhold medication till they try harder?

Disease Comparison (cont.)

Diabetes

- Even in highly motivated patients, only a small percentage will succeed without medication.
“Abstinence” from medication is lowest priority

Addiction

- Abstinence is still often the underlying goal, without which treatment (and the patient) is judged a failure???

Disease Comparison: Conclusion

- Chronic disease may be controllable, but not usually curable
- Medications, if available, are useful to promote this “disease control”
- Results will be suboptimal
- There is a “disconnect” between treatment of addiction vs. other chronic diseases
- In fact, there is a special term: Medication Assisted Treatment
- In other chronic diseases in medicine, we just call it:

TREATMENT!

Choices in Dealing with Opioid Addiction

- Withdrawal management, formerly referred to as “detoxification”
- Short-term medication use
- Long-term medication use
- But always accompanied by “counseling”

Withdrawal Management

- Assume “good” counseling
- Relapse rate for opioid addiction in 1 year: 95%
- There is no such thing as an “addictionectomy”
- Analogy: “Let’s get your diabetes controlled, and then send you home with diet and exercise only”

Short Term Medication

- Assume “good” counseling
- Relapse rate uncertain, not enough study, likely poor
- But appears to be better than just withdrawal management
- Analogy: “You can have your diabetes medication for awhile, but after that you shouldn’t need it anymore”

Long Term Medication

- Assume “good” counseling
- Lots of research (50years) to show good results
- Good results = improved functioning as a person, as a family member, as an employee and as a member of society
- Many studies consistently show societal expenses are reduced as well, ranging from \$4 to 7 for each dollar spent on maintenance treatment

Medications for Opioid Addiction

- Methadone
- LAAM - no longer marketed
- Buprenorphine=subutex and suboxone: partial opiate agonist +/- antagonist
- Naltrexone
- We're decades behind in research compared with diabetes

Opioids - methadone

- Synthesized in Germany in the 1940s
- Claim to fame is its long duration of action, unlike other opioids, due to protein binding in tissues
- Researched in 1960s by pharmacologist Vincent Dole and psychiatrist Marie Nyswander
- Concept of methadone maintenance

Opioids - methadone

- Mu receptor agonist
- Large numbers of studies consistently show efficacy
- It allows normalization of the hypothalamic-pituitary-adrenal axis
- Heavily federally regulated when used for opiate dependence (vs. use for pain)

Why Opioid Maintenance?

Theory

- Stable brain levels eliminate alternating euphoria and withdrawal that encourage continued use

Reality

- With proper dosing, opiate-dependent patients rarely report euphoria after use, or craving at 24 hr.

Why Opioid Maintenance?

Theory

- Hence, long-acting opioids are less reinforcing, reducing abuse potential

Reality

- Patients' "illicit" use of methadone is primarily to "hold" them until they can get more short-acting opiates. Use of methadone rarely meets DSM 5 substance use disorder criteria

Why Opioid Maintenance?

Theory

- These stable levels appear to allow a “repair” or “return toward normal” of opioid receptor systems in the brain

Reality

- Research confirms “improved” opioid systems, including, e.g., the hypothalamic-pituitary-adrenal axis, which affects stress response, immunity, and other systems

Why Opioid Maintenance?

Theory

- Given the foregoing, the phrase “just substituting one drug for another” completely fails to capture the idea

Reality

- In fact, patients stabilized on methadone, “look” more like normal non-addicted individuals, both psychometrically and in their behaviors

Why All the Negative Press?

