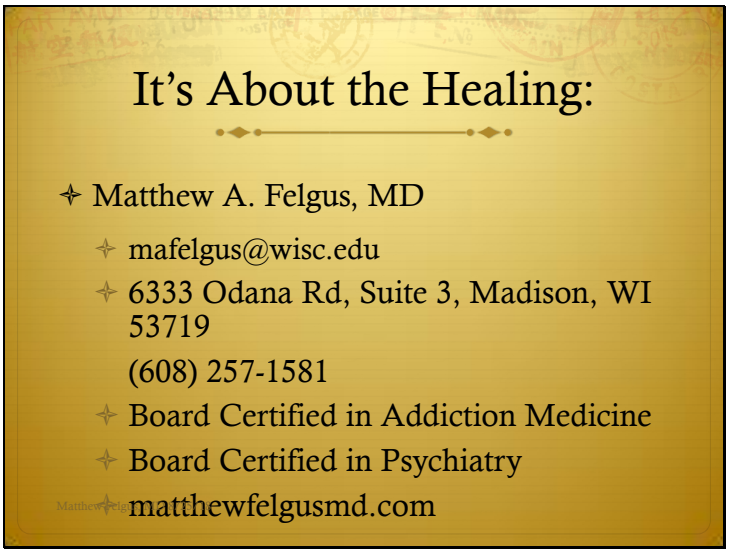
Slide 1

It's About The Healing:
Opioid Replacement Therapy is not forever, is it?
Matthew Felgus, MD 8/25/18

Slide 2


It's About the Healing:
Matthew A. Felgus, MD
mafelgus@wisc.edu
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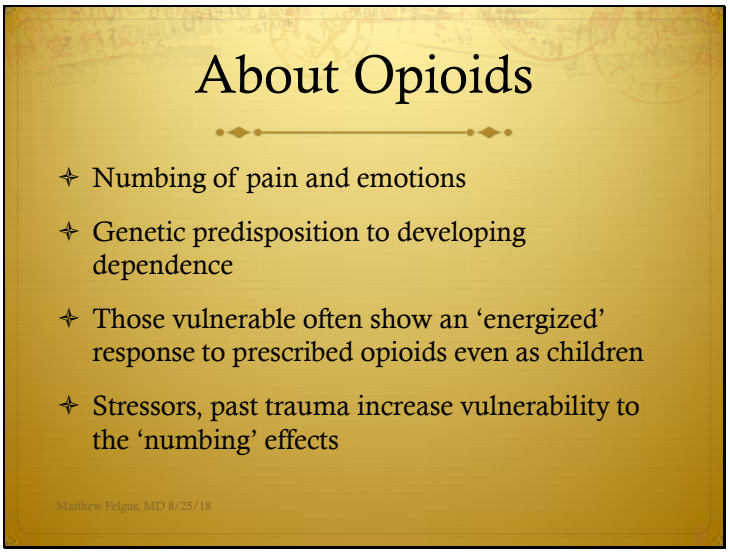
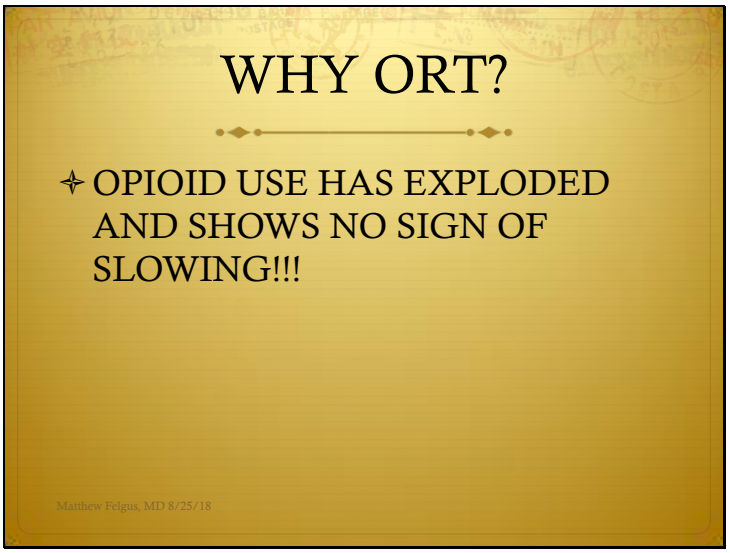
(608) 257-1581
Board Certified in Addiction Medicine
Board Certified in Psychiatry
matthewfelgusmd.com

