National American Indian and Alaska Native
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

IOWA

SAMHSA
Substance Abuse and Mental Health Services Administration

The Brave New World of Medication-Assisted Treatment of Opioid and other SUD for Native American/Alaska Native Populations

Special Guest Speaker
Michael G. Bricker MS, CADC-II, NCAC-2, LPC

September 13, 2023

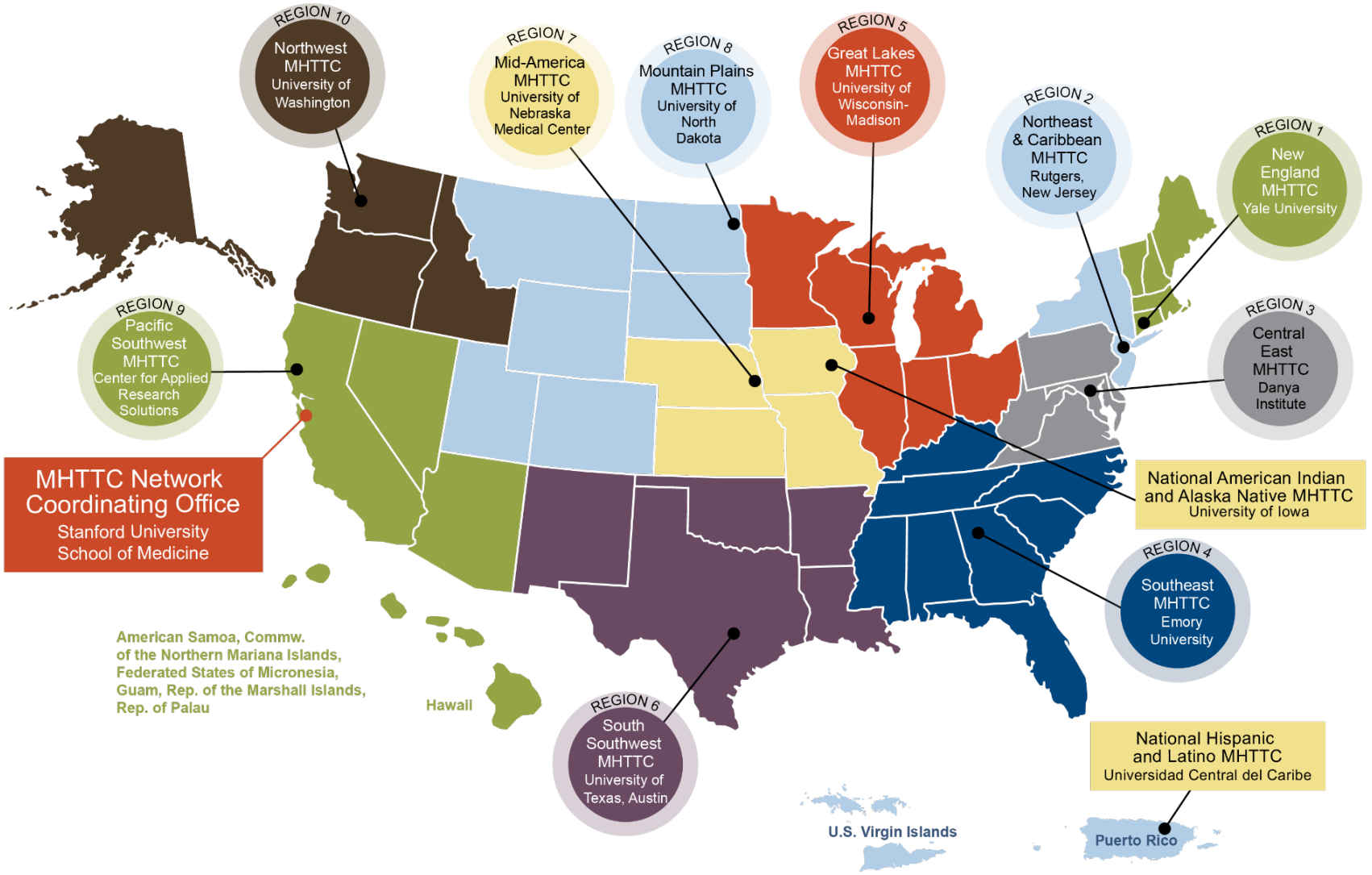
MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network

American Indian & Alaska Native Mental Health Technology Transfer Center



SAMHSA

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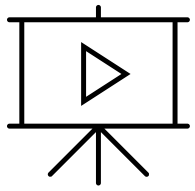
The National American Indian and Alaska Native Mental Health Technology Transfer Center is supported by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

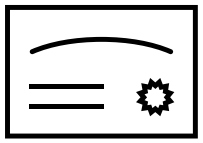
The content of this event is the creation of the presenter, and the opinions expressed do not necessarily reflect the views or policies of SAMHSA, HHS, or the American Indian & Alaska Native MHTTC.

Follow-up

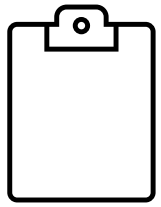
Following today's event, you will receive a follow up email, which will include:



Links to the presentation slides and recording, if applicable



Information about how to request and receive CEUs, Certificate of Attendance, if applicable



Link to our evaluation survey (GPRA)

Land Acknowledgement

We would like to take this time to acknowledge the land and pay respect to the Indigenous Nations whose homelands were forcibly taken over and inhabited.
Past and present, we want to honor the land itself and the people who have stewarded it throughout the generations.

This calls us to commit to forever learn how to be better stewards of these lands through action, advocacy, support, and education.
We acknowledge the painful history of genocide and forced occupation of Native American territories, and we respect the many diverse indigenous people connected to this land on which we gather from time immemorial.

While injustices are still being committed against Indigenous people on Turtle Island, today we say thank you to those that stand with Indigenous peoples and acknowledge that land reparations must be made to allow healing for our Indigenous peoples and to mother earth, herself.

Dekibaota, Elleh Driscoll, Meskwaki and Winnebago Nations
Ttakimaweakwe, Keely Driscoll, Meskwaki and Winnebago Nations
Keokuk, Sean A. Bear, 1st. Meskwaki Nation

Today's Speaker

STEMSS® Support Together for Emotional and Mental Serenity & Sobriety®

Mike Bricker MS, CADC-II, NCAC-2, LPC since 1984 has been a consultant on "dual recovery" from substance use and mental disorders through the STEMSS® Training Institute and specializes in blending western research-based treatment with other Wisdom Traditions. He is also a Behavioral Health Clinician for Strong Integrated Behavioral Health in Eugene OR. Mike has worked extensively among Native American and Alaska Native Peoples. He served 10 years as Program Director for the Yukon-Kuskokwim Health Corp. in bush Alaska and was awarded the ANTHC Behavioral Health Aide Program Award in 2009 for his work educating Native counselors. He was also Clinical Director of the Tse nani a Hi (Rainbow Bridge) Residential Program on the Navajo Nation. More recently, he has developed training workshops for the Klamath, Shoshone-Bannock, Mandan and Yakima Tribes. Mike is a seasoned trainer who presents regularly at national conferences, and a NAADAC Approved Education Provider. He has been a clinician, consultant and teacher for over 35 years.

Contact: mike.bricker@STEMSSinstitute.org (541) 246-8053
Michael G Bricker MS, CADC-2, NCAC-2, LPC
Approved Clinical Supervisor – LPC/LMFT
NAADAC Approved Education Provider

"I don't think we're in Kansas anymore..."

The Brave New World of Medication-Assisted Treatment of Opioid and other Substance Use Disorders for Native American and Alaska Native Populations

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Michael G Bricker
MS, CADC-II, NCAC-II, LPC
Behavioral Health Clinician

Wednesday
Sept. 13th 2023

Webinar Presenter

Michael G Bricker MS, CADC-2, NCAC-2, LPC

Behavioral Health Clinician – LifeStance Behavioral Health

Trainer & Consultant

https://STEMSSinstitute.org

Michael G. Bricker MS, CADC-II, NCAC-2, LPC

The STEMSS® Institute

Support Together for Emotional and Mental Serenity & Sobriety

Consultation in recovery from substance use and mental disorders

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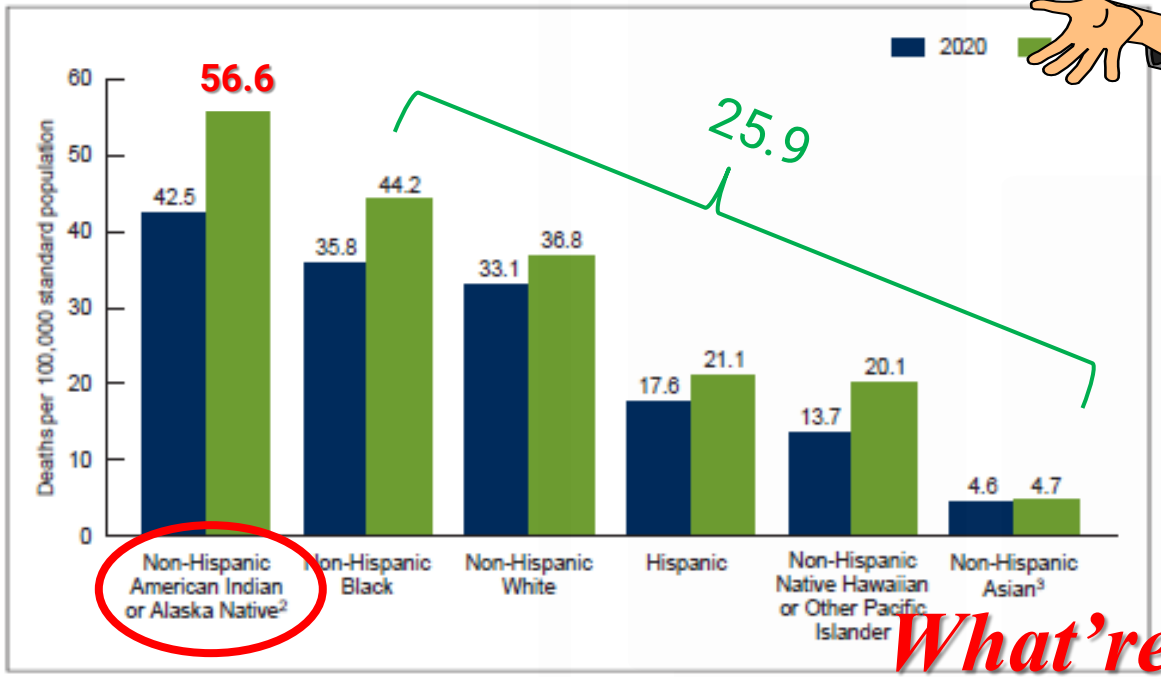
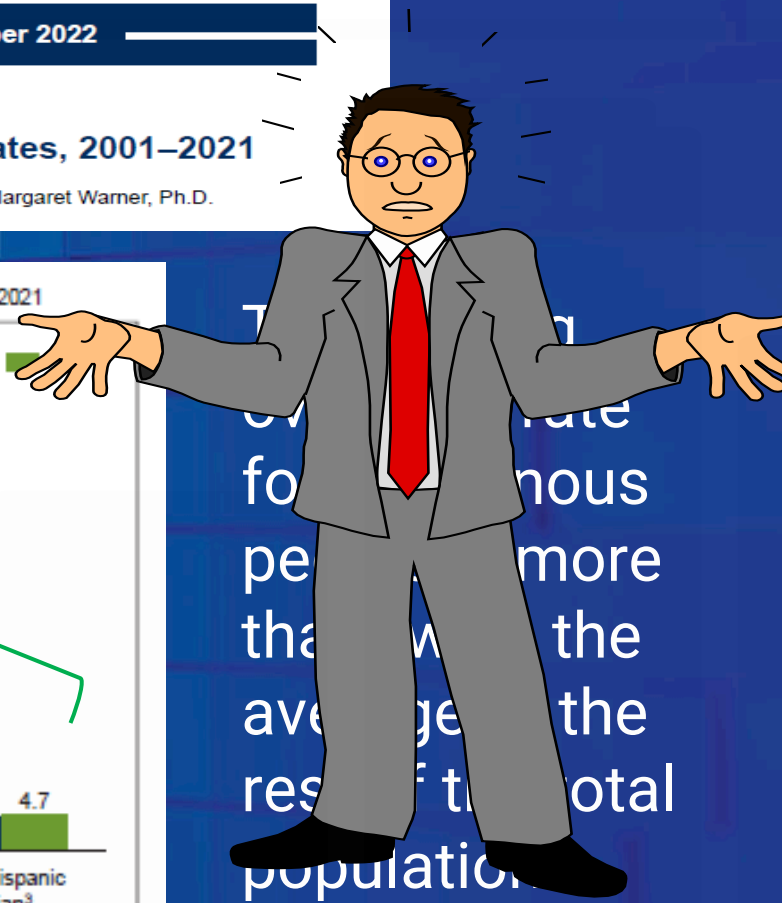
NCHS Data Brief ■ No. 457 ■ December 2022

Drug Overdose Deaths in the United States, 2001–2021

Merianne Rose Spencer, M.P.H., Arialdi M. Miniño, M.P.H., and Margaret Warner, Ph.D.

Figure 3. Age-adjusted rate of drug overdose deaths, by race and Hispanic origin: United States, 2020 and 2021





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What're we gonna do?!?

Webinar Learning Objectives

1. Identify three methods to reduce the impact of opioid overdose and other Substance Use Disorders on Native American and Alaska Native populations

2. Articulate several philosophical, dialectic and practical considerations between "abstinence-based" and "medication-assisted" treatment modalities.

3. Identify the FDA/DEA - approved and experimental medications for assisting patients in recovery from alcohol, opioid and stimulant use disorders.

4. Become familiar with evidence - based MAT resources either designed for or adaptable to treat Native patients dealing with opioid, alcohol and other substance use disorders.

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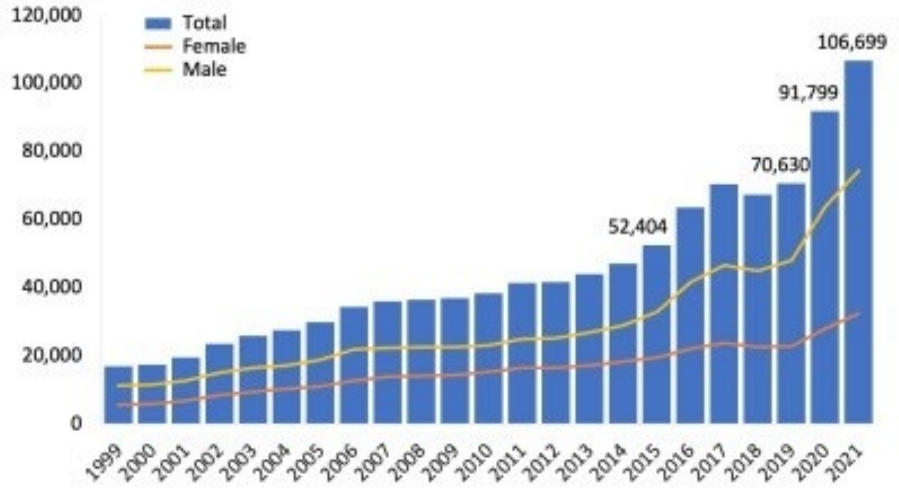
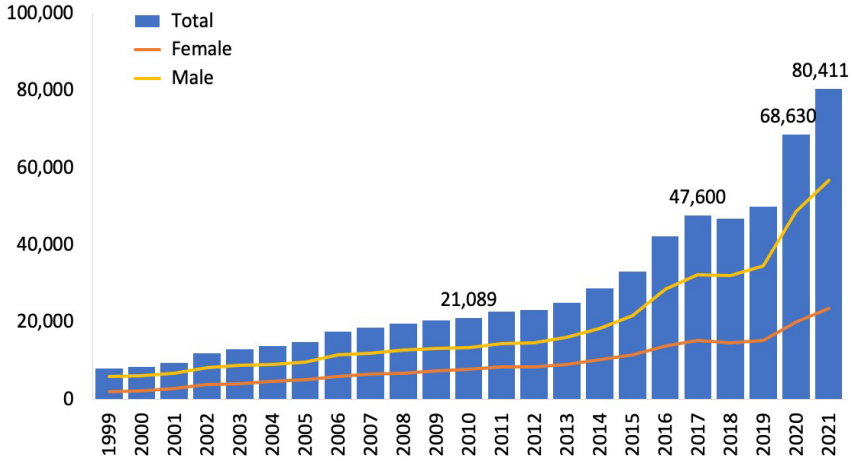
The Scope of the Problem

Figure 1. National Drug-Involved Overdose Deaths*, Number Among All Ages, by Gender, 1999-2021



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

Figure 3. National Overdose Deaths Involving Any Opioid*, Number Among All Ages, by Gender, 1999-2021