- Continued social stigma attached to addiction, especially if you can't "fix it yourself"
- Continued stigma on the part of the treatment community---outcomes-based science has not yet replaced ideology
- Opiate-addicted individuals stigmatize themselves, believing they are "guilty"
- Stigmatization of treatment programs

Things have changed

- Marked improvement in overall quality of methadone clinics
- Doses more individualized
- More care with take-home medication
- More counseling provided
- The general public is relatively unaware of the efficacy/improvement in treatment programs

Opioids - methadone

- Can only be used in the treatment of opiate addiction by Opioid Treatment Programs - OTPs
- OTPS require Federal licensing and are HIGHLY regulated in operation
- An individual physician (who is not a licensed OTP) MAY NOT USE METHADONE for the purpose of treating addiction, be it withdrawal management or maintenance (exception: hospitalized pt)
- But it CAN be used by individual physicians to treat pain

Opioids - methadone

- Does it work
- Yes, but -
- Must be adequate dosing; metabolism is markedly individualized; blood levels are available
- Must be sufficient length of treatment, often years
- Must have counseling
- Charleston Center's results

Opioids - methadone

Best used for patients who:

- Have high tolerance
- Have more severe disease
- May be using multiple other substances
- Have higher psychiatric co-morbidity
- Have failed other treatments
- Have more “dysfunctional” lifestyle

Opioids - buprenorphine

- Partial opiate agonist
- Buprenorphine = Subutex
- Buprenorphine + naloxone = Suboxone
- Buprenorphine sublingually absorbed, naloxone not
- But if broken down to use IV, the naloxone's opioid blocking effect predominates, preventing intoxication and possibly precipitating acute withdrawal

Opioids - buprenorphine

- DATA 2000 (Drug Addiction Treatment Act)
- Allows licensed physicians who undertake the required education to be “waivered”
- Receive special “X” DEA number to allow use of buprenorphine for treating opiate addiction in office practice --
OBOT=office-based opiate treatment

Opioids - buprenorphine

- Suboxone use is opioid maintenance analogous to methadone maintenance
- Schedule V medication
- The idea is to bring drug treatment into the privacy of the primary care doctor's office, de-stigmatizing opioid dependence, and getting people into treatment earlier in the course of their disease

Opioids - bupreorphine

- Does it work
- Yes, but -
- Not all doctors (or their office staff) are skilled at dealing with the addicted population
- Counseling still necessary, but availability is not always optimum
- It IS abusable
- An individual doc can only treat 30 patients at a time for the first year, and no more than 100 at a time thereafter (can apply to increase to 275 after another year)

Opioids - buprenorphine

Best used for patients who:

- Have less developed tolerance
- Have less severe disease or are earlier in disease course
- Are using no other substances, or using only minimally
- Have less psychiatric co-morbidity
- Have a more functional lifestyle, who have “lost less”
- Are able to be more compliant with recommendations

Opioids - naltrexone

- Naltrexone is a complete opiate antagonist
- If taking naltrexone, the idea is to block all effects of any opioid administered, thereby preventing intoxication, hopefully ultimately extinguishing opioid drug-taking behavior
- May reduce craving as well
- May be given orally or by IM injection
- Not a controlled substance, can be Rx'ed by any licensed physician

Opioids - naltrexone: oral

- Does it work
- Yes, but -
- Compliance is an issue; one can just stop taking it
- Probably works best with supervised/closely followed administration
- Has been useful especially in professionals

Opioids - naltrexone: IM

- Brand name Vivitrol, lasts 28 days through slow release
- Does it work
- Yes, but -
- Very expensive (~\$1,000/dose)
- You can't get any pain relief from opioids if you need it
- Can be over-ridden under close medical supervision in an emergency

Opioids - naltrexone

Best used for patients who:

- Have less severe disease
- Do not need opioids for chronic pain
- Refuse, for whatever reason, the use of agonist therapy
- Have professional standing, and/or may be under close monitoring

Pregnancy Considerations

- Misuse of short-acting opiate drugs is associated with complications: miscarriage, infections, premature delivery, low birth weight and others
- Other factors influence outcomes: access to prenatal care, socioeconomic status, use of nicotine/alcohol/non-opiate drugs, and other factors
- After decades of research, the standard of care is: opioid maintenance through pregnancy
- Can use methadone or buprenorphine