Slide 3


About Opioids
Numbing of pain and emotions
Genetic predisposition to developing dependence
Those vulnerable often show an 'energized' response to prescribed opioids even as children
Stressors, past trauma increase vulnerability to the 'numbing' effects
Matthew Felgus, MD 8/25/18

Slide 4


WHY ORT?
OPIOID USE HAS EXPLODED AND SHOWS NO SIGN OF SLOWING!!!
Matthew Felgus, MD 8/25/18

Slide 5

WHY ORT?
Effective, proven treatment in reducing use
Matthew Felgus, MD 8/25/18

Slide 6

WHY ORT?
Effective, proven treatment in reducing use
Keeps clients in treatment (carrot)
Matthew Felgus, MD 8/25/18

Slide 7

WHY ORT?
Effective, proven treatment in reducing use
Keeps clients in treatment (carrot)
Blocking agent for other opioids
Matthew Felgus, MD 8/25/18

Slide 8

WHY ORT?

- Effective, proven treatment in reducing use
- Keeps clients in treatment (carrot)
- Blocking agent for other opioids
- Less likely to be abused (but not impossible)

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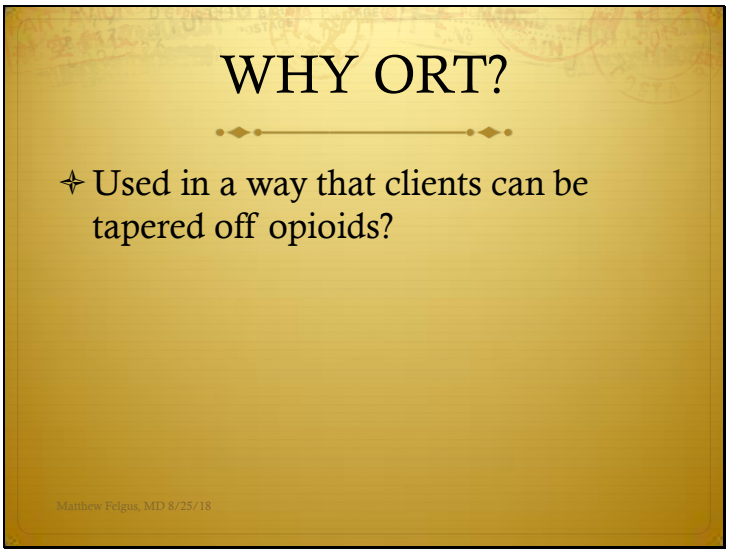
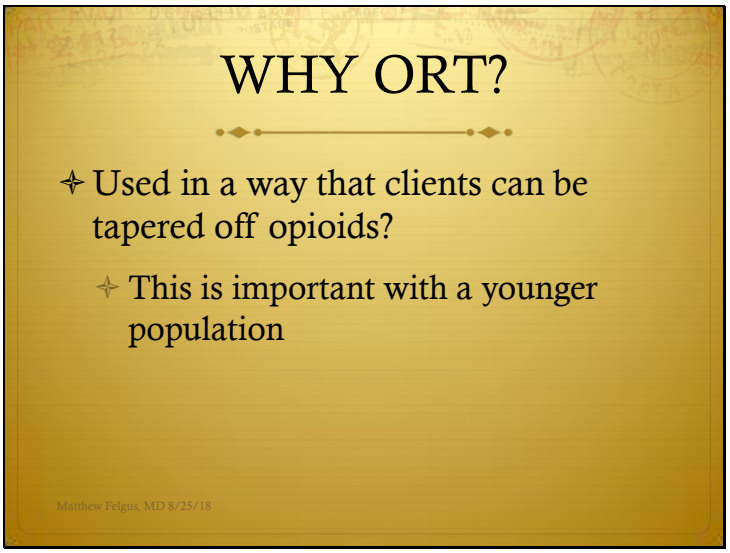
Slide 9


