WHAT YOU NEED TO KNOW ABOUT MAT FOR OPIOID USE DISORDER

THE EVIDENCE ABOUT EFFECTIVENESS, COST, SAFETY AND DIVERSION REDUCING RECIDIVISM AND REENTRY CONFERENCE ANCHORAGE, AK MARCH 2019

Sarah Spencer DO, ABAM

LEARNING OBJECTIVES:

• To learn the basic science behind the disease of OUD and how MAT works to treat OUD
• To understand the evidence behind the efficacy of MAT for OUD in reducing morbidity, mortality, relapse, criminal activity and cost to society.
• To explore common misconceptions around MAT and to understand how stigma creates a barrier to treatment and recovery.

About Myself

Moved from Maine in 2009
Board certified in Family and Addiction Medicine
I’ve been providing MAT for OUD in rural AK since 2010 (Currently in Ninilchik and Homer)
Medical director and founding member of Homer’s syringe access program
Overdose Response Trainer for State AK Project HOPE (Free Narcan Kits) AK), Senior physician consultant for SAMSHA grant funded Opioid Response Network, State Targeted Response Technical Assistance (STR-TA) Consortium
EPIDEMIOLOGY AND BIOLOGY OF OPIOID USE DISORDER

Nugget: Addiction Animation

“In all my years as a physician, I have never, ever met an addicted person who wanted to be an addict.”
Dr. Nora Volkow
NIDA Director
DrugAbuse.gov
Shame, Stigma, and Blame Never cured anyone.

But Practicing Evidence Based Medicine Does!
OD killed more than people in 2015 than car crashes and gun homicides combined.

In 2016 more Americans died of OD than died in the entire Vietnam war.
In 2017:
- 71 Heroin deaths
- 50 Rx opioid deaths

1000 overdose deaths in 10 years

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

Evidence Based Treatment

"Access to medication – assisted treatment can mean [the] difference between life or death."

Michael Botticelli, October 25, 2016
Director, White House Office of National Drug Control Policy
Why is addiction the only chronic disease in which we punish patients for exhibiting symptoms of their disease?

- Patient admitted to the hospital with heart attack...
  - Told it's her fault because of diet, high stress job, and history of tobacco use
  - Advised to call a list of cardiologists/cath labs
  - Told she can't get aspirin or cholesterol medication until she sees a nutritionist first
  - Sent home with a stem reminder to not have another heart attack

- Patient admitted to the hospital with endocarditis...
  - Told it’s her fault because of her substance use disorder
  - Advised to call a list of treatment programs
  - Told she can't get addiction medication until she sees a counselor first
  - Sent home with a stem reminder to not use drugs

Relapse rates for drug addicted patients are compared with those suffering from diabetes, hypertension, and obesity. Together, it makes sense because both are not caused by a substance, but rather a lack of intervention. Drug addiction should be treated like any other chronic illness, with care and support given to improve outcomes.
Mortality rate after 1st Heart attack is about 7% at one year

We would never send a patient home without Aspirin, which reduces mortality by 22%.

Mortality rates after first overdose are also 7% at one year.

However patients are routinely sent home without MAT, which reduces mortality by 80%.

**ADDICTION IS NOT A PERSONALITY FLAW**

*It is a chronic brain disease*

We can give it to rats (and they don’t have much of a personality)

However it does change peoples personalities...
What is addiction?

- Primary, chronic disease of brain reward, motivation, memory and related circuitry
- Characterized by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviours and interpersonal relationships, and a dysfunctional emotional response

ASAM, 2011

**TABLE 1** Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired control</td>
<td>- Opioids used in larger amounts or for longer than intended</td>
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<tr>
<td></td>
<td>- Unsuccessful efforts or desire to cut back or control opioid use</td>
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<tr>
<td></td>
<td>- Excessive amount of time spent obtaining, using, or recovering from opioids</td>
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<td></td>
<td>- Craving to use opioids</td>
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<tr>
<td>Social impairment</td>
<td>- Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use</td>
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<tr>
<td></td>
<td>- Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems</td>
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<tr>
<td></td>
<td>- Reduced or given up important social, occupational, or recreational activities because of opioid use</td>
</tr>
<tr>
<td>Risky use</td>
<td>- Opioid use in physically hazardous situations</td>
</tr>
<tr>
<td></td>
<td>- Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use</td>
</tr>
<tr>
<td>Pharmacological</td>
<td>- Tolerance as demonstrated by increased amounts of opioids needed to achieve</td>
</tr>
</tbody>
</table>