SUMMARY

- Opioid addiction is a chronic, relapsing “disease” similar to diabetes mellitus type 2
- While primary treatment for both is “counseling,” medications are often/usually necessary
- Relatively few medications exist for opioid addiction, but efficacy is good
- The choice of medication should be individualized, as always in medicine -- there is no “one size fits all”
- Ideology, stigma and lack of knowledge still remain significant barriers to effective MAT

Resources

- American Society of Addiction medicine: www.asam.org
- Substance Abuse and Mental Health Services Administration: www.samhsa.gov
- Treatment Improvement Protocol 43 (TIP): Medication-Assisted Treatment in Opioid Addiction

Recovery Oriented Medication Assisted Treatment (MAT)

Christine Martin, MA, LMFT, CACII

South Carolina Association for the Treatment of Opioid
Dependence (SCATOD)

christine.martin@centerforbehavioralhealth.com



BHG - Aiken Treatment Center
410 University Parkway, Suite 1560
Aiken, SC 29801
803-641-6911

Columbia Metro Treatment Center
421 Capital Square
Columbia, SC 29169
803-791-9422

Greenville Metro Treatment Center
602C Airport Road
Greenville, SC 29607
864-234-7952

Recovery Concepts of the Upstate
1653 E. Main Street
Easley, SC 29640
864-306-8533

BHG - Spartanburg Treatment Center
239 Access Road
Spartanburg, SC 29303
864-503-0207

**Crossroads Treatment Center
Charleston**
2470 Mall Drive, Unit C & D
North Charleston, SC 29406
843-207-4721

Greenwood Treatment Specialists
110 Court Avenue, West
Greenwood, SC 29646
864-407-4160

Rock Hill Treatment Specialists
1274 E Main St
Rock Hill, SC 29730
(803) 526 7666

Center for Behavioral Health
2301 Cosgrove Ave, Suite F
North Charleston, SC 29405
843-529-0700

Crossroads Treatment Center Columbia
1421 Bluff Road
Columbia, SC 29201
803-733-5855

York County Treatment Center
377 Ruben Center Dr. Suite 101
Fort Mill, SC 29715
803-547-7238

Starting Point of Darlington
1451 Retail Row
Hartsville, SC 29550
843-383-4848

Center of Hope of Myrtle Beach
104 George Bishop Parkway
Myrtle Beach, SC 29579
843-903-6212

Crossroads Treatment Center Greenville
157 Brozzini Court. Suite E
Greenville, SC 29615
864-288-7636

Palmetto Carolina Treatment Center
325 Inglesby Parkway, Unit F
Duncan, SC 29334
864-433-8443

Starting Point of Florence
1341 North Cashua Drive
Florence, SC 29501
843-673-9320

Charleston Center
5 Charleston Center Drive
Charleston, SC 29401
843-958-3364

Crossroads Treatment Center Seneca
209 Oconee Square Drive
Seneca, SC 29678
864-888-2337

Recovery Concepts
124-A Boardwalk Drive
Ridgeland, SC 29936
843-645-2770

Southwest Carolina Treatment Center
341 West Beltline Blvd.
Anderson, SC 29625
864-222-9798

Objectives

- Learn about the various setting in which Medication Assisted Treatment (MAT) for Opioid Use Disorders (OUD) is provided
- Understand the concept of success in MAT and of Medication Assisted *Recovery* (MAR)
- Review some of the barriers that prevent persons with an Opioid Use Disorder from accessing and remaining engaged in MAT

Where to Access MAT

- Three medications approved for use in the treatment of an OUD:
 - Methadone (full agonist)
 - Buprenorphine (partial agonist)
 - Extended Release Injectable Naltrexone (antagonist)

Methadone	Buprenorphine	Extended Release Injectable Naltrexone
SAMHSA-certified Opioid Treatment Programs (OTP) dispense methadone or buprenorphine for daily administration on site. Stable patients may eventually take medication dispensed by the OTP home for at-home administration.	Physicians must have board certification in addiction medicine or addiction psychiatry and/or complete special training to qualify for a federal waiver to prescribe buprenorphine. Any pharmacy can fill the prescription.	Any licensed individual with prescriptive authority may prescribe and/or order administration by qualified staff

History

- The first medication assisted treatment option for Opioid Use disorders was developed in the 1960's in response to the post WWII heroin epidemic occurring in NYC (French Connection). At the time, heroin related overdose was the leading cause of death in NYC in young adults.
- Recognition that traditional avenues of treatment weren't working well, and even several attempts at a "maintenance" treatment had not worked well.
- Methadone maintenance began as a research project at The Rockefeller University in NYC under the direction of Dr. Vincent P. Dole and Dr. Marie E. Nyswander.