*Among deaths with drug overdose as the underlying cause, the "any opioid" subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2), methadone (T40.3), other synthetic opioids (other than methadone) (T40.4), or heroin (T40.1). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

https://youtu.be/odwEuiWs9yQ

Opioid epidemic timeline by cohort

https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates (2023)

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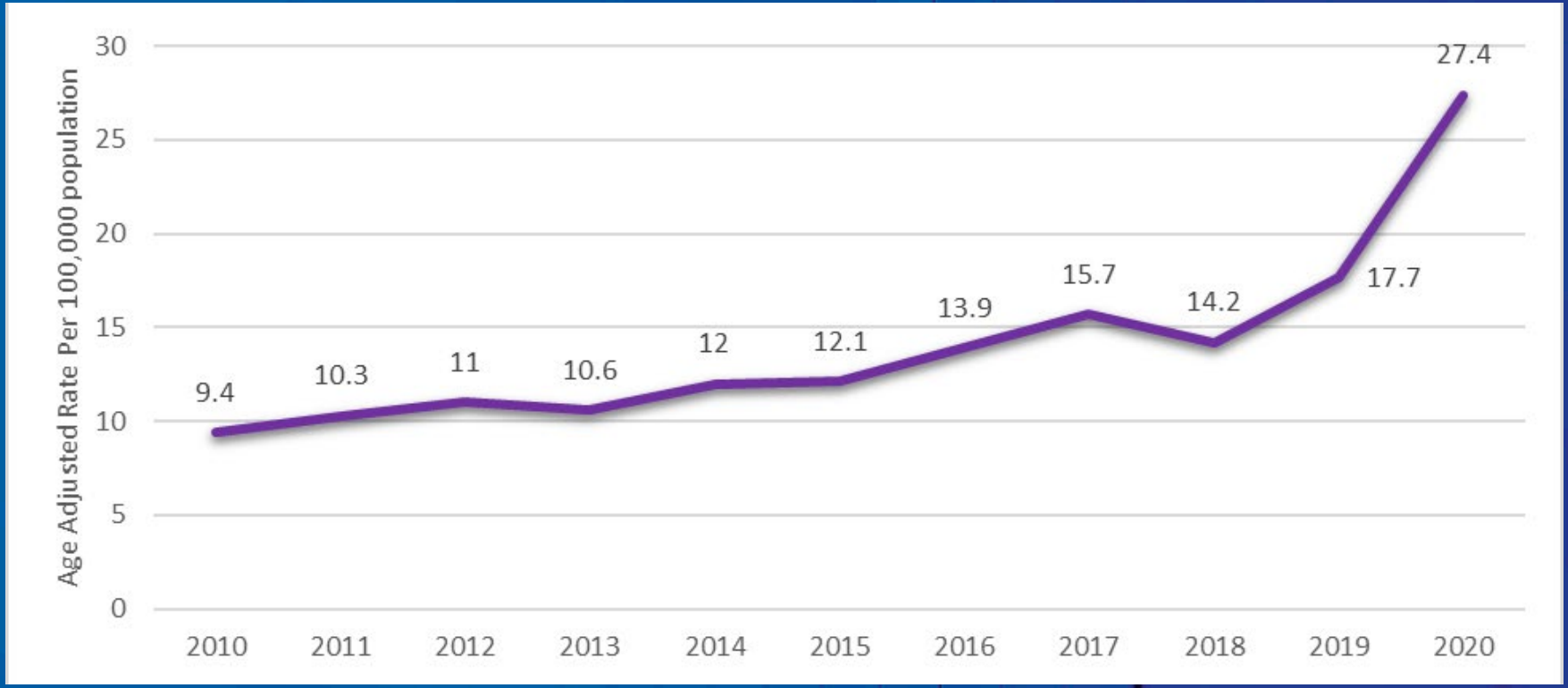
Overdose Deaths Involving Opioids Among American Indian and Alaskan Natives, U.S. 2010-2020



https://www.cdc.gov/injury/budget/opioidoverdosepolicy/TribalCommunities.html

THE OPIOID CRISIS

Impact on Native American Communities

What are Opioids?

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, etc.

The misuse of and addiction to opioids can lead to overdose and deaths.

Heroin and fentanyl overdoses are driving the recent and rapid increase in opioid-related deaths throughout the U.S., including Indian Country.

Overdose deaths due to any type of opioid use have been on the rise among Native Americans since 2000.

The current opioid-related overdose death rate is 13.7 deaths per 100,000 Native Americans, which exceeds the national rate of 13.1 per 100,000.

https://tribalepicenters.org/wp-content/uploads/2018/03/AASTEC-opioids-fact-sheet.pdf

In your handouts

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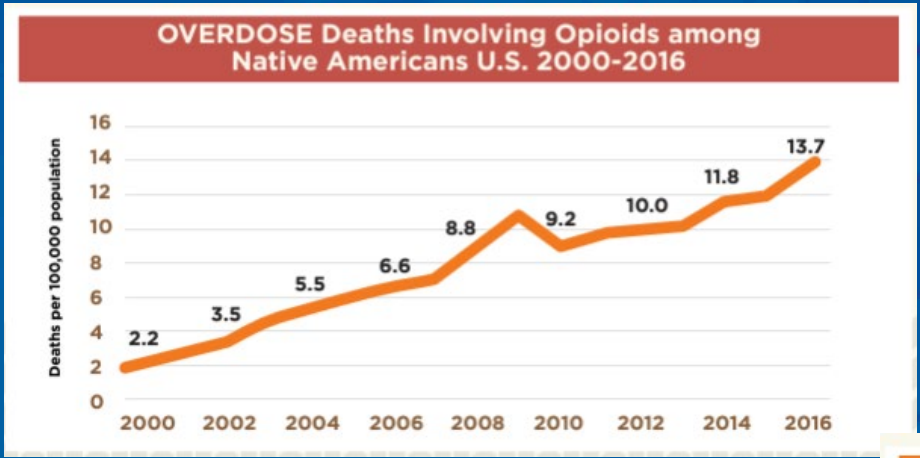
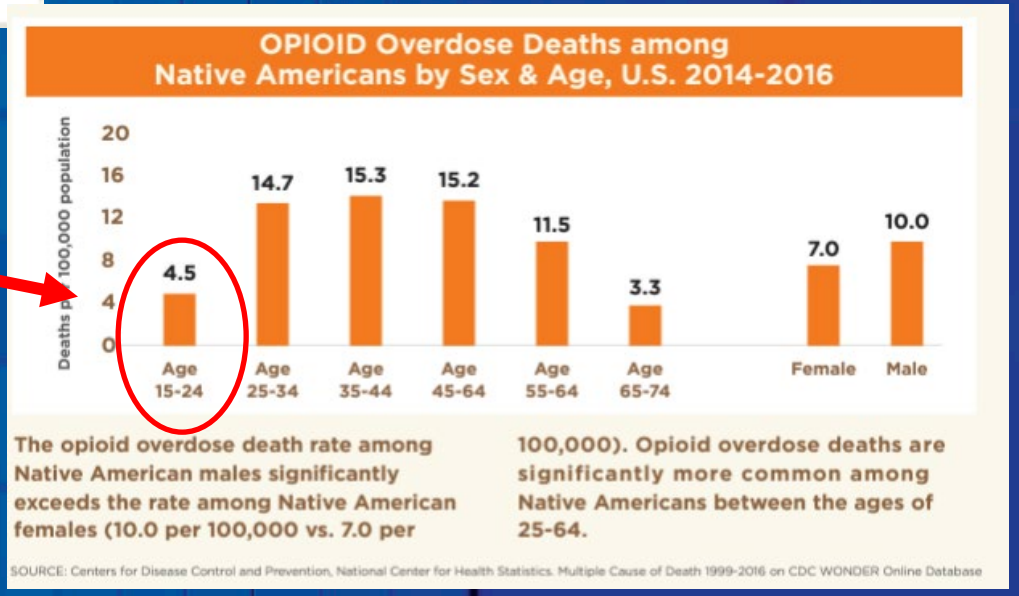


A recent FBI report shows that Mexican drug cartels are specifically targeting Indian Country. High unemployment on the Reservation means many turn to trafficking and dealing. Cartels know that many Tribes lack sufficient law enforcement resources

Among American Indian/ Alaska Native adolescents, opioid overdose deaths more than doubled between 2010 and 2021 – largely due to counterfeit fentanyl contaminants.

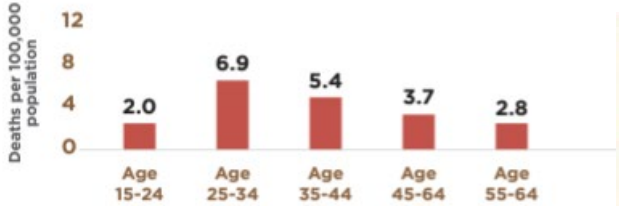


https://www.uclahealth.org/news/adolescent-drug-overdose-deaths-rose-exponentially-first

Heroin

Heroin is an illegal drug derived from opium which people inject, sniff, snort, or smoke. Some street names for heroin include: *smack, dope, China white, and tar.*

HEROIN Overdose Deaths among Native Americans by Sex & Age, U.S. 2014-2016



More than twice as many Native American men (4.0 per 100,000) die from a heroin overdose than Native American women (1.8 per 100,000).

The most cor
overdose dea
25-34 (6.9 pe
(5.4 per 100,

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of

https://tribalepicenters.org/wp-content/uploads/2018/03/AASTEC-opioids-fact-sheet.pdf

Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug.

Most used at least **3** other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and **death** for users.

People who are addicted to...

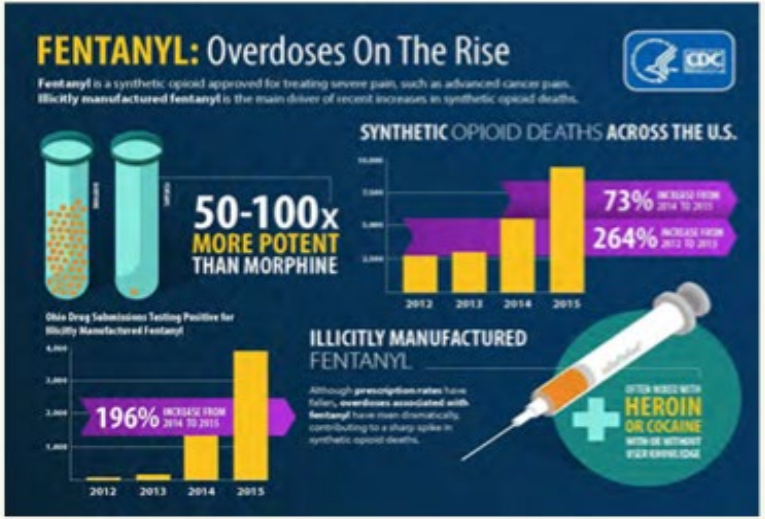
ALCOHOL	MARIJUANA	COCAINE	Rx OPIOID PAINKILLERS
are 2x	are 3x	are 15x	are 40x

...more likely to be addicted to heroin.

It's not just about opioids!

More than 1 in 5
Native American high school students who used a prescription pain medication (Rx Pain Killer) without a doctor's order also used heroin in the past 30 days (22%).

22%



Fentanyl

Fentanyl is a synthetic (man-made) opioid that is 50x more potent than heroin and 100x more potent than morphine. There are two types of fentanyl:

Pharmaceutical fentanyl, which is primarily prescribed to manage acute and chronic pain associated with advanced cancer.

Non-pharmaceutical fentanyl, which is illicitly manufactured, and is often mixed with heroin and/or cocaine—with or without the user's knowledge—in order to increase the drug's effect.

Some street names for fentanyl include: ***Apache, China Girl, Jackpot, Dance Fever, and TNT.***

Most OD's… especially among young people… don't know their drug is laced with illicit fentanyl

https://tribalepicenters.org/wp-content/uploads/2018/03/AASTEC-opioids-fact-sheet.pdf

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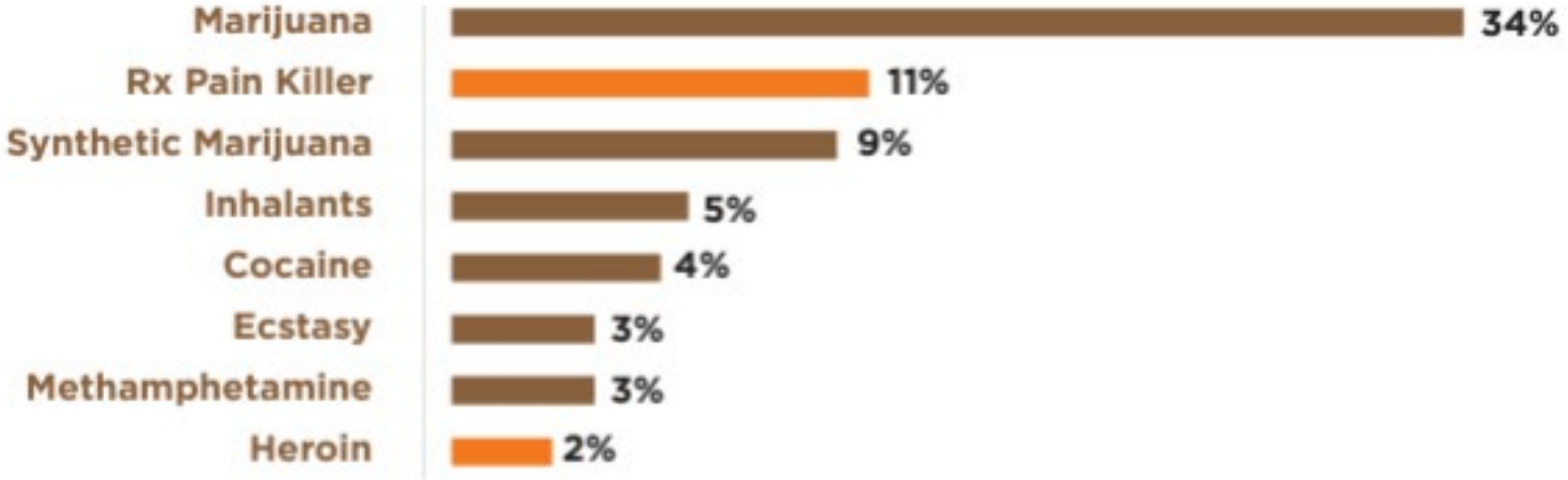
CURRENT Drug Use (Past 30 Days) Native American High School Students New Mexico 2015



More than 1 in 10 Native American high school students in New Mexico (11%) used a prescription pain medication (Rx Pain Killer) without a doctor's order in the past 30 days. Approximately, 2% reported current heroin use.