WHY ORT?
Used in a way that clients can be tapered off opioids?
Matthew Felgus, MD 8/25/18

Slide 10


WHY ORT?
Used in a way that clients can be tapered off opioids?
This is important with a younger population
Matthew Felgus, MD 8/25/18

Slide 11

WHY ORT?
Used in a way that clients can be tapered off opioids?
This is important with a younger population
One component of a well-rounded treatment program
Matthew Felgus, MD 8/25/18

Slide 12

WHY NOT ORT?
Over reliance on medication vs. recovery tools
Matthew Felgus, MD 8/25/18

Slide 13

WHY NOT ORT?

- Over reliance on medication vs. recovery tools
- Doses can be too high (clients appear 'stoned')

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Slide 14

WHY NOT ORT?

- Over reliance on medication vs. recovery tools
- Doses can be too high (clients appear 'stoned')
- Establishing a pattern of dependence on opioid medications at a young age

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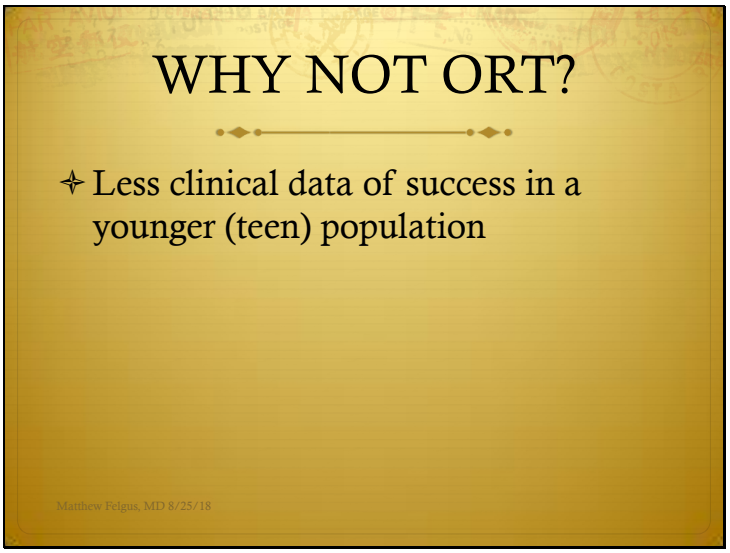
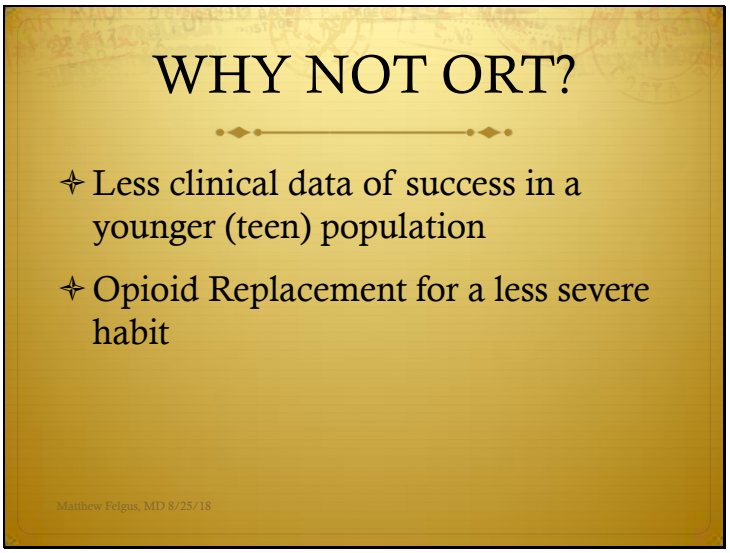
Slide 15


WHY NOT ORT?
Less clinical data of success in a younger (teen) population
Matthew Felgus, MD 8/25/18

Slide 16


WHY NOT ORT?
Less clinical data of success in a younger (teen) population
Opioid Replacement for a less severe habit
Matthew Felgus, MD 8/25/18

Slide 17

WHY NOT ORT?