History

- Nyswander and Dole's work created the foundation of the current model used in methadone maintenance treatment
- Key findings
 - No euphoric/analgesic effects at stable doses
 - Doses between 80-120mg held at level to block the euphoric and tranquilizing effects of continued opioid misuse
 - No change in tolerance level over time
 - Could be taken once a day
 - Relieved craving attributed to relapse
 - Medically safe and nontoxic

History

- Narcotic Treatment Act 1974: Created a requirement that practitioners conducting methadone treatment register as a Narcotic Treatment Program (NTP)
- The Drug Addiction Treatment Act of 2000 (DATA 2000): Created the waiver which allows physicians to prescribe certain opioids (buprenorphine) to treat opioid addiction without having to register as a NTP

Two Models for Opioid Agonist Treatment

Opioid Treatment Programs (OTP)	Office-Based Opioid Treatment (OBOT)
<ul style="list-style-type: none">• Direct administration of medication (methadone or buprenorphine) on a daily basis.• Individuals stable on the medication and abstaining from substance use, who have actively engaged in a recovery process and are demonstrating improved overall functioning can earn/accrue “take-home” medication.• Heavily regulated by federal agencies (CSAT, DEA) and state agencies (DHEC, Board of Pharmacy)• Accreditation requirements (CARF, Joint Commission, etc.)• Behavioral interventions, s. a. individual/group counseling, are required components of care.• Low rates of diversion due to heavy monitoring and required diversion control measures/plan	<ul style="list-style-type: none">• Buprenorphine prescribed by specially waived physicians• Can treat up to 30 patients in the first year. After one year can apply to increase the limit to 100. After one year at the 100 patient limit, can apply to increase the limit to 275 (with additional requirements)• The actual practice of the individual physicians are guided by federal regulations for OBOT; however, actual sites/offices are no under regulation or accreditation requirements• Must be able to demonstrate the capacity to refer to counseling/behavioral health treatment

Medication Assisted Recovery

- **Medication Assisted Treatment (MAT):** The use of medications in conjunction with behavioral therapies for the treatment of Opioid Use Disorder (OUD). Widely considered the most effective treatment option for OUD. MAT assists in stabilizing bodily and brain functioning which allows for engagement in a process of psychosocial rehabilitation and recovery.
- **Medication Assisted Recovery (MAR):** A non-stigmatizing description of the recovery *made possible* through successful use of MAT. No medication can cure OUD; however, medication can play a critical and even lifesaving role in helping people achieve and sustain long-term recovery.

Harm Reduction and Recovery Oriented Care

- When Nyswander and Dole began their work on the methadone maintenance pilot, it was initially conceptualized as a palliative care model with a primary goal of reduction in personal and societal harm.
- Then something happened...
- Research participants began to actively seek and desire psychosocial recovery.

“It was these patients that gave all of us in those halcyon days such hope and enthusiasm as to the possibility of eventually cutting heroin addiction down to a small problem.”