**Factors Leading to Addiction**

- Biology / Genetics
  - Genetics
  - Gender
  - Mental disorders

- Drugs
  - Effect of drug itself
  - Route of administration

- Brain Mechanisms
  - Early use
  - Availability
  - Cost

- Environment
  - Chaotic home and abuse
  - Parent's use and attitude
  - Peer influences
  - Community attitudes
  - Poor school achievement

- Addiction
Non-Opioid-Dependent and Opioid-Dependent Brain Images

PET scan images show changes in brain function caused by opioid dependence. The lack of red in the opioid-dependent brain shows a reduction in brain function in these regions.


Why Can’t Addicts Just Quit?

Because Addiction Changes Brain Circuits

Addiction Cycle

Emotional Trigger

Guilt

Using

Craving

Ritual
Evidence-based addiction treatment is aimed at correcting the brain adaptations associated with addiction, not physical dependence.

Because physical dependence is normal and reversed with a slow taper, treatment medications simply maintain some of the existing physical dependence in order to suppress symptoms of craving and withdrawal. This allows the patients to make behavioral changes that will rewire the brain reversing some of the changes of addiction.

Once the slow and deliberate process of reversing destructive brain adaptations is significant, a slow taper resolves the remaining physical dependence.
Abstinence is Not the Only Marker of Recovery

[The FDA] intended “to correct a misconception that patients must achieve total abstinence in order for MAT to be considered effective.”

Alex Azar, Health and Human Services Secretary
Feb 2, 2018

How do we define success in recovery?

- Staying out of jail
- Forming meaningful interpersonal relationships
- Being able to care for your children
- Regaining trust of family and friends
- Having a safe, stable place to live
- Improved physical health
- Ability to contribute to community and feel a sense of purpose in life

PHARMACOLOGY
Major Features of Methadone

**Full Agonist at mu receptor**
- Long acting
  - Half-life ~ 15-60 Hours
- Weak affinity for mu receptor
  - Can be displaced by partial agonists (e.g., buprenorphine) and antagonists (e.g., naloxone, naltrexone), which can both precipitate withdrawal

**Monitoring**
- Significant respiratory suppression and potential respiratory arrest in overdose
- QT prolongation

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How does Methadone Work?
- Little or no euphoria / "high"
- Long acting (at least 24 hours)
- Prevents withdrawal
- Reduces craving
- Blocks effects of other opioids
- Permits normal functioning: stability
Major Features of Naltrexone

**Full Antagonist at mu receptor**
- Competitive binding at mu receptor

**Long acting**
- Half-life:
  - Oral ~ 4 Hours
  - IM ~ 5-10 days

**High affinity for mu receptor**
- Blocks other opioids
- Displaces other opioids
- Can precipitate withdrawal

**Formulations**
- Tablets: Revia® FDA approved in 1984
- Extended-Release intramuscular injection: Vivitrol® FDA approved in 2010

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Naltrexone Treatment: Mechanism

There are two possible mechanisms of therapeutic effect:

- **Behavioral mechanism:** blockade of the reinforcing effects of heroin leads to gradual extinction of drug seeking and craving
  - Patients who use opioids while on naltrexone experience no effect of exogenous opioids and often stop using them

- **Pharmacological mechanism:** naltrexone decreases reactivity to drug-conditioned cues and decreases craving thereby minimizing pathological responses contributing to relapse
  - Patients on naltrexone often have decreased urges to use opioids
  - As naltrexone has a different mechanism of action than methadone or buprenorphine, it may be acceptable to, or effective for different subgroups of patients, thus helping to attract more patients into effective treatment overall

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MAT: Medication Assisted Therapy

**Depot Naltrexone: Vivitrol**

- Monthly injection for assisted abstinence therapy
- Intended to prevent any reward from opioid use, and thus gradually reduce cravings
- Patient must have already completed withdrawal, or complete wean off mu agonist therapy (or will precipitate withdrawal)
- Increasing use in correctional facilities and residential programs
- Some patients opt for Vivitrol after "detoxing" or after completion of an abstinence program
- Overall outpatient numbers are still low
- **NOT** a medication to be initiated in the E.D.
PHARMACOLOGY OF BUPRENORPHINE