- Less clinical data of success in a younger (teen) population
- Opioid Replacement for a less severe habit
- It is possible to abuse opioid replacement meds (methadone and suboxone)

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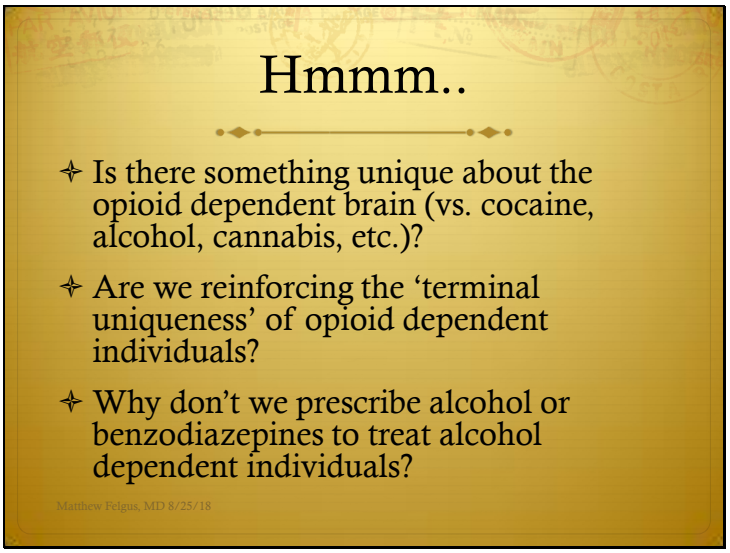
Slide 18


Hmmm..
Is there something unique about the opioid dependent brain (vs. cocaine, alcohol, cannabis, etc.)?
Are we reinforcing the 'terminal uniqueness' of opioid dependent individuals?
Why don't we prescribe alcohol or benzodiazepines to treat alcohol dependent individuals?
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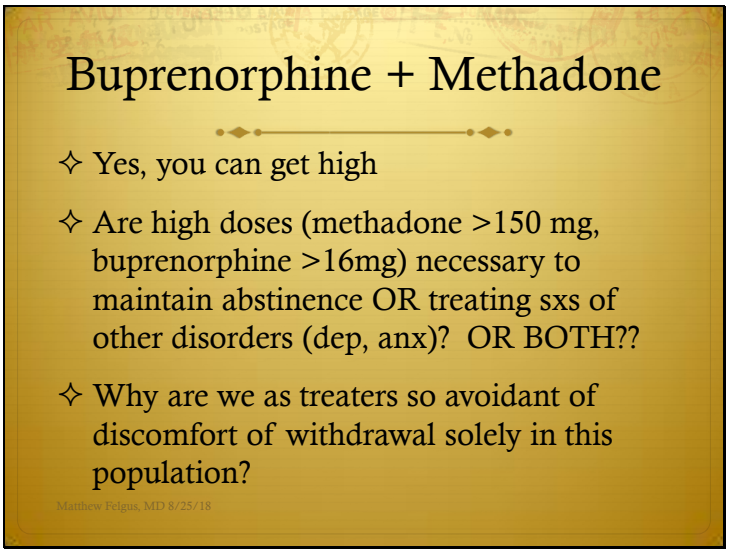
Slide 19


Buprenorphine + Methadone
✧ Yes, you can get high
✧ Are high doses (methadone >150 mg, buprenorphine >16mg) necessary to maintain abstinence OR treating sxs of other disorders (dep, anx)? OR BOTH??
✧ Why are we as treaters so avoidant of discomfort of withdrawal solely in this population?
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Slide 20

Buprenorpnine

- Dosage Range: not agreed upon
- Research shows receptors saturated at 16mg although some prescribers go MUCH higher
- Manufacturer does NOT recommend >24
- Quick detox vs. slow (1+yr.) detox vs. maintenance
- Is it possible to taper off without relapse?