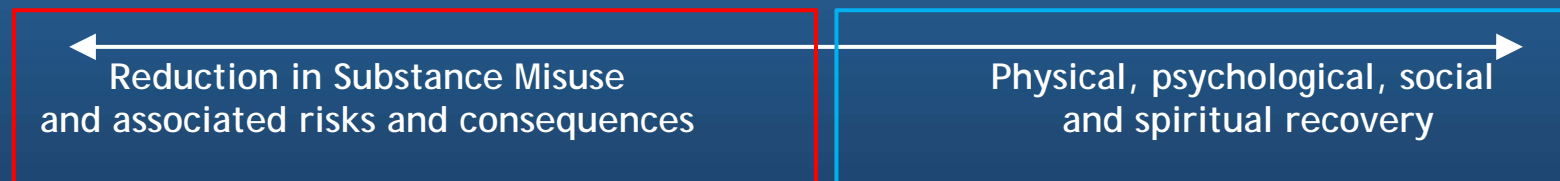
Harm Reduction and Recovery Oriented Care

- Harm Reduction: Aimed at minimizing the person with the substance use disorder's risks to self, others, and the community.
- Recovery Oriented Care: Aimed at facilitating the person with the substance use disorder's entry into recovery and helping them sustain long-term recovery.
- They don't have to be mutually exclusive
- In Opioid Treatment we tend to view it in this way:

We hope for recovery for every individual that enters our care, but we'll also accept harm reduction as a positive outcome of treatment

Harm Reduction and Recovery Oriented Care

- Low Threshold does not mean Low Expectations (and it certainly doesn't mean enabling)
- Low Threshold Services: minimal pre-requisites for treatment entry and minimal requirements for treatment retention
 - Benefit = capture and retain more individuals in need of services
 - Continued opportunity to *increase* recovery prospects
 - Methadone treatment attracts more voluntary participation than any other addiction treatment modality¹
- Positive Treatment Outcomes:



1. Kreek, M. J. (2000) Methadone-related agonist therapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of the New York Academy of Science*, 909, 186-216

Recovery Status

- The Hall-of-Fame asterisks effect
- The recovery status of persons utilizing MAT for their OUD should be evaluated by the same criteria and definition of recovery that applies to the resolution of *all* substance use disorders
- SAMHSA's working definition of recovery:
 - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
- Betty Ford Institute:
 - A voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship
 - *"...formerly opioid-dependent individuals who take naltrexone, buprenorphine or methadone as prescribed and are abstinent from alcohol and all other nonprescribed drugs would meet this definition of sobriety."*

Effectiveness

- With over 50 years to support it, methadone treatment is considered the most effective treatment for chronic heroin dependence
 - NIH: “the safety and efficacy of MAT has been unequivocally established. ...[M]ethadone maintenance coupled with relevant social, medical and psychological services has the highest probability of being the most effective of all treatments for opioid addiction.”¹
- One study found that those who receive MAT are 75% less likely to have an addiction-related death than those who do not receive MAT²
- MAT has been shown to improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity; increase patients’ ability to gain and maintain employment, improve birth outcomes among women who have substance use disorders and are pregnant, and lower a person’s risk of contracting HIV or hepatitis C by reducing the potential for relapse.³

1. “Confronting an Epidemic: The Case for Eliminating Barriers to Medication-Assisted Treatment of Heroin and Opioid Addiction,” Legal Action Center, March 2015.

2. Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, SAMHSA, 2008.

3. <https://www.samhsa.gov/medication-assisted-treatment/treatment>

Underutilization

- It is estimated that nearly 80% of individuals with an Opioid Use Disorder are not receiving treatment¹
- In 2010 only 28% of admission for a heroin use disorder had a treatment plan which included MAT²
- Only 5.5% of individuals enrolled in methadone treatment were referred by the systems in which persons with a heroin use disorder are most likely to be encountered (health care and criminal justice systems)³
 - 9.6% referred by other SUD treatment providers
 - 4.2% healthcare providers
 - 6.1% other community referrals
 - **72.8% are self-referred or referred by friend/family**

1. Medication Assisted Treatment of Opioid Use Disorder: Pocket Guide. Substance Abuse and Mental Health Services Administration. SMA16-4892PG

2. <http://archive.samhsa.gov/data/2k12/TEDS2010N/TEDS2010NTOC.htm>

3. United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Treatment Episode Data Set - Admissions (TEDS-A) - Concatenated, 1992 to Present [Computer file]. ICPSR25221-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2009-09-21. doi: 10.3886/ICPR25221.