Buprenorphine is a partial opioid agonist/antagonist (Mu partial agonist/Kappa antagonist)

- **Mu Agonist effect** = positive reinforcement without withdrawal symptoms and minimizing cravings
- **The agonist effects of buprenorphine reach a plateau and no longer continue to increase with further increases in dose—the “ceiling effect.”**
- **Lower risk of abuse, addiction, and side effects compared to full opioid agonists.**
- **Maximal effects are less than those of full agonists like heroin and methadone.** Hard to get “high” off it
- **Buprenorphine binds very tightly to the opioid receptor and blocks other full agonists from binding, and can precipitate withdrawal symptoms if administered to an opioid-addicted individual while a full agonist is in the bloodstream.**

FORMULATIONS OF BUPRENORPHINE

- **Buprenorphine/naloxone SL/buccal films (Generic/brand, many strengths)**
- **IV Buprenorphine**
- **Buprenorphine/naloxone 5/15 tabs (Generic/brand)**
- **Two-month Buprenorphine SQ depot injection**
- **Probuphine**
- **Transdermal and Buccal Buprenorphine products used for chronic pain (Butrans/ Belbuca) are not generally considered too low dose to be used in MAT for OUD**

Buprenorphine is an antagonist (i.e., prevents stimulation) of the kappa opioid receptor

Stimulation of the kappa opioid receptor plays a role in producing some of the major symptoms associated with opioid withdrawal, such as chronic depression.

By attaching to the kappa receptor and slowing its activity, **buprenorphine may reduce depression induce positive mood and feelings of wellbeing**

(Rothman et al., 2000)
Efficacy of MAT Medications

- Abstinence only treatment models, relapse rate >90%
- Methadone has 60-70% retention
- MAT with Buprenorphine about 50-60% retention at 1 year Individuals discharged at 1 year or less had high relapse rate
- XR-Naltrexone has 35% retention at 6 mos
  more difficult to start, higher dropout in more severe OUD

Patients who may be better candidates for agonists

- Patients with history of overdoses, particularly following detoxification
- Patients with limited social supports (unstable lives, homelessness)
- Patients who have been opioid-free but never felt “normal”
- Patients in whom psychiatric illness emerged/ worsened after previous detoxifications (with or w/o naltrexone)
- Patients with chronic pain requiring chronic opioid treatment
- Patients with severe GI disorders exacerbating during withdrawal/abstinence
- Patients with advanced liver disease
  - Concerns about hepatotoxicity were not based on representative data and the black-box warning was removed from the medication label
  - Patients with LFT’s less than 3-5 times upper normal limit have minimal risk
Selection of Candidates for Naltrexone

- Patients who are not interested or able to be on opioid maintenance
- Highly motivated for abstinence from all opioids (e.g., active in 12-step programs)
- In professions where treatment with agonist is still controversial (e.g., healthcare professions, police)
- Patients who are detoxified and abstinent but at risk for relapse
  - Rehospitalized from a controlled setting (inpatient, residential program)
  - Moving back to old neighborhood
  - Increased stress or worsening of psychiatric problems
- Patients who failed prior treatment with agonist
  - Continued to have urges and used of opioids, non-compliance with agonist, swollen/muscular agonist, dropped out of treatment
- Patients with less severe form of disorder
  - Short history of use, lower level of use
- Young adults who often unwilling to commit to a long-term opioid maintenance
- Individuals who use opioids sporadically
- Patients successful on agonist who want to discontinue them without making relapse

DRUG OR MEDICINE?
In a study of clinicians who work with drug courts, respondents felt that the reason judges don’t allow methadone is because of their personal biases against methadone as a valid treatment. One clinician commented, “Methadone always has this stigma associated with it…. People can’t think of it as medicine.”

The clinical implications of these biases can be grim. A judge in New York ordered a defendant taken off of methadone treatment, stating that it does not enable a person “to actually rid him or herself of the addiction.” The man subsequently died from overdose.

We tend to have a biased perception: We think:

- Patients who improve, leave and are forgotten
- Patients who do not improve return frequently and are remembered
- Leads us to think that most patients do not improve
  …contrary to scientific data.