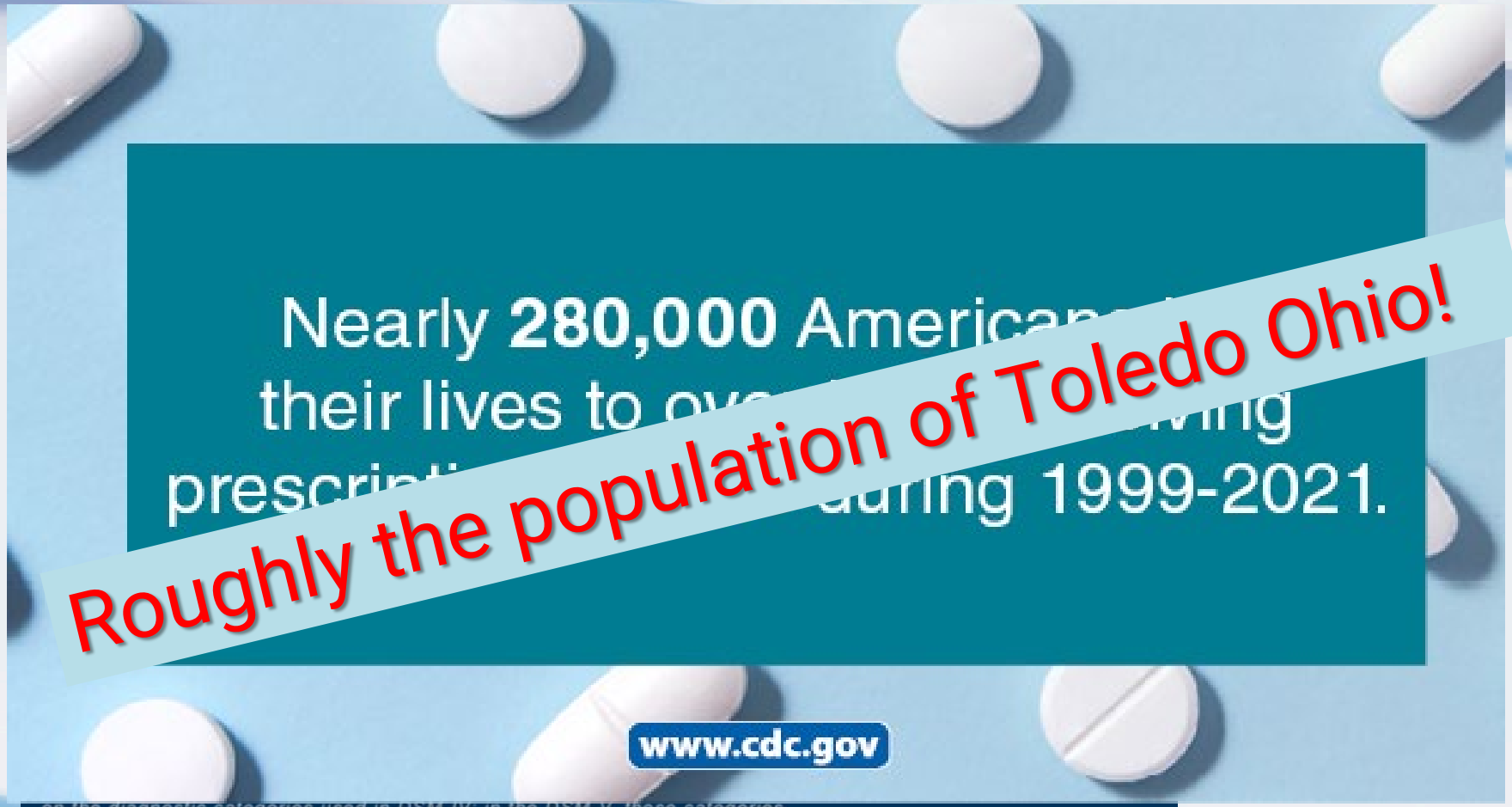
Source: New Mexico Youth Risk and Resiliency Survey 2015

How to Protect Yourself, Your Family and Our Community:

- **TALK TO YOUR KIDS.** Tell your children about how deadly opioid drugs can be. Children who learn about the risks of drugs at home are less likely to use drugs than those who don't. Surveys show that two-thirds of teens who misuse prescription painkillers got them from friends, family members, and acquaintances.
- **SAFE STORAGE.** Keep opioids and other prescription medicine in a secure place. Count and monitor the number of pills you have and lock them up. Ask your friends, family members, and babysitters to do the same.
- **DISPOSE LEFTOVER PRESCRIPTION MEDICATION.** If you have unused prescription opioids at the end of your treatment, find your community drug take-back program or your pharmacy mail-back program, or follow guidance for disposal at home (i.e., flushing down toilet).
- **TALK TO YOUR DOCTOR.** Discuss alternatives to opioids for pain relief with your doctor. Your doctor may suggest other non-addictive medicines or certain complementary and alternative treatments—such as acupuncture—as a first step for treating chronic pain.
- **DON'T TAKE OPIOIDS WITH ALCOHOL AND OTHER MEDICATIONS** like benzodiazepines (such as Xanax® and Valium®), muscle relaxants (such as Soma® or Flexeril®), hypnotics (such as Ambien® or Lunesta®), and/or other prescription opioids. These drugs and substances can enhance each other's effects, leading to dangerous intoxication and possible overdose.
- **ASK FOR HELP.** If you or a family member may be misusing opioids or developing an addiction, don't hesitate to seek help from your IHS or tribal health clinic or behavioral health program. Treatment options include counseling and medication assisted therapy.
- **KNOW WHAT TO DO IN AN OVERDOSE EMERGENCY.** Ask your health provider about Naloxone, which can be used at home to prevent opioid overdose deaths. Always call 911 if you believe someone is experiencing an overdose.

ALBUQUERQUE AREA SOUTHWEST TRIBAL EPIDEMIOLOGY CENTER
www.aastec.net • 1-800-658-6717

In your handouts



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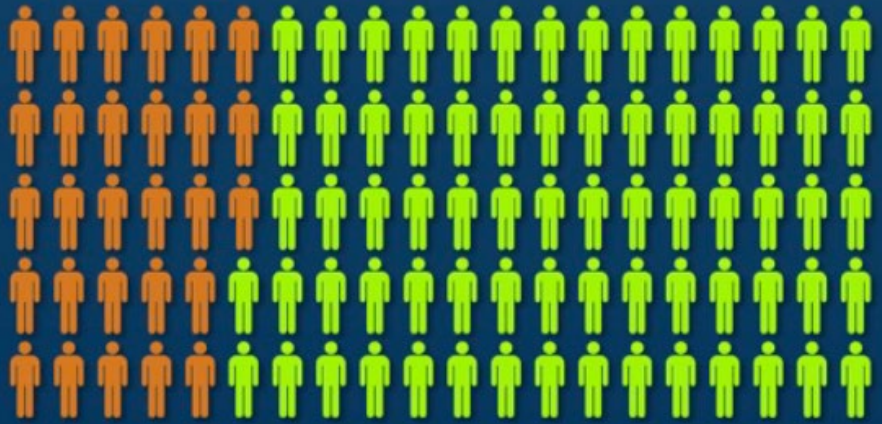
Treatment Gap

Use of pain relievers or heroin in the past month 2012



28% ≈ *1.5 million*
opioid and heroin patients receiving medications *

72% ≈ *3.7 million*
no treatment received

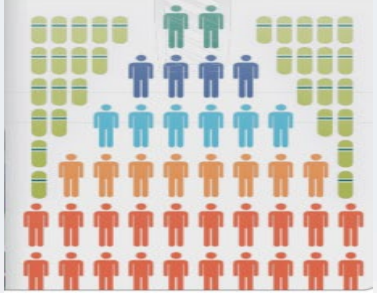
5,197,000 total users surveyed

**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

Reality Check

RATES OF OPIOID ABUSE/ DEPENDENCY FAR EXCEED the maximum buprenorphine/ methadone **TREATMENT CAPACITY** in nearly all states



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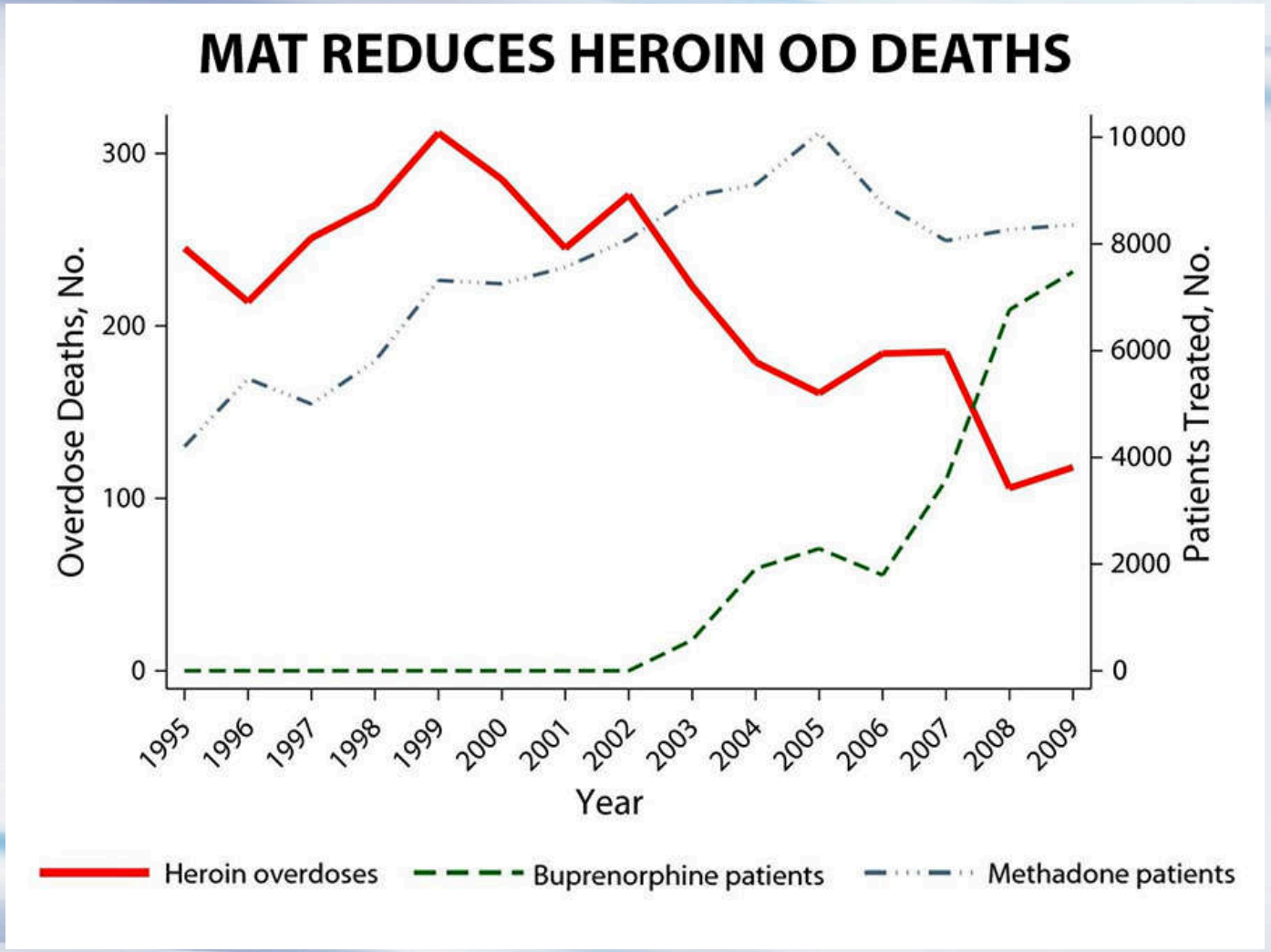
ASAM National Practice Guideline



Why the need for Medication -Assisted Treatment?

Opiates and Opioids

- **Opiates** are present in opium e.g. morphine, codeine, thebaine *(codeine methylenol ether)*
- **Opioids** are manufactured as
  - **Semi-synthetic opioids** derived from an opiate (e.g. heroin from morphine)
  - **Synthetics opioids** completely synthesized to have function similar to natural opiates (e.g. methadone)

Agonist, antagonist and partial agonist medications

Antagonists have affinity but zero intrinsic efficacy; therefore they bind to the target receptor but do not produce a response. They "block" the receptor.

EXAMPLES:

- Naloxone (Narcan – opioid receptors)
- Naltrexone (opioid receptors & alcohol)
- Prazocin (alcohol - noradrenergic receptors)
- Acamprosate (alcohol - NMDA receptors)

Agonists are drugs with both affinity (they bind to the target receptor) and intrinsic efficacy (they change receptor activity to produce a response). They mimic the effects of the main drug.

EXAMPLES:

- Methadone (opioid receptors)
- Benzodiazepines (alcohol)

Partial Agonists have affinity but moderate intrinsic efficacy; therefore they bind to the target receptor but produce only a mild response. They down-regulate the receptor.

EXAMPLES:

- Buprenorphine (opioid receptors)
- Suboxone (combines buprenorphine with naloxone)

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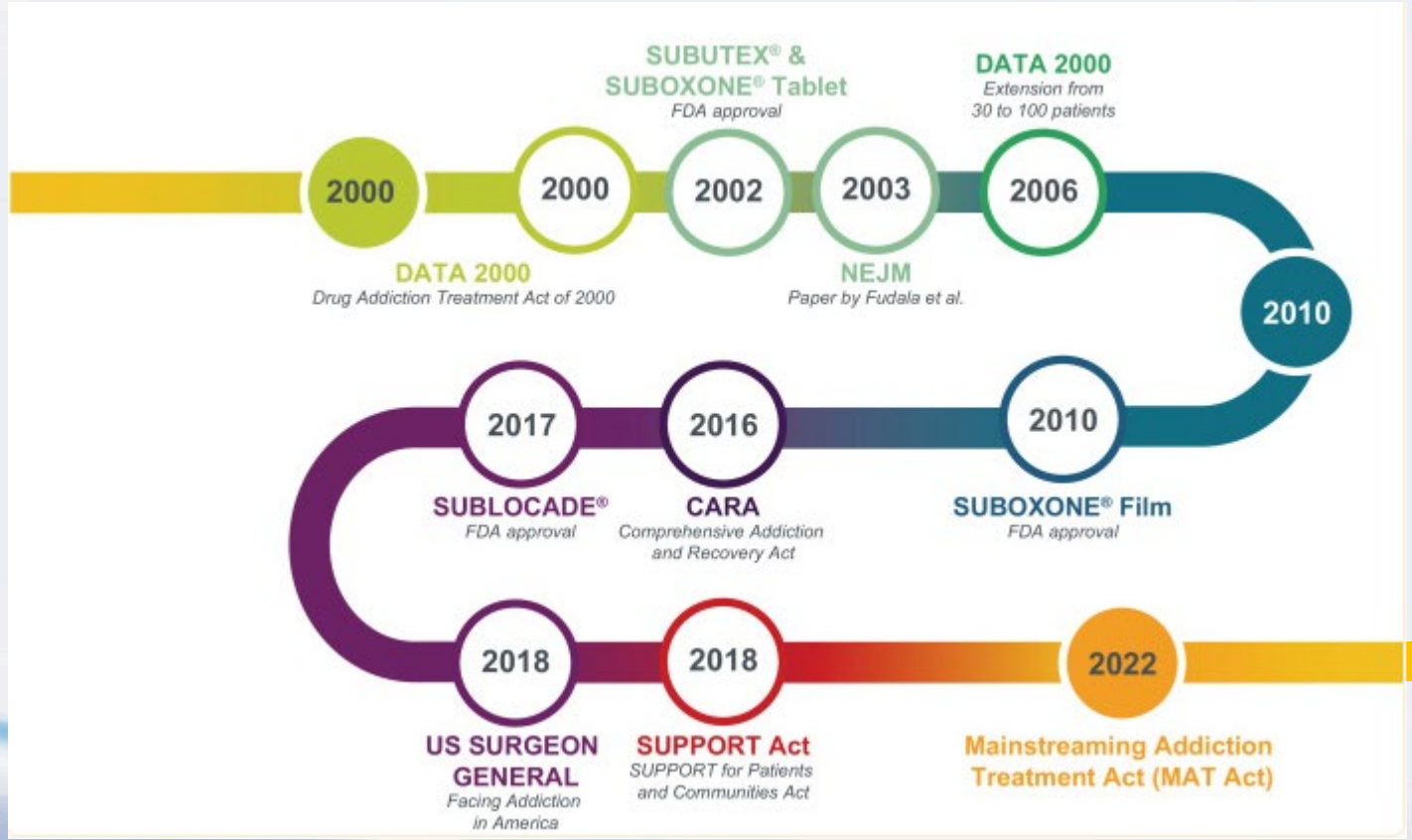
Methadone treatment in Indian Country

- Historically, no Licensed Opioid Treatment Centers for methadone on Tribal Lands
- OTC's are Federally licensed, Tribes are sovereign
- Available for urban NA/AN populations only…
- …severely limiting treatment options to stem the tide of overdose deaths
- Buprenorphine is now safer, more accepted and widely available for Native populations

Timeline of buprenorphine approval



1/12/2023 – FDA removes restrictions:

- No more “DATA waiver”
- Only need DEA Rx license
- No limits or caps on patients

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Medically Supervised Withdrawal "Opioid Acute Detoxification"

- Low rates of retention in treatment
- High rates of relapse post-treatment
  - < 50% abstinent at 6 months
  - < 15% abstinent at 12 months

O'Connor PG. *JAMA*. 2005.
Mattick RP, Hall WD. *Lancet*. 1996.
Stimmel B et al. *JAMA*. 1977.