Barriers - Stigma

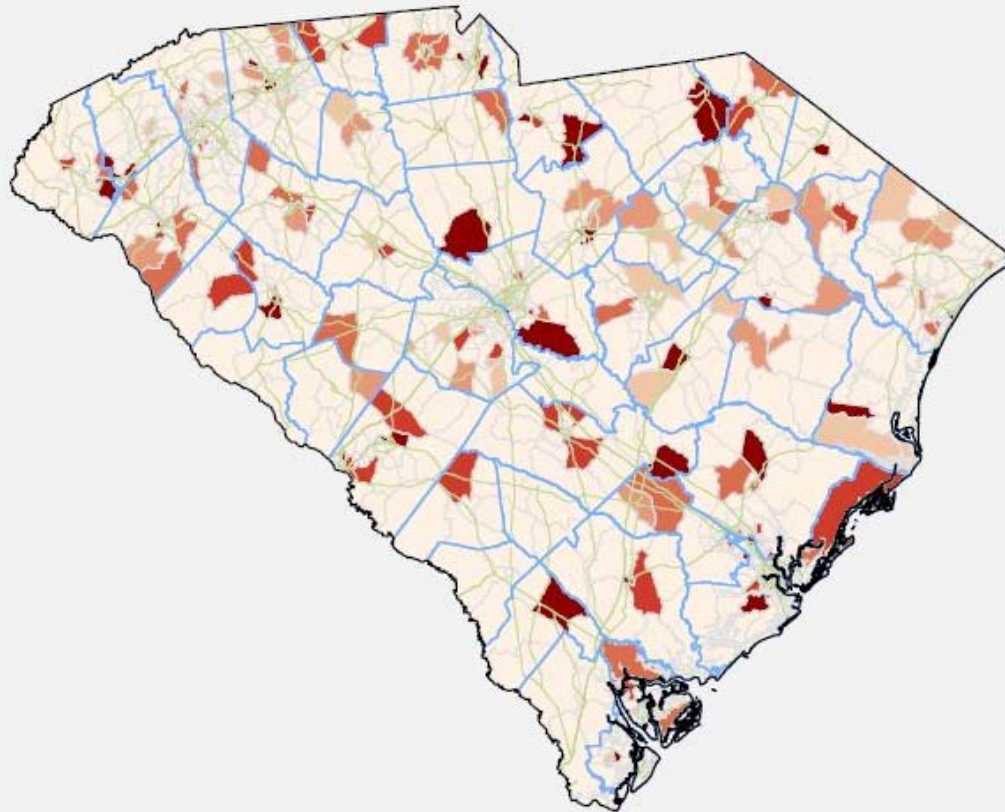
- Belief that they're using the medication "to get high"
- It's simply substituting one drug for another
- It's a "crutch"
- It "keeps them addicted"

Resultant Discrimination

- Loss of child custody, loss of employment, discharge from healthcare practices when participation in medication assisted treatment for their OUD is discovered
- Denial of needed medication for pain on the false assumption that pain is relieved by the MAT medication
- Denial of access to other addiction treatment modalities and recovery supports (e. g. residential treatment, recovery homes that don't allow participants to take MAT medications; lack of access to continuous MAT medications while receiving detoxification services for other substance issues like alcohol withdrawal)

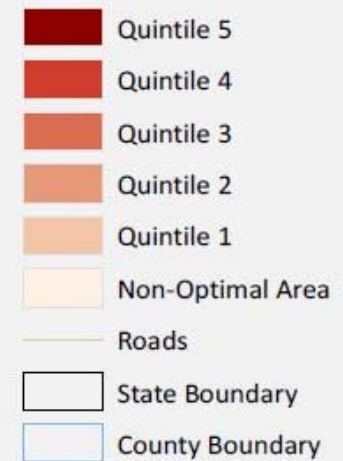
Barriers - Lack of Access

South Carolina 2016 Potential Areas for Addressing Service Gaps for Opioid Treatment