Drug vs Medication:

Drugs are what people use to get high.

Medications are what people use to get well under a physician’s care.

Because people taking them will not feel or act high on appropriate doses, medications do not compromise people’s recovery.

Addressing Myths About Medications

Methadone and buprenorphine DO NOT substitute one addiction for another. When someone is treated for an opioid addiction, the dosage of medication used does not get them high, it helps to reduce opioid cravings and withdrawal symptoms. These medications restore balance to the brain circuits affected by addiction, allowing the patient’s brain to heal while they work towards recovery.

Addiction is defined by the American Society of Addiction Medicine as compulsive drug use despite harmful consequences. Taking a daily prescribed medication that improves functioning, health, and quality of life, while reducing other drug use and improving overall wellness does not meet this definition.

People taking opioid agonist therapy depend on a daily medication to keep their disease in remission, the same way that people with diabetes, hypertension, hyperlipidemia, hypothyroidism, and nearly every chronic medical condition do.

“The combination of preferential use of opioid antagonist therapy despite its limited scientific support in comparison with methadone and buprenorphine, the lack of access to opioid agonist therapy initiation for those who need it, and the forced withdrawal of stable patients upon entry into the criminal justice system is ethically concerning. This approach ignores respect for patient autonomy, limits access to evidence-based health care, and results in negative outcomes for individuals, communities, and society. The example of drug court judges mandating withdrawal from successful opioid agonist therapy raises additional concerns in situations in which a judge is making life-or-death clinical decisions. It also highlights how treatment for addiction is approached differently from any other medical illness. Imagine if a judge required that a person with diabetes stop insulin therapy and instead be treated with diet and exercise because he or she didn’t “believe” in medication treatment for diabetes.” —Sarah Wakeman MD, Why it’s inappropriate not to treat incarcerated patients with opioid agonist therapy, AMA J Ethics. 2017;19(9):922-930. doi: 10.1001/journalofethics.2017.19.9.stas1-1709.

REDUCTION IN MORTALITY
A study in Washington State found that the risk of death from drug overdose was 129 times higher in the first 2 weeks after release from prison compared to the general population.
MAT use during incarceration reduces the hazard of all-cause death during the first four weeks of incarceration by 94%

Being on MAT in the four weeks post-release reduced the hazard of death by 75%

Some evidence linking the impact of opioid substitution therapy on mortality among prisoners in 20-year data linkage study. Trends & issues in crime and criminal justice no. 498, Australian Institute of Criminology, June 2015, Natasa Gisev

IS MAT WORTH THE COST?

According to several conservative estimates,

Every $1 investment in addiction treatment programs yields a return of between $4 and $7

In reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included,

total savings can exceed costs by a ratio of 12 to 1

NIH/NIDA
Treating criminal justice-involved persons with methadone or buprenorphine resulted in a cost savings of nearly $18,000 per person over 6 months compared to detoxification alone. A California law allowing qualified drug offenders to enter treatment instead of jail or prison saved the state close to $100 million in its first year.

REDUCTION IN CRIME AND RECIDIVISM

Adapted from Bell & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991

Reduction in crime by years in methadone maintenance treatment

Crime among 491 patients before and during MMT at 6 programs

Years in Methadone Maintenance Treatment

75.6% reduction in crime rate

Years

6

12

0

2

3

4

5

6

0

100

200

300

Crime Days Per Year

A

B

C

D

E

F

Before TX

During TX
REDUCTION IN RELAPSE

HIGH RATE OF RELAPSE TO IV DRUG USE AFTER DROP-OUT FROM METHADONE TREATMENT

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Months Since Stopping Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1 to 3</td>
</tr>
<tr>
<td>26.9</td>
<td>4 to 6</td>
</tr>
<tr>
<td>28.1</td>
<td>7 to 9</td>
</tr>
<tr>
<td>32.1</td>
<td>10 to 12</td>
</tr>
</tbody>
</table>

Percent IV Users

Number needed to treat to save 1 life = 5-10!
Clinical evidence shows that people may need treatment with medications for long periods of time to achieve a sustained recovery. Some may even need a lifetime of treatment. The FDA recently revised the labels of buprenorphine products to reflect this fact.