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Slide 21

Buprenorphine/ Naloxone

- Yes, you can get high….if not opioid dependent
- Diversion of prescription
  - Party drug for those without an opioid habit
  - Prevention of opioid withdrawal in those using
  - Self detox for those trying to quit

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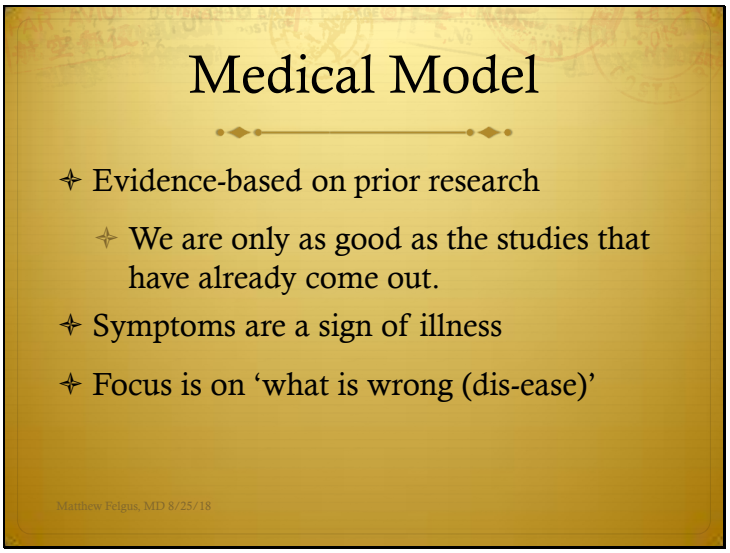
Slide 22

Buprenorphine/Naloxone

- MDs over-rely on medical model
  - "Everyone with chronic pain should be on Suboxone."
- Safer than other opioids, yes…but
- Are opioids truly the best treatment for chronic pain?

Slide 23


Medical Model
Evidence-based on prior research
We are only as good as the studies that have already come out.
Symptoms are a sign of illness
Focus is on 'what is wrong (dis-ease)'
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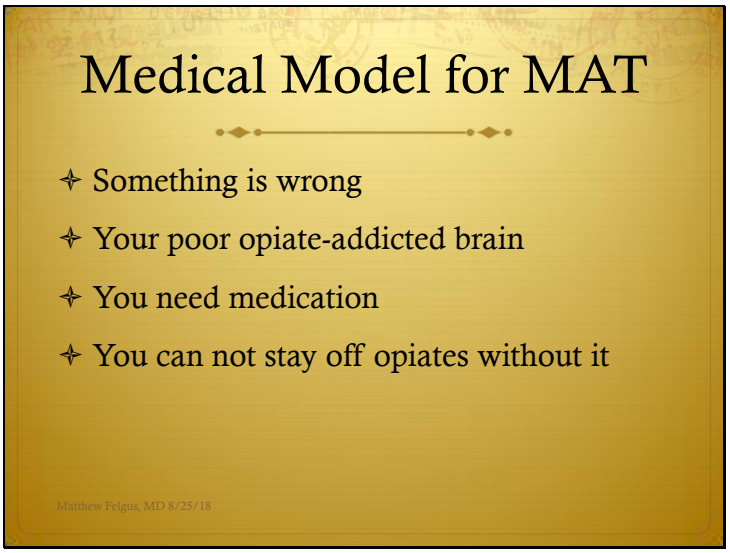
Slide 24


Medical Model for MAT
Something is wrong
Your poor opiate-addicted brain
You need medication
You can not stay off opiates without it
Matthew Felgus, MD 8/25/18

Slide 25

A Real Doctor-Patient Interaction:

- Pt: "Doc, I want to start getting off methadone. I feel ready to be clean."
- Addiction-specialist MD: "Do you want to be clean or do you want to be well? 91% of people who come off of opioid replacement relapse."