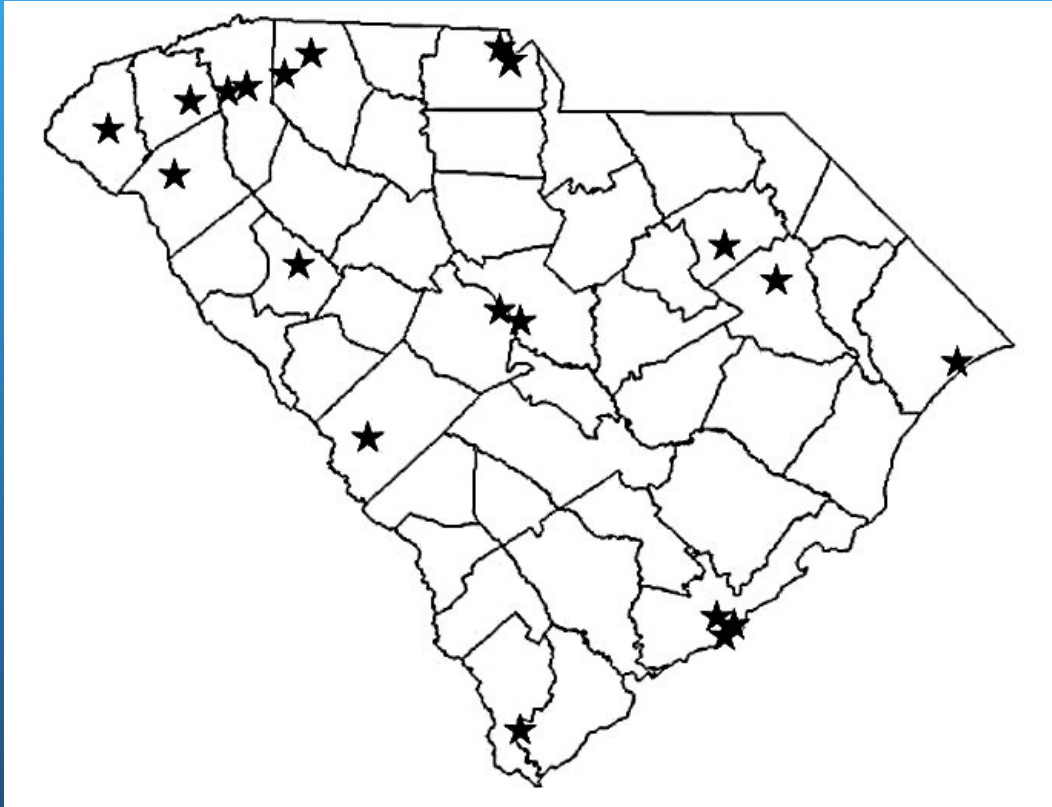


Data Sources:
Drug Use: NSDUH (2012)
Facilities: SAMHSA (2016)
Population: ACS 5-year average (2010-2014)

Optimal Areas



Barriers - Lack of Access



★ Locations of
Opioid
Treatment
Providers

Barriers - Funding

- South Carolina is one of only 16 states that does not provide some form of Medicaid reimbursement for services provided in an Opioid Treatment Program
- Medicaid coverage of buprenorphine treatment is limited
- Prior authorization requirements for buprenorphine are often burdensome and sometimes even nonsensical
- Of the 20 Opioid Treatment Programs in South Carolina, only one has funding to aid patients unable to afford or pay for treatment services

Conclusion

- While some persons with an Opioid Use Disorder may achieve sustained remission without the support of medication, some will require prolonged if not lifelong use of medications to facilitate physical, psychological, social and spiritual recovery
- Medication Assisted Treatment is effective and proven
- Achieving recovery with the support of medications is possible and should be treated and valued on par with other avenues of achieving and sustaining recovery
- Much work needs to be done to eliminate stigma and to reduce barriers that restrict access to these effective treatments and to open up more avenues to recovery