- "Detox" is not treatment, it is just the start of abstinence
- Increased rates of overdose due to decreased tolerance

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Reasons for Relapse

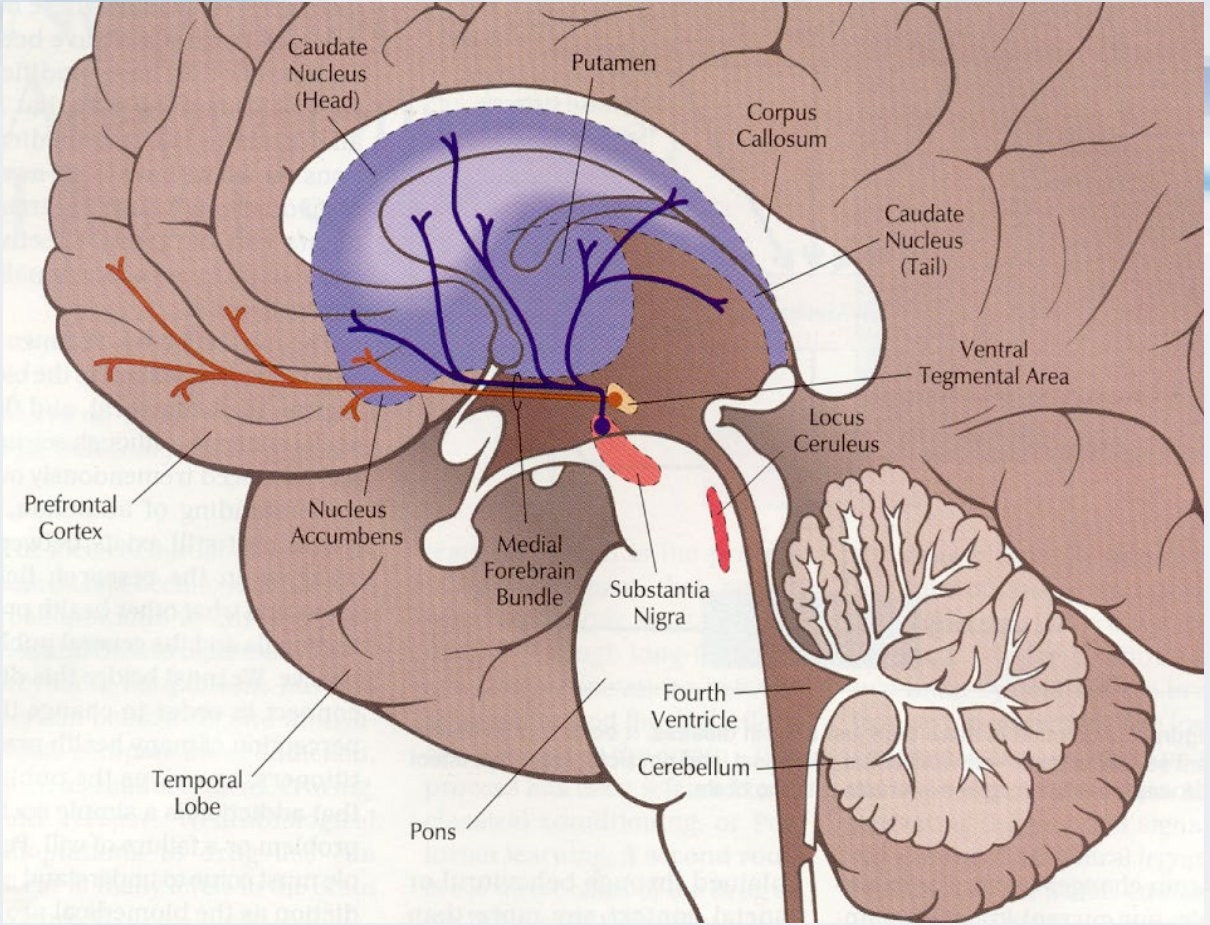
- **Protracted abstinence syndrome (chronic withdrawal)**
  - Generalized malaise, fatigue, insomnia
  - Poor tolerance to stress and pain (artificially lowered threshold)
  - ↑ Opioid craving
- **Conditioned cues (triggers)**
- **Priming with small dose of drug**

Kleber H et al. *Dialogues Clin Neurosci*. 2007.

Opiate Reward Reinforcement

Reward/Reinforcement is in part controlled by mu receptors in the <u>Reward Pathway</u>:

- Ventral Tegmental Area (VTA)
- Nucleus Accumbens with projections to Prefrontal Cortex
- Dopaminergic system



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DSM 5 Opioid Use Disorders[1]

1. Tolerance[2]
2. Withdrawal[2]

Loss of Control

3. Larger amounts and/or longer periods
4. Inability to cut down on or control use
5. Increased time spent obtaining, using or recovering
6. Craving/Compulsion

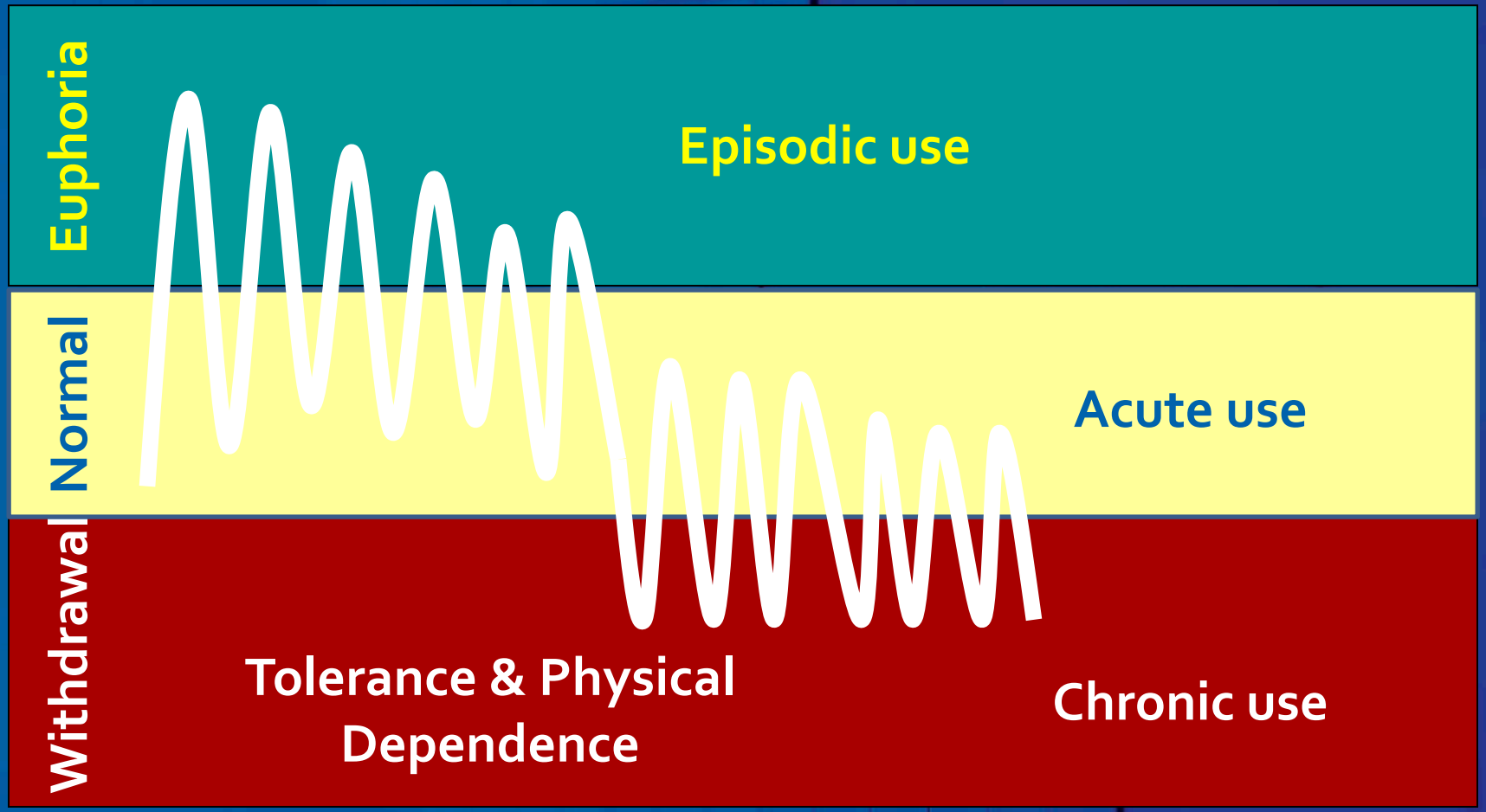
Use Despite Negative Consequences

7. Role failure, work, home, school
8. Social, interpersonal problems
9. Reducing social, work, recreational activity
10. Physical hazards
11. Physical or psychological harm

[1] Mild (2-3), F11.10
moderate (4-5), severe (≥6) F11.20
[2] Not valid if opioid taken as prescribed
ICD-10 F11.929 *(eg. Chronic pain)*

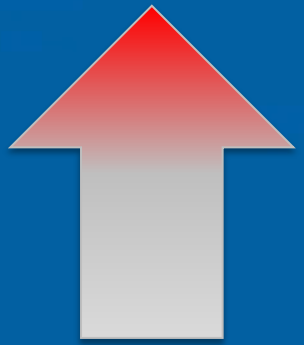
APA (2013) *Diagnostic and statistical manual of mental disorders* (5th ed.)

Natural History of Opioid Use Disorder



Opioid Tolerance & Physical Dependence

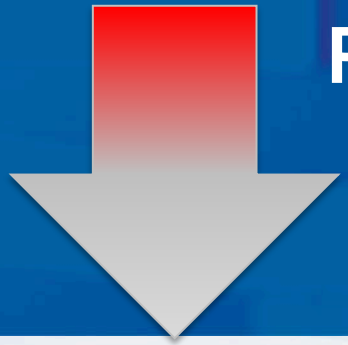
Both tolerance and physical dependence are physiological adaptations to chronic opioid exposure



Tolerance:

Increased dosage needed to produce specific effect

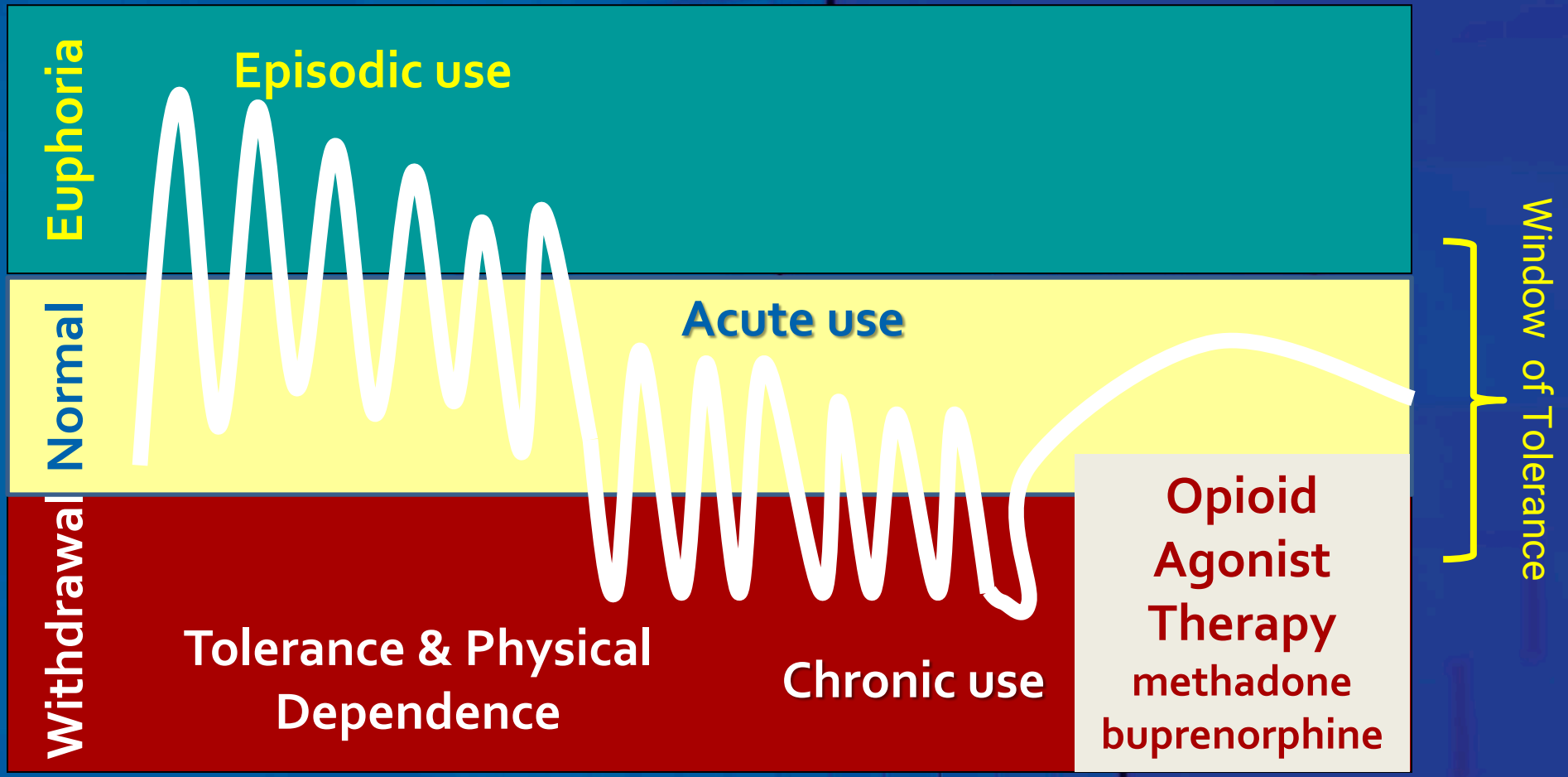
Develops rapidly for CNS and respiratory depression



Physical Dependence:

Signs and symptoms of withdrawal by abrupt opioid cessation, rapid dose reduction

Treatment of Opioid Use Disorder w Medication



COWS: Clinical Opioid Withdrawal Scale

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____
Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal	

https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

Medications to Treat Opioid Use Disorder

- **Goals**
  - Alleviate signs/symptoms of physical withdrawal
  - Opioid receptor blockade
  - Diminish and alleviate drug craving
  - Normalize and stabilize perturbed brain neurochemistry
- **Options**
  - **Opioid Antagonist**
    - **Naltrexone** (full opioid antagonist)
  - **Opioid Agonist**
    - **Methadone** (full opioid agonist)
    - **Buprenorphine** (partial opioid agonist)

Primary goal… **keep them alive!**

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Let's examine our biases…

Do you believe that a person on long-term opioid maintenance therapy with methadone, buprenorphine or suboxone can be considered "in recovery"?

(a) no, they are still taking an addictive substance

(b) yes, as long as they're taking it only as prescribed

(c) only if they no longer exhibit the other symptoms of SUDs except tolerance & withdrawal

…we all have 'em, you know!

Buprenorphine Treatment: The Myths and The Facts

NIDA National Institute on Drug Abuse

SAMHSA A Life in the Community for Everyone

ATTC Unifying science, education and services to transform lives.

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Drug*	Medication
The motivation to use a drug is a brain reward (euphoria, or getting high).	The motivation to use medication is to prevent and treat an illness.
The pattern of using drugs is marked by dosages and methods of administration—such as injection or smoking—that create spikes and slumps in the drug's concentration in a person's blood. The dosage escalates and the drug is administered more frequently.	The pattern of using medication is marked by dosages, dosing schedules, and methods of administration that produce steady concentrations of the drug in a person's blood.
Drug use is characterized by self-monitoring, a progressive loss of control, and secrecy and dishonesty.	Control and monitoring of medication is maintained via open, honest communication with physicians and family members.
The net effect of drug use is a progressive deterioration in the quality of life.	The net effect of medication use is a progressive improvement in the quality of life.
Drug use (other than alcohol use by adults) often involves breaking the law.	Medication is taken within laws that govern its manufacture, sale, possession, and use.
Drug use is often accompanied by other self-destructive and socially harmful behaviors.	Medication use is often accompanied by other health-promoting and recovery-enhancing behaviors.
Drug use often occurs within a drug-saturated social network.	Medication use occurs within a pro-recovery social network.

"Isn't this just another drug?"

MYTH #1: Patients are still addicted

FACT: Addiction is ***pathologic*** use of a substance and ***may*** or ***may not*** include physical dependence.

- ✓ Physical dependence on a medication for treatment of a medical problem ***does not*** mean the person is engaging in pathologic use and other dysfunctional behaviors.

MYTH #2: Buprenorphine is simply a substitute for heroin or other opioids

FACT: Buprenorphine ***is*** a replacement medication; it is ***not simply*** a substitute

- ✓ Buprenorphine is a legally prescribed medication, not illegally obtained.
- ✓ Buprenorphine is a medication taken sublingually, a very safe route of administration.
- ✓ Buprenorphine allows the person to function normally.

MYTH #3: Providing medication alone is sufficient treatment for opioid addiction

FACT: Buprenorphine is an important treatment option. However, the ***complete*** treatment package must include other elements, as well.

- ✓ Combining pharmacotherapy with counseling and other ancillary services increases the likelihood of success.

MYTH #4: Patients are still getting high

FACT: When taken sublingually, buprenorphine is slower acting, and does not provide the same "rush" as heroin.

- ✓ Buprenorphine has a ceiling effect resulting in lowered experience of the euphoria felt at higher doses.

Buprenorphine Efficacy Summary

- Studies (RCT) show buprenorphine more effective than placebo and equally effective to moderate doses (80 mg) of methadone on primary outcomes of:
  - Abstinence from illicit opioid use
  - Retention in treatment
  - Decreased opioid craving
  - Accidental overdose

Bottom line:

we can't get 'em sober if they're dead!