Slide 26

Evidence Based…

- ONE study reported that as many as 91% of those in recovery will experience a relapse
- This was a prospective follow-up of 109 opiate dependent patients admitted to residential addiction treatment in Ireland for detox and short-term Opiate Replacement
  - Smyth BP, Barry J, Keenan E & Ducray K (2010); Irish Medical Journal

Slide 27

Evidence Based…

- Treatment was abstinence-based with opiate replacement only for detox
- No long-term Opiate Replacement
- No mental health services mentioned
- 99 patients relapsed
  - Smyth BP, Barry J, Keenan E & Ducray K (2010); Lapse and Relapse Following Inpatient Treatment of Opiate Dependence. Irish Medical Journal 103(6) pp176-179.

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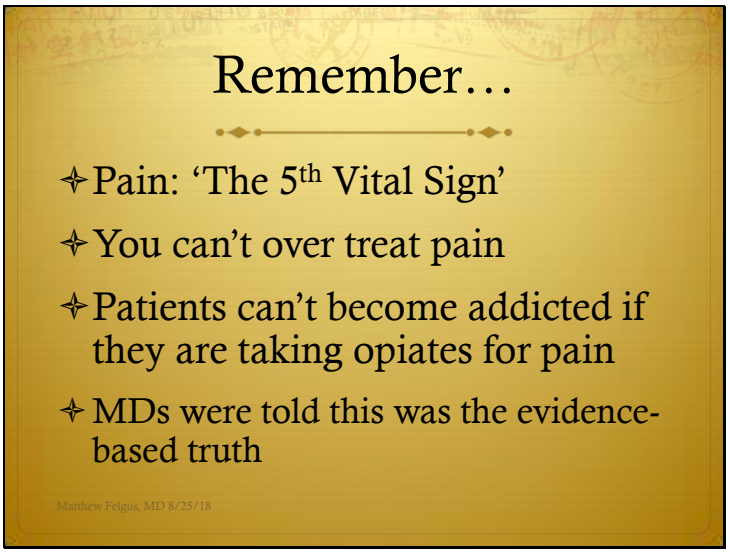
Slide 28

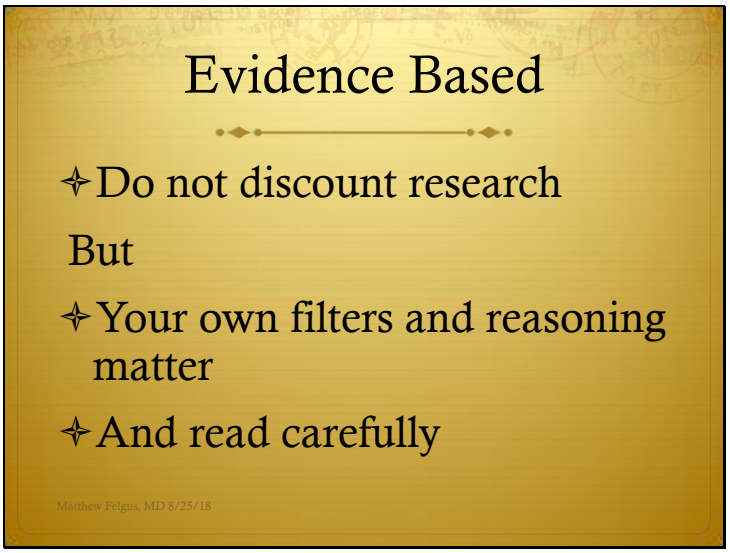
Evidence Based

- Most of the studies on pain medication or antidepressants are funded by companies that produce the medication
- Could there be some skewing of the data?
- If studies show a negative result, can they be dropped, never submitted for publication and disappear from all but buried company records?