Understanding the Use of Diverted Buprenorphine
Just because a medication has value on the street does not mean that it is being used to “Get High”

If you woke up tomorrow morning with the worse flu you’ve ever had…

• Shaking chills and profuse sweating
• Vomiting, diarrhea and abdominal cramping
• Severe pain in every muscle and joint of your body
• A feeling of restlessness so severe that you wanted to tear your skin off
• An overwhelming feeling of despair and hopelessness

How much money would you pay for a single dose prescription medication that would relieve your symptoms for 24 hours?

opioid withdrawal is hell on earth

“It feels like the worst flu you ever had, the sickest you’ve ever been, at times suicidal thoughts and complete and total confidence that you are never ever going to feel better.”

“For days, I shook uncontrollably. I sweat through my sheets.”

“I wanted to tear my hair out of my skull and my scratch the skin off of my body.”

“It feels like the day your wife left and your kitten died and there were no more rainbows anywhere and never will be again.”
“If they do not get relief of their withdrawal symptoms in the ED, they will commit desperate acts to find relief on the street” –Drs. Ketcham and Strayer

The minority proportion of people who use buprenorphine illicitly to get high has been shown to decrease over time, which could suggest that people abandon this goal after they experience the drug’s blunted reward effects. Indeed, patients in treatment for OUD rarely endorse buprenorphine as the primary drug of misuse.

Non-opioid treatments do not address cravings, which leave the patient much more vulnerable to self-treating with street drugs, which are more lethal than ever before.

Understanding the use of diverted buprenorphine.

WHAT PATIENTS USE DIVERTED BUPRENORPHINE FOR

- Prevent cravings
- Prevent withdrawal
- Maintain abstinence
- Wean themselves off drugs
- Drug of choice to “get high”
Diverted Buprenorphine = Harm Reduction?

“The diverting patient is taking their bup and selling it to exactly the people who need to be using it… prior exposure to buprenorphine is predictive of success in a bup MAT program… When they are ready to make a change they will remember how effective bup is for dope sickness… Every day that a patient is administered bup in the ED is a day they are not injecting heroin, and a day that they are protected from overdose… So when you unintentionally write a Rx for a bup diverter, you might be saving lives too” -Drs. Ketcham and Strayer.

MAT for patients with severe OUD or polysubstance use

XR-Naltrexone

Can be useful in patients with a dual-diagnosis of Opioid and Alcohol use disorders.

(although a combination of Buprenorphine with Antabuse can also be used)
Monthly Injectable Buprenorphine (Sublocade)

Useful for patients who benefit from buprenorphine but have trouble with medication compliance.

- Patients who cannot reliably attend scheduled and random monitoring appointments due to transportation (no vehicle), location (lives off road system) or employment barriers (slopes workers)

- Patients who are at high diversion risk
  - Patients actively using other illicit substances such as meth
  - Homeless patients who have difficulty storing their medications
  - Patients who have sold their buprenorphine in the past

Risk vs. Benefit

“Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks.”

FDA Drug Safety Communication, 9/12/2017

What About Polysubstance Use?

Buprenorphine treatment by baseline cocaine use

- Buprenorphine Rx for pts using cocaine vs. no cocaine
- Followed at 1, 3, 6, mo
- Same treatment retention rate
- Improvements in opioid use

[Cunningham, C. G., et al. (2003), Buprenorphine Treatment Outcomes in Prosecuted Heroin-Dependent Cocaine Users and Non-Cocaine Users. Am. J. Addict., 12: 263-289]
Opioid use by baseline cocaine use, treated with buprenorphine

- Compared those using cocaine and opioids who started buprenorphine
- No difference in opioid use
- Followed for 3, 6 months
- Same reduction in opioid use
- Overall cocaine use improved

Contrary to the commonly held belief that opioid agonist treatment alone is inferior to such treatment combined with psychosocial treatment (which many will understand to mean counseling), patients can receive as much benefit by using the medications during which they are at risk of premature death. The use of medication combined with buprenorphine with formal counseling while patients remain on waiting lists may mitigate this risk during delays in treatment.

If patients are unable or unwilling to participate in SUD counseling, they can still benefit from MAT.

Lack of access/participation in SUD counseling should not be a barrier to MAT access.

In fact, no rigorous study has ever shown that the addition of psychosocial services to opioid agonist therapy alone has been shown to improve outcomes in the treatment of opioid use disorder.