Johnson et al. *NEJM.* 2000. Fudala PJ et al. *NEJM.* 2003. Kakko J et al. *Lancet.* 2003.

Oral Naltrexone Efficacy (opioid MAT)

- Oral naltrexone
  - Duration of action 24-48 hours
  - FDA approved 1984
    - 10 RCTs ~700 participants to naltrexone alone or with psychosocial therapy compared with psychosocial therapy alone or placebo
    - No clear benefit in treatment retention or relapse at follow up
  - Most benefit in highly motivated patients
    - Impaired physicians > 80% abstinence at 18 months
    - Close monitoring and frequent Urine drug screens
    - MUCH better research outcomes for alcohol

Cochrane Database of Systematic Reviews 2006

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Buprenorphine Formulations

- **Sublingual forms** (tablets and films)
  - **"Combo"** (buprenorphine/naloxone)
  - **"Mono"** (buprenorphine only)
    - Approved for moderate to severe Opioid Use Disorders
    - Can be used **OFF LABEL** for pain

- **Parenteral** and **transdermal** patch forms
  - Approved for pain but **NOT** OUDs
  - **Can not be used OFF LABEL** for OUDs

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Purpose of Naloxone in "combo"

- Naloxone has limited bio-availability by mouth or sublingual, but is active parenterally (e.g. injected subcutaneous, IM or IV)
- The combo product, if crushed, dissolved and injected:
  - naloxone may cause initial withdrawal if the person is physically opioid - dependent.
  - naloxone will block, or attenuate, the opioid agonist effect of the buprenorphine
  - therefore safer if diverted, and
  - decreasing diversion and misuse

Comer S. *Addiction*. 2010.

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Buprenorphine/Naloxone Bioavailability

- If dissolved sublingually
  - Buprenorphine is active
  - Naloxone is not active
- If swallowed
  - Buprenorphine not active (minimal oral bioavailability)
  - Naloxone not active
- If injected
  - Buprenorphine active, but
  - Naloxone active x 20 minutes so attenuates the parenteral "rush"
- Not time-released so tablets/film strip can be split

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Buprenorphine Safety

- **Highly safe medication**
  - for both acute and chronic dosing
- **Primary side effects:**
  - nausea and constipation *(like other mu agonist opioids, but may be less severe and more self-limiting)*
- **No evidence of significant disruption in cognitive or psycho-motor performance with buprenorphine maintenance**
- **No evidence of organ damage with long-term dosing of Buprenorphine "mono" or "combo"**

Abuse Potential of Buprenorphine

- Euphoria in non-opioid dependent individuals
- Abuse potential less than full opioid agonists
- Abuse among opioid-dependent individuals is relatively low
- Combination product theoretically less likely to be abused by IV route
- Most illicit use is to prevent or treat withdrawal and cravings

Yokel MA et al. *Curr Drug Abuse Rev.* 2011. Lofwall MR, Walsh SL. *J Addic Med.* 2014.

Be careful of concurrent sedative-hypnotics!

Use or abuse of alcohol and other sedative-hypnotics are relative contraindications to buprenorphine

- Deaths have resulted from injecting buprenorphine and benzodiazepines
- Avoid alcohol while taking buprenorphine to avoid overdose

Identify and refer patients who are willing and able to undergo medically supervised withdrawal management from alcohol, benzodiazepines, or other sedatives

Fishman et al. 2005; McNicholas, 2008; Lavie et al. 2005.

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All best practices require frequent Urine Drug Screening for compliance & detecting diversion

Drug/Medication	Primary Metabolite	Ave. Detection Time (days)
Opiates (heroin, morphine)	Morphine	2-3
Semisynthetic Opioids (oxycodone, hydrocodone)	Variable Must be tested specifically	2-3
Methadone	EDDP	2-3
Buprenorphine	Nor-buprenorphine	2-3
Cocaine	benzoylecgonine	2-3
Amphetamines		2-3
Benzodiazepine	Varies by medication type	Variable with half life Unreliable immunoassays
Marijuana Occasional Marijuana Chronic	THC	1-3 Up to 30

Long-Acting Buprenorphine Injections

Who is most appropriate for XR-buprenorphine? Patients appropriate for XR-buprenorphine are adults who have initiated treatment with a transmucosal buprenorphine-containing product delivering the equivalent of 8 to 24mg of buprenorphine daily. The patient may be transitioned to XR-buprenorphine only after a minimum of 7 days on transmucosal buprenorphine. Patients and providers may opt for XR-buprenorphine for a variety of reasons, including but not limited to:

- Convenience of not having to carry and self-administer a medication daily;
- Difficulty taking a medication daily on a consistent basis;
- Patient concern that resuming use may be easier or more tempting if relying on the need to take a medication daily;
- Patient preference, eg Inability to tolerate transmucosal formulations because of side effects such as nausea;
- Current living environment impedes safe storage of controlled substances. For example, living in a shelter that is unable to store medications safely, living on the street, or having minors in the home where there is a concern about medication access/safety.

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Long-Acting Buprenorphine Injection *(approved 2017)*

What is long-acting (XR) buprenorphine injection? Long-acting buprenorphine injection (XR-buprenorphine, currently available brand name: Sublocade) is an injectable formulation of buprenorphine that is given once a month to assist people in obtaining and sustaining long-term recovery from opioid use disorder (OUD).

There may be additional XR * buprenorphine brands approved in the future and this guidance will be updated accordingly. XR buprenorphine is one of several options for medication for addiction treatment (MAT) for OUD.

* Brixadi *(2023)*

Sublocade – monthly dosing

- Indicated for moderate-to-severe opioid use disorder (OUD) in adults who have initiated treatment with a transmucosal buprenorphine-containing product and have been on a stable dose of transmucosal buprenorphine treatment for ≥7 days
- Prescribe as part of a complete treatment plan that includes counseling and psychosocial support
- 300 mg SC once monthly for the first 2 months, followed by a maintenance dose of 100 mg/month
- May increase maintenance dose to 300 mg monthly if 100-mg dose tolerated, but do not demonstrate a satisfactory clinical response, as evidenced by self-reported illicit opioid use or urine drug screens positive for illicit opioid use

Long-Acting Buprenorphine Injection *(approved 2023)*

Brixadi – weekly or monthly dosing

- Indicated for moderate-to-severe OUD in adults who have initiated treatment with a single dose of a transmucosal buprenorphine product or who are already being treated with buprenorphine
- Not currently receiving buprenorphine treatment
    - Recommended weekly target dose: 24 mg SC q7days
    - Titrate up over first week as follows
    - To avoid precipitating an opioid withdrawal syndrome, administer a test dose of transmucosal buprenorphine 4 mg when objective signs of mild to moderate withdrawal appear
    - If dose of transmucosal buprenorphine is tolerated without precipitated withdrawal, administer first dose of Brixadi (weekly) 16 mg SC
    - Administer an additional dose of 8 mg Brixadi (weekly) within 3 days of the first dose to achieve the recommended 24-mg (weekly) dose
    - If needed, during this first week of treatment, administer an additional 8 mg dose, waiting at least 24 hr after previous injection, for a total weekly dose of 32 mg
    - Administer subsequent weekly injections based on the total weekly dose that was established during Week 1
    - Dosage adjustments can be made at weekly appointments
    - Maximum weekly dose is 32 mg

Injectable Naltrexone - Vivitrol®

- Multicenter (13 sites in Russia) Funded by Alkermes
- DB RPCT, 24 wks, n=250 w/ opioid dependence
- XR-NTX vs placebo, all offered biweekly individual drug counseling
- Increased weeks of confirmed abstinence (90% vs 35%)
- Increased patients with confirmed abstinence (36% vs 23%)
- Decreased craving (-10 vs +0.7)

(No Black Box LFTs Warning Label for IM formulation)

Krupitsky E et al. *Lancet*. 2011.

Checking my bias…

As a Counselor, how comfortable would you be in treating patients on MAT?

(a) I am pretty confident in my ability to counsel MAT clients
(b) I'm willing, but I need to get more education and training on medications
(c) I don't feel comfortable myself, but I'm not opposed to MAT
(d) I'm opposed to MAT for most clients

The “Bible”

The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

AKA: The ASAM National Practice Guideline

1st to include all FDA-approved medications in single document

https://eguideline.guidelinecentral.com/i/1224390-national-practice-guideline-for-the-treatment-of-opioid-use-disorder

NEW – revised 2020

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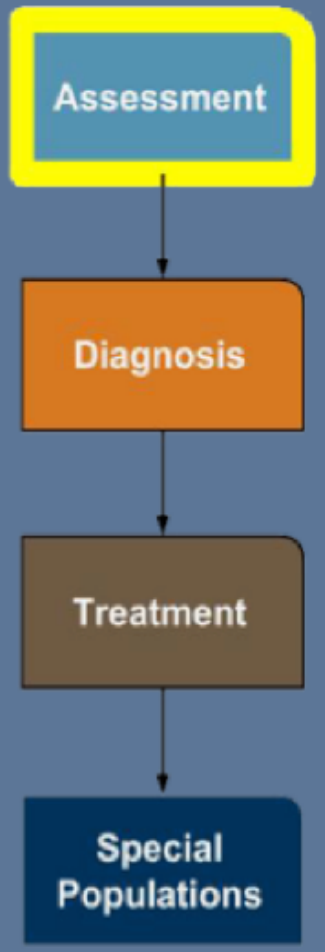

Before you begin… what are your biases?

ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

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BIOPSYCHOSOCIAL ASSESSMENT

- **Identify and refer any acute medical or psychiatric needs**
  - Physical exam & labs – LFTs, Hepatitis, HI V etc.
  - Pregnancy test & contraception queries
- **Full Mental Health assessment** *(incl. ACEs)*
- **Evaluation of past & present Substance Use**
  - Poor prognosis if used with other substances
  - Tobacco use & cessation counseling
- **Social & environmental factors**
  - Social determinants of health

Diagnosis

- Provider confirms OUD diagnosis
- History & physical exam
- Scales measure OUD withdrawal symptoms
- Frequency of urine drug testing determined

Absolutely essential!

Treatment Setting

- Clinician & patient share treatment option decisions
- Consider patient preferences & treatment history & setting to determine medication
- Venue as important as medication selected
- Office treatment may not be suitable for patients with selected drug addiction issues
- OTPs offer daily dosing and supervision

Assess for acuity, length of use and community supports

Opioid Withdrawal Management (cont'd)

- Buprenorphine can be used to manage withdrawal symptoms
- Combination buprenorphine & low dose oral naltrexone to manage withdrawal & facilitate ER injectable naltrexone shows promise
- Clonidine to support opioid withdrawal
- Anesthesia ultra-rapid opioid detoxification (UROD) is NOT recommended - too high risk
- Increased risk of OD or death with stopping agonist therapy & resuming opioid use

Warn especially about the latter – the cause of most OD deaths during relapse

Buprenorphine + Naloxone

- Reduce buprenorphine diversion
- Frequent urine drug tests (including buprenorphine)
- Frequent visits until stable
- If/when taper, should be slow & monitored
- 7-14 days between buprenorphine to naltrexone
- Buprenorphine to methadone no time delay
- No recommended time limit for treatment

Brand names:

Pills – Subutex®

Films – Suboxone®

(all available as generic)

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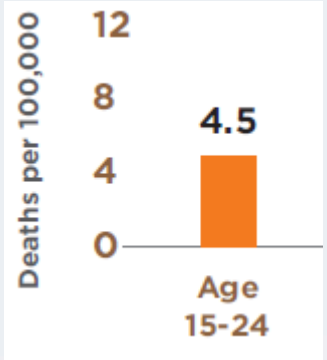
ASAM National Practice Guideline

Opioid-Addicted Adolescents and Young Adults

Current treatment options for opioid-addicted adolescents and young adults are often unavailable and when found, clinicians report that the outcome leaves much to be desired.

States have different requirement for admitting clients under age 18 to addictions treatment. It is important to know the your local requirements.



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Opioid-Addicted Adolescents and Young Adults

Buprenorphine is FDA approved for use with opioid dependent persons age 16 and older

Research conducted through the NIDA Clinical Trials Network (CTN 010) demonstrated that it can be safely and effectively used with young adults.

This research also indicated that medical treatment likely needs to be longer than current standard treatment indicates.

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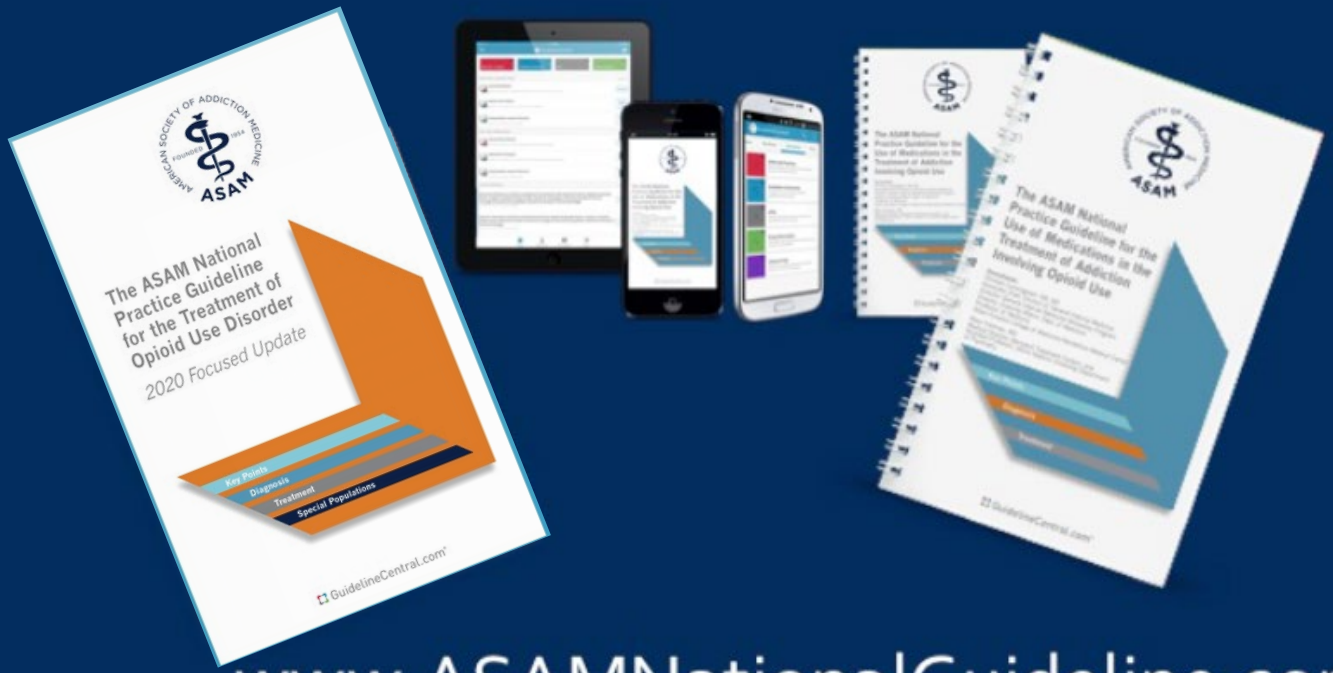
Use of Pharmacologic Treatment with Adolescents

- Pharmacologic therapy is recommended for all adolescents with severe opioid use disorder
- Buprenorphine is considered first line treatment
  - Most methadone clinics cannot admit patients under 18 years old, though methadone may be a good option for young adults with unstable living arrangements as daily visits provide structure and eliminate the need to manage medications at home
  - Naltrexone is also an option for adolescents and also may be clinically useful for adolescents/young adults living away from home, or patients with co-occurring alcohol use disorders

How To Get More Information



www.ASAMNationalGuideline.com

https://eguideline.guidelinecentral.com/i/1224390-national-practice-guideline-for-the-treatment-of-opioid-use-disorder

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It’s not just opioids!

Tobacco

Cigarette smoking is more common among AI/AN than almost any other racial/ethnic group in the United States.

- ***More than 1 in 5 (22.6%) AI/AN adults smokes cigarettes***
- Smoking increases the chances of losing members from your tribal community to smoking-related illnesses
- It increases the chances of losing elders to smoking-related diseases or exposure to secondhand smoke before they can pass down tribal customs and traditions

Psychostimulants

Methamphetamine use in AIAN communities has also increased as a greater number of AIANs report that this is their drug of choice [5]. ***AIANs reported using methamphetamine at higher rates than heroin, marijuana, cocaine, and other drugs*** [6]. A more recent study found that approximately 15% of AIANs reported lifetime use of stimulants such as cocaine and methamphetamines [7].

Alcohol

The alcohol-involved death rate among AIANs was five times higher than that in the general population, at 50.5 deaths and 10.4 deaths per 1,000,000, respectively [3]. Moreover, this rate was 64% higher than it was in 2006, when the rate was 30.8 deaths per 100,000 [3].

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8910676/

Methamphetamine Misuse…

…because most persons with opioid abuse misuse other drugs as well!

The National Institute of Drug Abuse (NIDA) established the Methamphetamine Clinical Trials Group (MCTG) to conduct studies of medications for methamphetamine.

Paxil (Paroxetine or Pexeva)
Modafinil (Provigil®)
Mirtazapine (Remeron)
Naltrexone (ReVia® Vivitrol®)

www.addictionrecoveryguide.org/medication/methamphetamine

Source: University of California - Los Angeles May 19, 2015
Summary: The first study in the United States of Naltrexone's effect on methamphetamine users has found that this medication, approved by the US Food and Drug Administration for the treatment of alcoholism, is potentially a very promising treatment for methamphetamine addiction, researchers report.

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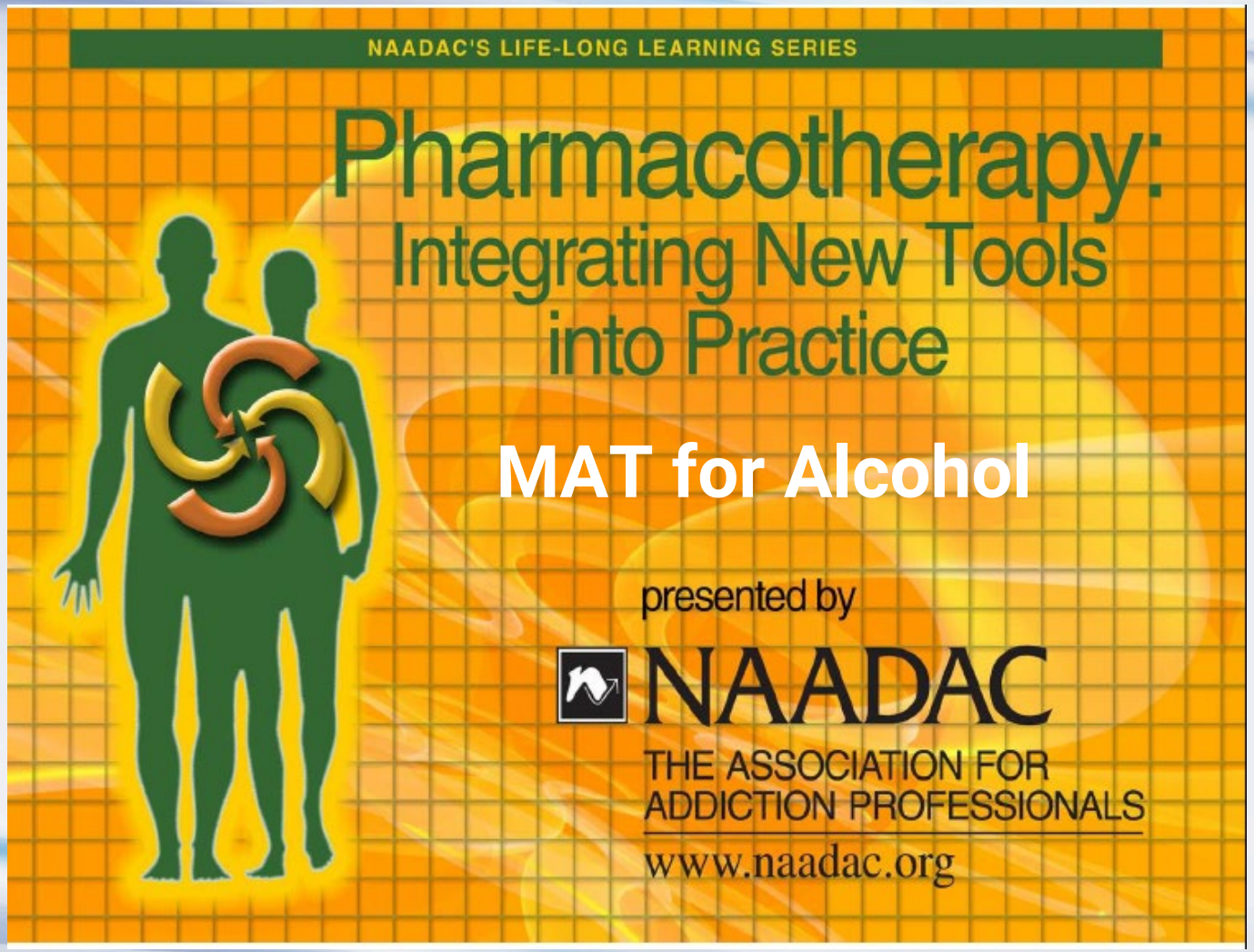
NOTE: these are considered "off-label" uses

Medication-Assisted Treatment for Nicotine

There are two quit-smoking medicines approved by the U.S. Food and Drug Administration that are pills: bupropion and varenicline.

- Bupropion (Zyban®) has many effects on the brain, including helping people quit smoking. It decreases craving and other nicotine withdrawal symptoms.
- Varenicline (Chantix®) lessens the pleasure from tobacco and reduces symptoms of withdrawal.
- Nicotine Replacement Therapy (NRT) with patch, gum or lozenges is an intermediate step in quitting tobacco.



Medications approved to support abstinence from alcohol

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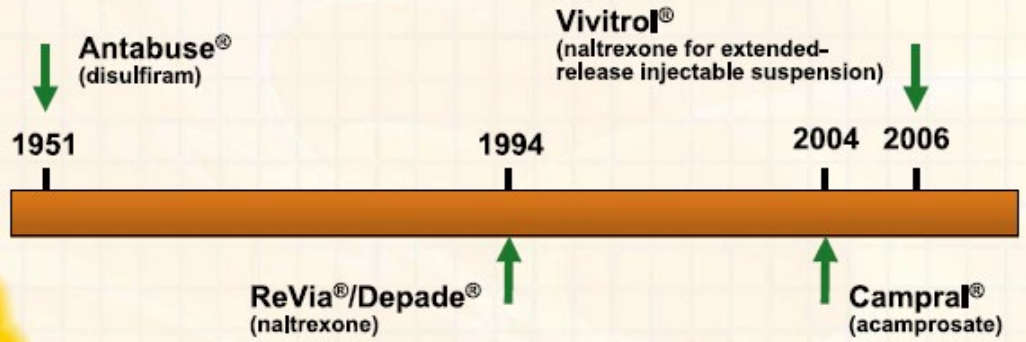
Pharmacotherapies for Alcohol Dependence

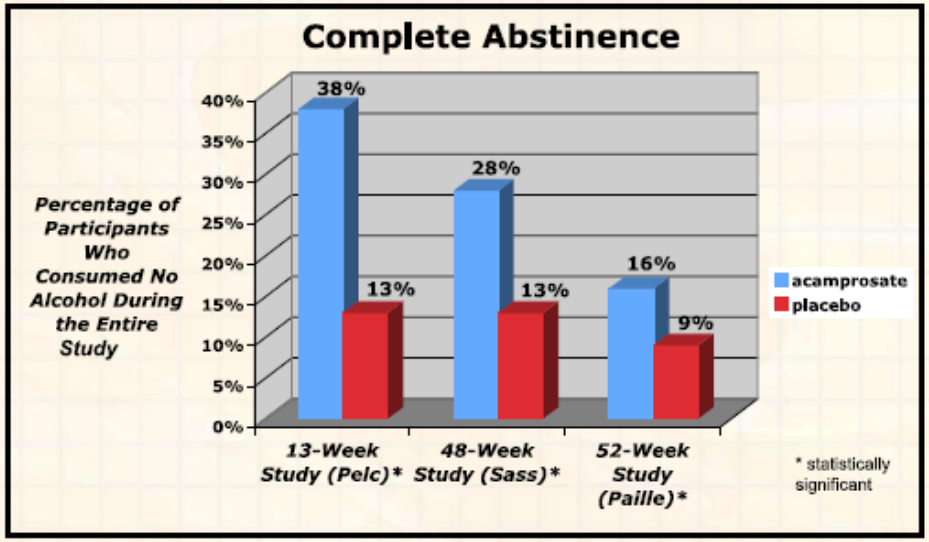
slide 87 - not in manual

There are currently four FDA-approved pharmacotherapies for alcohol dependence.



Scientific Research about Acamprosate (cont.)

Results: In all three studies, participants treated with acamprosate were able to maintain complete abstinence more frequently than those treated with placebo.[54]



Campral® *is very effective… however, compliance issues with 3x/day dosing*

Disulfiram or Antabuse

Disulfiram General Facts[61]

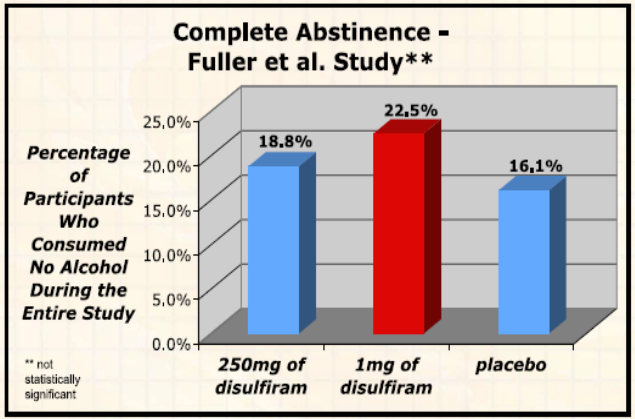
(information from medication package insert) slide 112 - page 75

- Generic Name:
  disulfiram
- Marketed As:
  Antabuse®
- Purpose:
  Discourages drinking by making the patient physically sick when alcohol is consumed.
- Indication:
  An aid in the management of selected chronic alcohol patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage.
- Year of FDA-Approval: 1951

Scientific Research about Disulfiram (cont.)

slide 126 - page 84

Results: Participants treated with disulfiram did not maintain complete abstinence more frequently than those treated with placebo.[66]



Naltrexone General Facts[68]

(information from medication package insert)

slide 133 - page 89

- Generic Name:
  naltrexone hydrochloride

- Marketed As:
  ReVia® and Depade®

- Purpose:
  To discourage drinking by decreasing the pleasurable effects experienced by consuming alcohol.

- Indication:
  In the treatment of alcohol dependence and for the blockade of the effects of exogenous administered opioids.

- Year of FDA-Approval: 1994

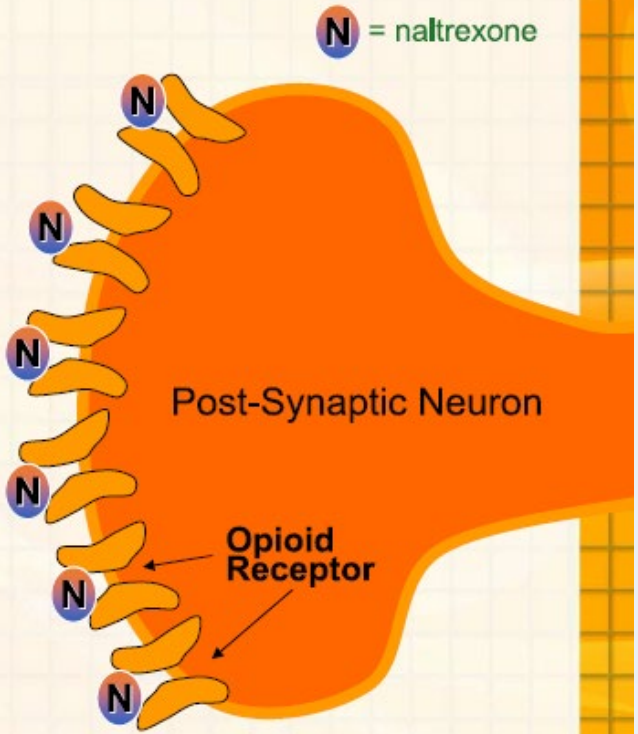
NOTE:
much better compliance in outpatient settings for alcohol than opioids

How Does Naltrexone Work? (cont.)[70]

slide 139 - page 92

Naltrexone is an opioid receptor antagonist and blocks opioid receptors.

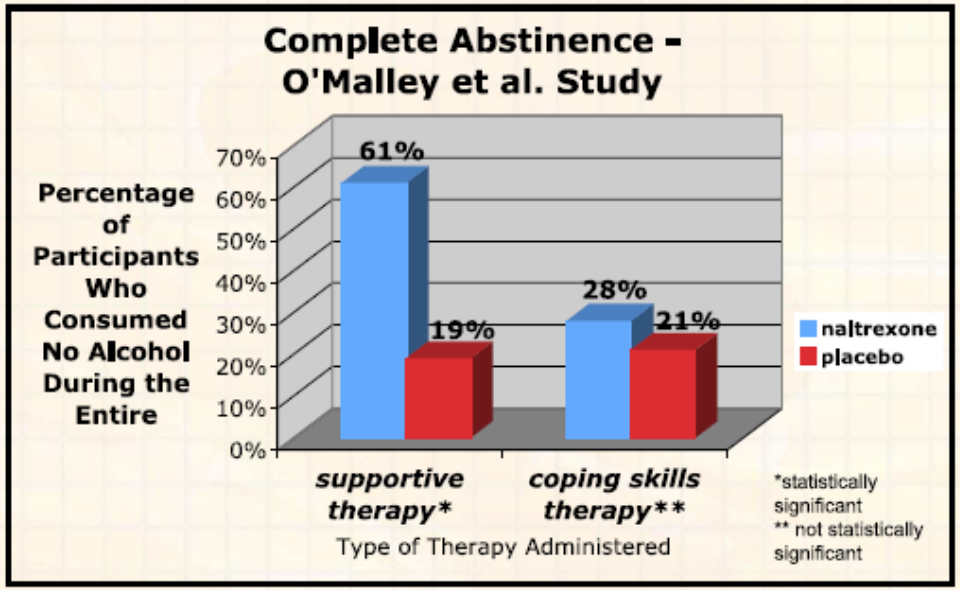
By blocking opioid receptors, the "reward" and acute reinforcing effects from dopamine are diminished, and alcohol consumption is reduced.



Naltrexone blocks the "buzz" … but NOT the hangover!

Scientific Research for Naltrexone (cont.)

Results: In some instances, participants treated with naltrexone were able to maintain complete abstinence more frequently than those treated with placebo.[74]



Extended-Release Naltrexone General Facts[76]

(information from medication package insert)

slide 154 - page 103

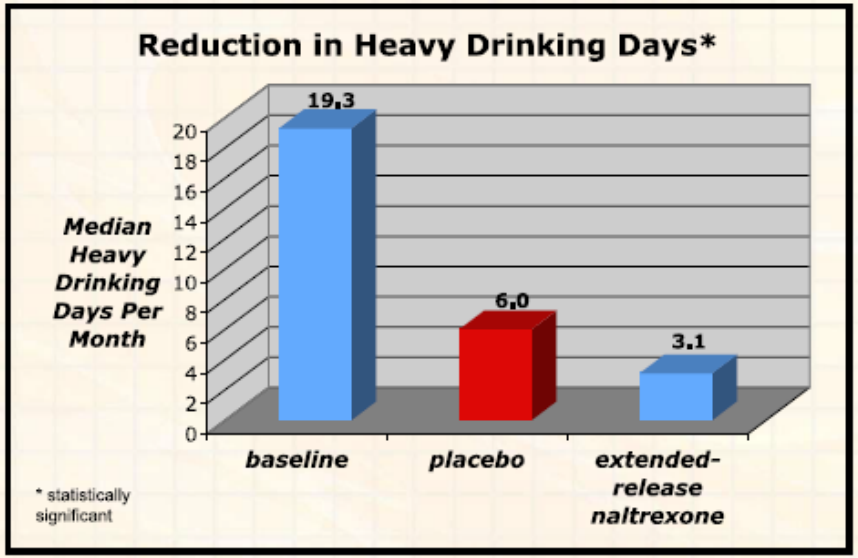
- Generic Name:
  naltrexone for extended-release injectable suspension
- Marketed As:
  Vivitrol®

- Purpose:
  To discourage drinking by decreasing the pleasurable effects experienced by consuming alcohol.
- Indication:
  For the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment.
- Year of FDA-Approval: 2006

Vastly preferable to oral formulation for prevent-ing relapse

Scientific Research about Extended-Release Naltrexone (cont.)

Results: Participants treated with extended-release naltrexone had a greater reduction in the number of heavy drinking days during the entire study than those treated with placebo.[83]



BUPRENORPHINE TREATMENT:

A Training For Multidisciplinary Addiction Professionals

Module VI:

Counseling Buprenorphine Patients

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Counseling Buprenorphine Patients

Counselor Responses:

- Be flexible
- Don’t impose high expectations
- Don’t confront
- Be non-judgmental
- Use a motivational interviewing approach
- Provide support & reinforcement

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Counseling Buprenorphine Patients

Stress the necessity of counseling along with medication for recovery.