Despite the demonstrated efficacy of maintaining abstinence by treating patients with opioid agonists, patients can remain on clinic waiting lists for months, during which they are at risk of premature death. The use of medication combined with buprenorphine with formal counseling while patients remain on waiting lists may mitigate this risk during delays in treatment.

The commonly held belief that opioid agonist treatment alone is inferior to such treatment combined with psychosocial treatment (which many will understand to mean counseling) is not supported by the research evidence and it results in limitations on the use of these effective medications.

The considered outcome (retention in treatment and use) it seems that adding any psychosocial support to standard maintenance treatment do not add additional benefits.

Incorporating MAT into Criminal Justice Systems: National Trends
• The Justice Department should increase the use of MAT in prisons, noting that multiple studies have shown that inmates who received treatment had lower recidivism rates than those who did not.

• Called for drug courts in each of the 93 federal judicial districts, to help direct offenders into treatment as an alternative to incarceration.

• Medications are underused by drug courts. However, as of 2015, state drug courts receiving federal grants must allow people being treated with medications for opioid addiction to continue their use.

A 2013 survey found that only 34 percent of US drug courts report permitting initiation of opioid agonist therapy in some circumstances, including continuation of treatment for those on agonist therapy.
WHEREAS, certain medically assisted treatments (M.A.T.) for addiction—including anticonvulsant medications such as naltrexone, and partial agonist medications such as buprenorphine—have been proven through rigorous scientific studies to improve addicted offenders’ retention in counseling and reduce illegal drug use, recidivism, technical violations, re-incarceration, hepatitis C infections, and mortality.

NOW, THEREFORE, BE IT RESOLVED THAT:

1. Drug Court professionals have an affirmative obligation to learn about current research findings related to the safety and efficacy of M.A.T. for addiction.

2. Drug Court programs should make reasonable efforts to attain reliable expert consultation on the appropriate use of M.A.T. for their participants. This includes partnering with substance abuse treatment programs that offer regular access to medical or psychiatric services.

3. Drug Courts do not impose blanket prohibitions against the use of M.A.T. for their participants. The decision whether or not to offer the use of M.A.T. is based on a particularized assessment in each case of the needs of the participant and the interests of the public and the administration of justice.

4. Drug Court Judges base their decision whether or not to permit the use of M.A.T. in part, on competent expert evidence or consultation. In cases in which a participant, the participant’s legal counsel, or a medical expert has requested the possible use of M.A.T., the judge articulates the rationale for allowing or disallowing the use of addiction medication.

While research supports long-term treatment with extended-release naltrexone as a relapse prevention intervention among a carefully selected patient population, there is support for its broad adoption of this medication as the only pharmacological option for people with opioid use disorder in the criminal justice system.

“When we have two agents that work [methadone and buprenorphine], why would you not use them? I can’t imagine anywhere else in medicine where anyone would use an unproven agent instead of a proven one.”

Kevin Fiscella, an addiction specialist, National Commission on Correctional Health Care

Recent journalism has explored the reasons for such broad support of extended-release naltrexone as an option, despite relatively little empirical evidence. What was uncovered was an extensive and expensive lobbying effort by the company Alkermes, which makes an extended-release naltrexone. This company’s effort appears to have largely bypassed scientific peer review and seems to have used correctional staffs’ distaste for opioid agonist therapy to its advantage. That extended-release naltrexone has no street value and no potential for abuse has helped the drug shake some of the skepticism directed toward medication-assisted treatment. For the last several years, the company has marketed the drug heavily to people in the criminal justice system, convincing judges and corrections officials to offer this drug to inmates and parolees. As a testament to the effectiveness of this strategy, the brand name of this drug appears in more than 70 bills and laws in 15 states.
Even when inmates maintain abstinence from opioids during incarceration, because opioid use disorder is a chronic relapsing illness, nearly three-quarters relapse to heroin use within 3 months of release and with simple referral to MAT upon release, as few as 8 percent enter treatment.

Naloxone is a lifesaving rescue medication which can reverse overdoses from heroin and other opioids, but nearly every jail or rehab sends at-risk people home without it.
Contact the STR-TA Consortium

- To ask questions or submit a technical assistance request:
  - Visit www.getSTR-TA.org
  - Email str-ta@aaap.org
  - Call 401-270-5900

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