Recovery and Pharmacotherapy:

- Patients may have ambivalence regarding medication.
- The recovery community may ostracize patients taking medication.
- Counselors need to be aware of their biases, have accurate information and appropriate training

Patient Management Issues

Medication alone is insufficient to treat drug addiction.

Prescribing Providers are responsible for providing or referring patients to counseling.

Contingencies should be established & agreed for patients who fail to follow through on referrals.

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Patient Management: Treatment Monitoring

Goals for treatment should include:

No illicit opioid drug use

No other drug use or diversion

Absence of adverse medical effects

Absence of adverse behavioral effects

Responsible handling of medication

Adherence to treatment plan

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Issues in 12-Step Meetings:

- Medication and the 12-Step programs
  - Program policy
    - "The AA Member: Medications and Other Drugs"
      - "We are not Doctors"
    - NA: "The ultimate responsibility for making medical decisions rests with each individual"
- Some meetings are more accepting of medications than others

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Counseling Buprenorphine Patients

A Motivational Interviewing Approach:

- Dealing with other drugs and alcohol
- Doing more than not-using

MIA-STEP

- Developed through the Blending Initiative
- Empirically supported mentoring products to enhance the MI skills of treatment providers
- Provides tools to help supervisors offer structured, focused, and effective supervision.
- The blending products are available at

www.drugabuse.gov/Blending www.attcnetwork.org

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Using Motivational Incentives

NIDA CTN research shows that treatment retention and drug abstinence are improved by providing low-cost reinforcement (prizes, vouchers, clinic privileges, etc.), for drug negative urine tests.

The Blending Product Promoting Awareness of Motivational Incentives (PAMI) provides information on this effective technique.

The blending products are available at:
www.drugabuse.gov/Blending www.attcnetwork.org

How Long Should Buprenorphine Maintenance Continue?

- No data to provide guidance on how long to treat a patient with buprenorphine/naloxone maintenance
- Studies as long as 16 weeks show high relapse rates with medical withdrawal ***only*** (Weiss et al., 2011)
- Patients can be retained long term; showed approximately 75% retention at one year with maintenance (Kakko et al., 2003)
- Continue maintenance as long as patient is benefitting from treatment (no opioid/other drug use, employment, educational goals pursued, improvement in relationships, improvement in medical/mental illnesses, engaged in psychosocial treatment)

Counseling Buprenorphine Patients

Relapse Prevention: Sample Topics

Dangerous Emotions

Loneliness, anger, deprivation

Be Smart, not Strong

Avoid the dangerous people and places

Don’t rely on will power

Avoiding Relapse Drift

Identify “mooring lines”

Monitor drift

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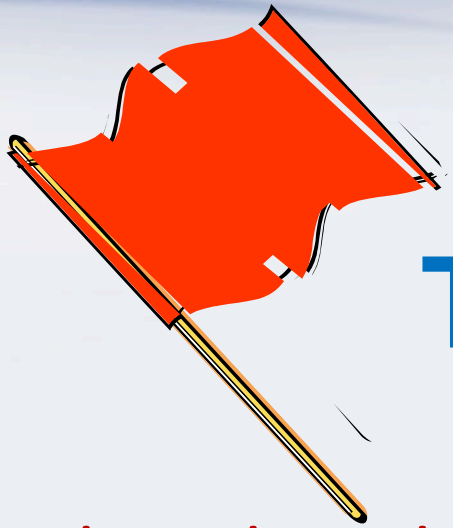

Trigger

A trigger is a stimulus which has been repeatedly associated with the preparation for, anticipation of, or use of drugs and/or alcohol. These stimuli include people, things, places, times of day, and emotional states.

(Center for Substance Abuse Treatment, 2006)

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Issues in Recovery: Craving

A strong desire for something – limbic activation of "acquired drive state"

Does not always occur in a straightforward way

It takes effort to identify and stop a drug-use related thought.

The further the thoughts are allowed to go, the more likely the individual is to use drugs.

(Center for Substance Abuse Treatment, 2006)

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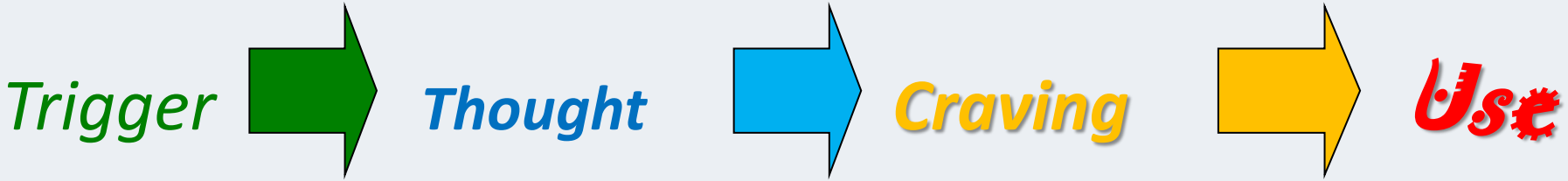
Triggers & Cravings

During addiction, triggers, thoughts, and craving can run together. The usual sequence, however, is as follows:



The key to dealing with this process is to not allow for it to start. Stopping the thought when it first begins helps prevent it from building into a craving.

(Center for Substance Abuse Treatment, 2006)

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In another group we learned about the "trigger → thought → craving → use" cycle. Let's take a little deeper look at that relapse process. It's important to realize that *relapse risk can begin in any one of the stages.* So we need to have something in place in each stage BEFORE the problem hits!

What is one TRIGGER that could start the ball rolling? _____

_____

How can you AVOID that trigger ? _____

_____

If you did make a choice to USE, how can you stop the cycle before it picks up speed?

_____

_____

_____

_____

Remember 2 things:

(1) You always need to have enough recovery "in the bank" to cover a "relapse check" if it comes in

(2) It's never the car you SEE that runs you over…

What is one THOUGHT that could start the ball rolling? _____

_____

What could you think INSTEAD? _____

_____

_____

How do you feel when you're having a drug CRAVING? _____

_____

How can you manage that FEELING without using? _____

_____

9/2014mgb

However, the relapse process isn't always linear! It can start anywhere

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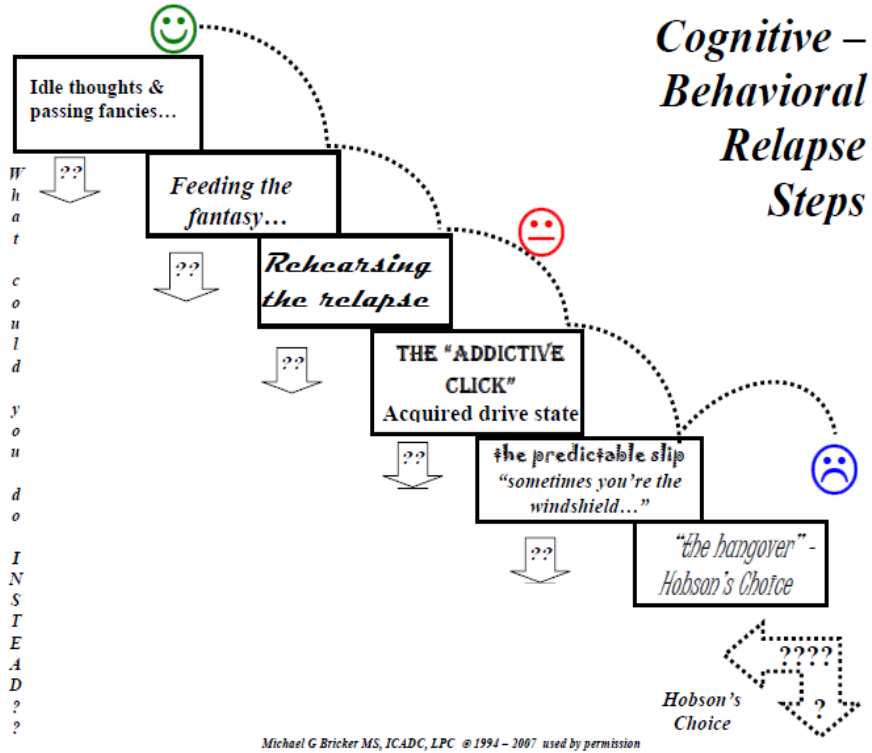
Often, relapse can start innocently enough…



Cognitive –Behavioral Relapse Process

Stages of Relapse	How do you do it?	What could you do instead?
1. "Fleeting thoughts & passing fancies"	*Give some examples:*	
2. **Feeding the fantasy: "an idle mind…"** *(remembering the "good times", cognitive distortions, control fantasies – "this time it'll be different", "mental masturbation", stinking thinking & poor me-ism)*	*What's YOUR fantasy?*	
3. **Relapse rehearsal & option reduction:** *(We begin acting out the fantasies – setting ourselves up with old behaviors, resentments, withdrawing from support, etc.)*	*How can you recognize your excuses?*	
4. **The "addictive click" – the acquired drive state:** *(Now we're "jonesing" – the monkey is looking for the car keys!)*	*How do you know when you're on the edge?*	
5. **The slip everybody else saw coming** - *"Sometimes you're the windshield… sometimes you're the bug!"*	*What do you tell yourself to make it "OK?"*	
6. **The hangover, and Hobson's Choice:** *"Would you rather be shot or hung?"*	*Physiological after-effects; guilt, shame & remorse; discouragement, demoralization & distrust; waking up to discover that…*	*…now you've only got two choices – keep on going, or try to stop. Not a good place to be… so don't go there!*

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Native “Practice-Based Evidence” for MAT

- SAMHSA Tribal Opioid Response grants
- **‘To Walk in the Beauty Way’:** Treating Opioid Use Disorder in Native Communities
- **Centering Indigenous Knowledge, Culture and Communities:** Approaches to Indigenous Evaluation and Opioid Overdose Prevention Programming
- **California MAT Expansion Project**

Tribal Opioid Response Grants

The purpose of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Tribal Opioid Response Grant (TOR) is to address the opioid crisis in Tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication for the treatment of opioid use disorder (MOUD).

https://www.samhsa.gov/tribal-affairs/tribal-opioid-response-grants

Tribal Opioid Response Treatment & Prevention

Treatment

TOR grant recipients used funds to provide treatment at all levels of care and to fill gaps across the treatment continuum. Grantees implemented outpatient, intensive outpatient, and residential treatment; individual and group counseling; and case management and referrals to other needed services. Grant recipients were also permitted to provide financial assistance to under- or uninsured clients to access OUD treatment.

TOR recipients utilized evidence-based practices (EBPs) for the treatment of SUDs including:

- Screening, brief intervention, and referral to treatment
- Cognitive-behavioral therapy
- Dialectical behavioral therapy
- Motivational enhancement
- Motivational interviewing
- Contingency management
- Eye movement desensitization and reprocessing

Prevention

TOR grant recipients conducted a range of activities aimed at preventing opioid misuse and overdose, including activities for elders, youth, and other community members to receive positive messaging, education, and training to increase their knowledge of opioids and other drugs.

Grant recipients conducted prevention outreach and education efforts through in-person events, signs and billboards, social media, TV, radio, and other media.

TOR recipients used prevention EBPs to conduct outreach and education with schools, Tribal leaders, and community members, including:

- Red Cliff Wellness School Curriculum
- PAX Good Behavior Game
- Healthy Way of Living Model
- Hidden in Plain Sight
- Gathering of Native Americans (GONA)
- American Indian Life Skills curriculum

Cultural Practices

In recognition of ancestral cultural knowledge, wisdom, ceremony, and practices of American Indian and Alaska Native Tribes, TOR recipients were encouraged to incorporate traditional approaches into their grant activities.

Some common traditional practices included:

- Sweat lodges
- Talking circles
- Traditional healers
- GONAs
- Teaching traditional values
- Smudging
- Traditional dance
- Storytelling
- Teaching of herbs
- Drum ceremonies
- Spiritual practices and prayer
- Medicine wheel activities
- Traditional craft making
- Healing fires
- Pow wow camps
- Equine therapy
- Wilderness expeditions
- Teaching farming, hunting, and fishing skills

https://www.samhsa.gov/sites/default/files/tribal-opioid-response-fy21-program-profiles.pdf

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Opioid Misuse and Overdose Prevention in Native Communities

The opioid crisis is a fast-growing epidemic for American Indian/Alaska Native (AI/AN) populations. Tribes are addressing the crisis using legal, medical, cultural, and preventive measures. This fact sheet presents up-to-date prevention practices being implemented in AI/AN communities across the nation. The purpose of this information is to help Native Connections grantees in planning to address opioid misuse in their communities, based on community needs and readiness levels.

Tribal Prevention Practices to Address Opioid Misuse

Beyond building awareness, tribes are taking steps to help their members address the many issues raised by opioid misuse. Below is a list of prevention practices, recommended by experts and tribal leaders, being used across the country in Native communities.[1]

- ***Institute overdose protection programs.*** Raise community awareness on using life-saving drugs for opioid overdoses and for recovery from opioid addiction with involvement from medical providers, first responders, and law enforcement are effective strategies.[2]
- ***Strengthen culture.*** Methods for strengthening culture include a campaign to encourage participation in cultural activities, creating communal/community gathering spaces, promoting traditional foods with cooking and health education, and sponsoring sober community events and cultural ceremonies. Additionally, integrating ceremonies and language into everyday life strengthens culture, as do language immersion opportunities.
- ***Reach youth early.*** Research shows substance misuse rates for AI/AN youth are significantly higher than national averages. For example, binge drinking and OxyContin use among AI/AN youth start earlier than non-AI/AN youth.[3] Given

https://www.samhsa.gov/sites/default/files/nc-oy1-opioid-fact-sheet-final-2017-12-6.pdf

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National Indian Health Board

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BEHAVIORAL HEALTH

- Behavioral Health Alerts
- Current Behavioral Health Projects
- Tribal Opioid Response Resource Toolkit
- Public & Behavioral Health Toolkits
- Behavioral Health Resources & Links
- HIV in Indian Country
- Prescription Drug Abuse Prevention

Tribal Opioid Response Resource Toolkit

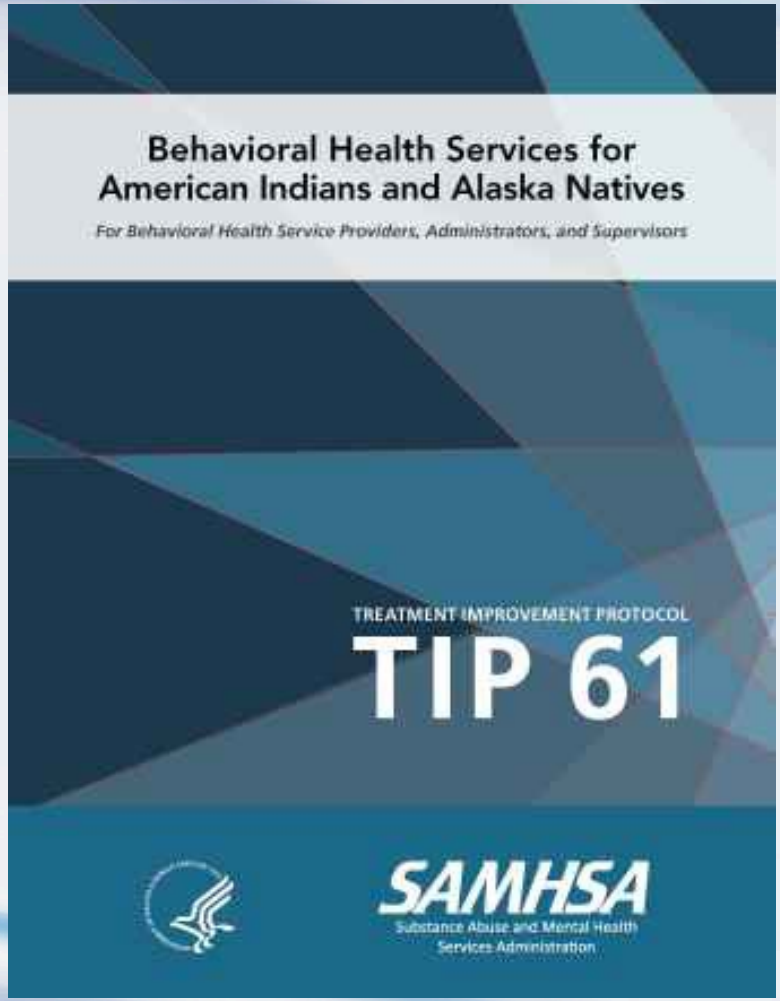
There has been a lot of attention and funding provided to the national opioid epidemic within recent years, especially the devastating impact it can have in Tribal communities. The collective intent of these funding opportunities is to reduce opioid related deaths in Tribal communities by implementing activities such as strategic plans, prevention and education medication assisted therapy, different forms of treatment, workforce development activities, community recovery support, and so forth. This Tribal Opioid Response Resource Toolkit provides an array of materials, tools, resources and links to support Tribes as they are working to combat the epidemic within their communities.

Culture & Health

- American Indian and Alaska Native Culture and Public Health Part I
- American Indian and Alaska Native Culture and Public Health Part IIa
- American Indian and Alaska Native Culture and Public Health Part IIb
- American Indian and Alaska Native Culture and Public Health Part IIc
- Culture and Public Health

Even if your Tribe doesn't have a Tribal Opioid Response grant, the resources are available

https://www.nihb.org/behavioral_health/tribal_opioid_response_resources.php



TIP 61 BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES

Executive Summary

For Behavioral Health Service Providers, Program Administrators, Clinical Supervisors, and Researchers

The Executive Summary of this **Treatment Improvement Protocol** summarizes substance use and mental illness among American Indians and Alaska Natives and discusses the importance of delivering culturally responsive, evidence-based services to address these behavioral health challenges.

TIP Navigation

Executive Summary
For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives
For behavioral health service providers

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives
For behavioral health service providers, program administrators, and clinical supervisors

Appendix and Index

Part 3: Literature Review
For behavioral health service providers, program administrators, clinical supervisors, and researchers

https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070

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SAMHSA Tribal Opioid Response Programs

TI-18-016: FY18 Tribal Opioid Response Grant (Short Title: TOR). The program aims to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication-assisted treatment (MAT) using one of the three FDA-approved medications for the treatment of opioid use disorder (OUD). The intent is to reduce unmet treatment need and opioid overdose related deaths through the provision of prevention, treatment and/or recovery activities for OUD. https://www.samhsa.gov/grants/grant-announcements/ti-18-016

TI-19-012: FY19 Tribal Opioid Response Grant (Short Title: TOR). The program aims to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication-assisted treatment (MAT) using one of the three FDA-approved medications for the treatment of opioid use disorder (OUD). The intent is to reduce unmet treatment need and opioid overdose-related deaths through the provision of prevention, treatment and/or recovery activities for OUD. https://www.samhsa.gov/grants/grant-announcements/ti-19-012

If you did not receive a TOR grant in 2018 and your tribe in not listed in Appendix K, you may apply for $50,000 (Appendix K).

SAMHSA

Tribal Opioid Response (TOR) Program

- The program aims to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication-assisted treatment (MAT) using one of the three FDA-approved medications for the treatment of opioid use disorder (OUD)
- The intent is to reduce unmet treatment need and opioid overdose-related deaths through the provision of prevention, treatment and/or recovery activities for OUD
- The program supplements current activities focused on reducing the impact of opioids and will contribute to a comprehensive response to the opioid epidemic

SAMHSA

National American Indian & Alaska Native
ATTC
Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

National American Indian and Alaska Native ATTC
Our National Center provides education and training opportunities for individuals and groups involved in providing substance abuse treatment and counseling, including health professionals in primary prevention and treatment for substance abuse. We are housed in the University of Iowa College of Public Health, but offer services nationwide for consulting, technical assistance, and continuing education seminars. We focus specifically on the American Indian and Alaska Native (AI & AN) communities.

Our mission is to strengthen and promote systematic behavioral health practice improvements for Native providers in order to honor and contribute to the health and well-being of tribal and urban Indian communities, as well as training non-Native providers using culturally informed practices so that communities have the resources to care for their people in the most culturally informed and knowledge – based way and Native providers can determine how to integrate western practices into their traditional methods.

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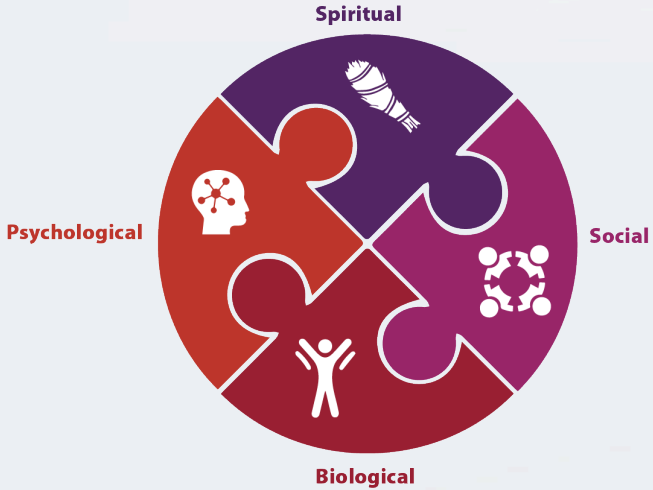
www.nihb.org/docs/04092020/SAMHSA%20Opioid%20Program%20Overview.pdf

‘To Walk in the Beauty Way’: Treating Opioid Use Disorder in Native Communities

Research explores the integration of medication-based treatment with the healing traditions of American Indian and Alaska Native communities

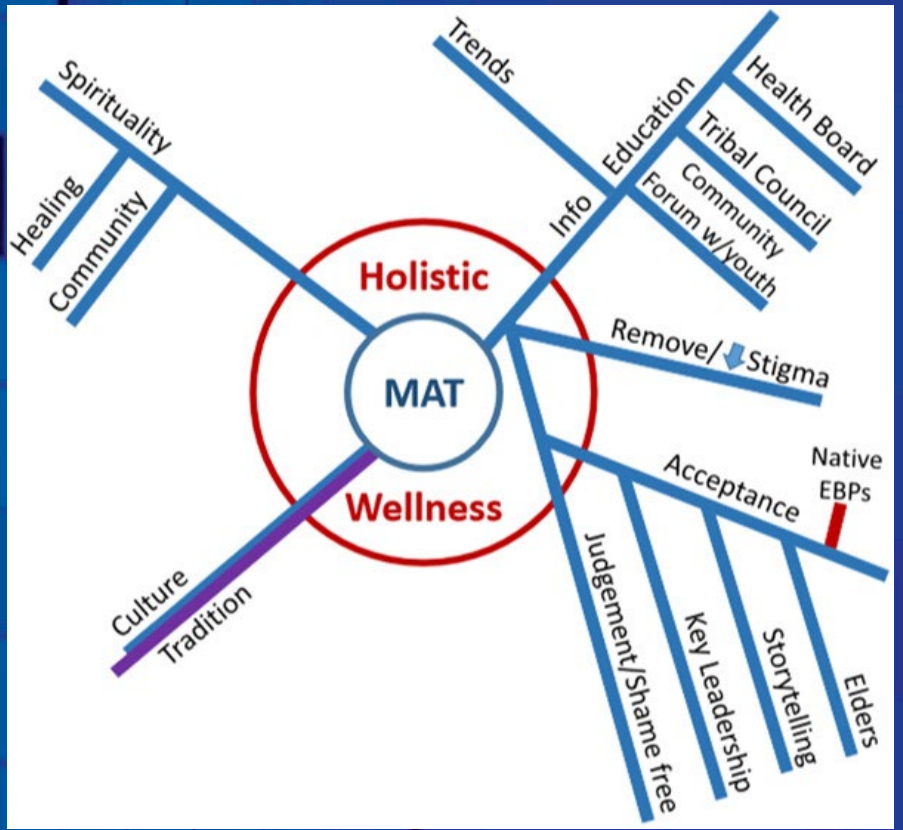
Native communities have been deeply affected by the opioid crisis, and many have been overwhelmed by opioid overdoses, deaths, and a strained healthcare system. Yet Native cultures' ancestral strengths and healing traditions may also provide unique insights into the successful integration of treatment for opioid use disorder in primary care and addiction treatment clinics serving AI/AN people.

“We think of addiction as a brain disease, and that is a great way to reduce stigma and help people get the treatment they need. But putting the brain at the center of everything is a narrow way of thinking,” said Kamilla Venner, Ph.D., assistant professor in the Department of Psychology at the University of New Mexico and member of the Ahtna Athabascan Tribe. “We need a more holistic view that goes beyond a person’s biology. We must integrate culture, societal factors, and even spirituality, when appropriate, into mainstream medical institutions and education.”



https://heal.nih.gov/news/stories/native-cultures

Centering culture in the treatment of opioid use disorder with American Indian and Alaska Native Communities:



American Journal of Community Psychology: 23 August 2022 https://doi.org/10.1002/ajcp.12620

Centering Indigenous Knowledge, Culture and Communities: Approaches to Indigenous Evaluation and Opioid Overdose Prevention Programming

This webinar, presented by Maya Magarati, PhD, and Angela Gaffney, MPA, will outline Seven Directions' core visions and framework against a backdrop of ONOJ, discuss ways to appropriately engage with Indigenous communities, and spotlight (1) the development and implementation of an Indigenous Evaluation Toolkit for tribal public health programs, and (2) other opioid overdose prevention resources and communities of practice for tribal public health practitioners as facilitated by Seven Directions.

Seven Directions (UW Department of Psychiatry & Behavioral Sciences) is hosting the 2023 Our Nations, Our Journeys (ONOJ) conference June 27-29 in Minnesota, a biannual, in-person gathering of 300 tribal and urban Indian public and behavioral health practitioners, leaders, researchers, and Indigenous students focusing on healing from the opioid epidemic.

https://attcnetwork.org/centers/attc-network-coordinating-office/centering-culture-treatment-opioid-use-disorder-american

Centering Indigenous Knowledge, Culture and Communities: Approaches to Indigenous Evaluation and Opioid Overdose Prevention Programming

AI/AN communities have implemented policy changes and sought better prevention and treatment methods to address the opioid epidemic, including integrating medications for opioid use disorder (MOUD), but there is a need to tailor MOUD delivery to AI/AN communities in a culturally responsive way, based on the integration of Indigenous and Western worldviews and framed by a healing tradition

https://www.youtube.com/watch?v=uA1jIwo4O7c

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California MAT Expansion Project

Described by its lead entities as "A unified response to the opioid crisis in California Indian Country," the Tribal MAT Project was designed to meet the specific opioid use disorder prevention, treatment, and recovery needs of California's Tribal and Urban Indian communities. In close partnership with representatives of the communities served, the California Department of Health Care Services developed the project to promote opioid safety, improve the availability and provision of MAT, and facilitate wider access to naloxone with special consideration for Tribal and Urban Indian values, culture, and treatments

https://californiamat.org/matproject/tribal-mat-program/

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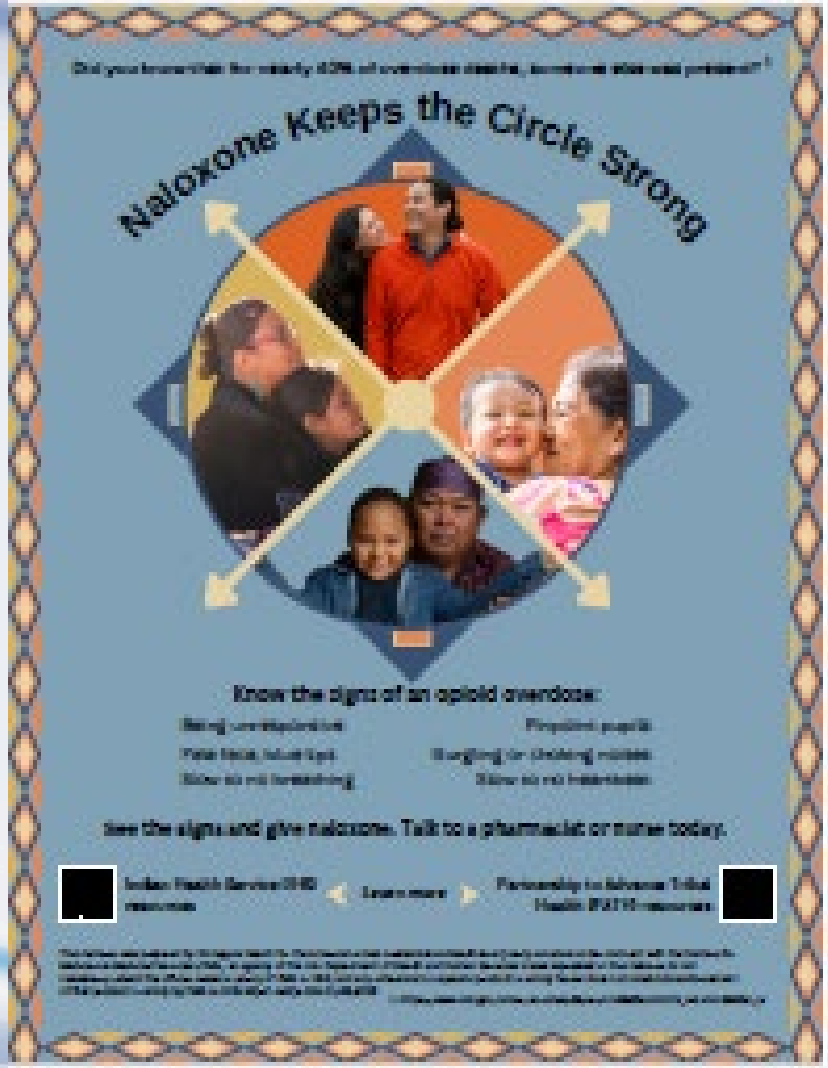

Naloxone is a key safety factor for OUD harm reduction & treatment

Link to the poster

https://comagine.org/sites/default/files/resources/Community_Poster_Naloxone_Keeps_Circle_Strong%20_blue.pdf

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Naloxone Keeps the Circle Strong

Pharmacist Guide:

Script for Starting the Naloxone Conversation

How to introduce naloxone:

- One risk with opioid medications is they can cause your breathing to slow or stop. Because you are taking [*medication name*], there is a risk that this could happen to you.
- Unfortunately, overdoses can happen to anyone, including children who may accidentally ingest them, so we like to make sure families have naloxone in their first aid kit.
- I'd like to talk with you about naloxone, a medicine given if you take more opioids than your body can handle.

How to describe what an overdose looks like and what to do:

- It's important to recognize the signs of an overdose, so you know how to help. People who are overdosing may be unresponsive, have pinpoint pupils, experience slow to no breathing, have blue lips or make choking noises.
- If any combination of these signs is occurring, call emergency services and give naloxone. Naloxone works if there are opioids in the person's system, but it also will NOT harm the person if there isn't. You can give the person naloxone even if you are unsure what's happening is an overdose.

How to explain why naloxone is important for your patient:

- Naloxone is a medication that can be given by anyone. It works by restoring normal breathing to a person whose breathing has slowed or stopped due to opioid medications, non-prescription opioids or illicit drugs like heroin or fentanyl-mixed drugs.
- Naloxone is a nasal spray and starts to work immediately.
- Naloxone is safe and can be given again after a few minutes if the person is not waking up or returning to normal breathing. There is no maximum dose. Most importantly, it can save the person's life.

Remember:

Focus on your patient's wellbeing.
Listen attentively.
Make space for their questions and concerns.
If possible, involve their loved ones.
Avoid stigmatizing or shaming language.

Learn more

Scan this code for "Say this, not that."

Start the conversation. Save a life.
Naloxone is first aid.

This material was prepared by Comagine Health for the American Indian Alaska Native Healthcare Quality Initiative under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. NQIIC-AIHQI-314-01/06/2023

Naloxone Saves Lives!

The U.S. Food and Drug Administration has approved Narcan, 4 milligram (mg) naloxone hydrochloride nasal spray for over-the-counter (OTC), nonprescription, use – the first naloxone product approved for use without a prescription. Naloxone is a medication that rapidly reverses the effects of opioid overdose and is the standard treatment for opioid overdose. Today's action paves the way for the life-saving medication to reverse an opioid overdose to be sold directly to consumers in places like drug stores, convenience stores, grocery stores and gas stations, as well as online.

https://comagine.org/sites/default/files/resources/Pharmacist_Start_Naloxone_Conversation_Script.pdf

“How do I know when I’m ready to stop treatment?”

Description	Progress Needed (DATE)	Making Good Progress (DATE)	Completed (DATE)
SAMHSA’s Four Elements of Recovery			
1. Health—is managing medical and mental health issues in a healthy way			
2. Home—has a stable and safe place to live			
3. Purpose—has meaningful daily activities, income, and resources			
4. Community—has relationships and a social network that provides support, friendship, love, and hope			

Thank you…

…for bringing hope,
help and healing
to the people
you serve!

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Michael G. Bricker MS, CADC-II, NCAC-2, LPC

The STEMSS® Institute

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Eugene OR 97405

Phone: **(541) 880 - 8886**

Email: **mbricker6421@gmail.com**

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Promoting dual recovery since 1984

For a copy of the slides:

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Scan the QR code on your smart phone, take a quick 5-question survey, and download a PDF file of all the slides

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