Slide 29


Remember…
Pain: 'The 5th Vital Sign'
You can't over treat pain
Patients can't become addicted if they are taking opiates for pain
MDs were told this was the evidence-based truth
Matthew Felgus, MD 8/25/18

Slide 30


Evidence Based
Do not discount research
But
Your own filters and reasoning matter
And read carefully
Matthew Felgus, MD 8/25/18

Slide 31

Medication Assisted Treatment…

- Saves lives
- Ideally equal parts of all of the above
- May consist of replacement or blocking agent

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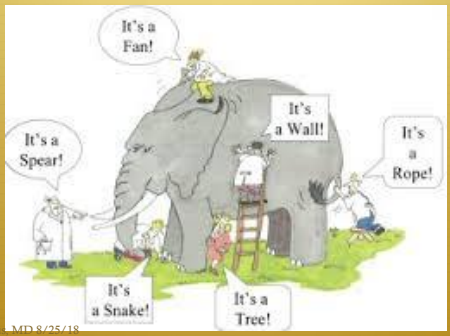
Slide 32

Do Addiction Specialists agree on the 'best' method for MAT?



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Slide 33

The Mental Health 'Big 4' for Driving Addiction
Anxiety
Depression
Trauma
Insomnia
and Pain
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Slide 34

MAT
Recovery is a state of mind, not whether someone is on opioid replacement
'There is a right way to work the 12 steps.' VS
'I've been going through the steps with my sponsor for 23 years. Every time, I go deeper.'
'Give me something so I don't feel this anymore.' VS
'I am trying to move myself forward.'

Slide 35

MAT

- Is NOT a wonder pill/film/shot
- How we give medication can be more important than what we give
  - Pill + guided healing makes the medication work better
  - Telling clients that the medication is but one piece of the puzzle sets expectation
  - MDs are not trained in healing

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Slide 36

55 year old female on Buprenorphine

"I'm feeling more stressed. This past month, I've gotten in more trouble with the IRS and I don't know if I'll be able to pay my mortgage. Can I get an increase so I can feel more comfortable?"

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Slide 37

Medications for Cravings?

- Anti-Craving medications do not address the underlying MH 'driver'
- What exactly is driving a craving?

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Slide 38

Treatment

- Helping people to heal what's inside them or numb out?
- We are living in a quick-fix, easy-out culture and our media is reinforcing this
- Marijuana as medicine? (Different question from legalization)

Slide 39

MAT Options

- How we offer MAT does matter
  - Medication is one tool
  - Medication is the tool
- We need to deal with underlying issues for effective treatment

Slide 40

Some MAT Options

- Saturate the opioid receptors with a high dose and stay there
- Taper as quick as possible (3-6mos)
- Taper slowly (4-5 years)
- See a counselor for mental health
- See an addiction counselor or group

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Slide 41

Treatment Model (Felgus)

- IN THE BEGINNING (approx. 60-90 days:)
  - Educate about anxiety vs. withdrawal differences and to distinguish
  - Don't call anxiety 'cravings'
  - Use anxiety medication (non-addicting) when indicated
  - Encourage once-daily dosing

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Slide 42

Treatment Model (Felgus)

- IN THE MIDDLE (3-12+ mos. or above 2 mg:)
  - Step-down gradual decrease better (4+ yrs.) vs. detox vs. lifelong
  - Mental preparation for decreases
    - Anxiety may ‘unmask’ as opiate dose lowered
    - Plan decreases for times of lower life stress
    - Q 3+ months based on individual progress

Matthew Felgus, MD, FCP, FAPA

Slide 43

Treatment Model (Felgus)

- IN THE MIDDLE
  - Don't fall into trap of 'status quo'/false sense of security (opioids mask emotions)
  - Utilize other medication when indicated
  - Encourage anxiety management
    - Therapy, individual and group
    - Relaxation/yoga/acupuncture
    - Exercise

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Slide 44

Treatment Model: Getting Stuck

- "I can't get below 2 mg! I'm never going to go back to pills or heroin so why can't I stay on this dose forever? I'm working full-time. I'm stable and enjoying my life. I get too anxious, have no energy and can't sleep when I try to go lower."

Slide 45

Let Sleeping Dogs Lie?

- Numbing out anxiety.
- Using opioid replacement as a sleep aid
- Using opioid replacement as a mood enhancer
- Using opioid replacement to maintain energy.

Slide 46

Treatment Model (Felgus)

- AT THE END (2 mg. and less:)
  - VERY important to continue therapy
  - Preparation for being opiate-free (vs. clean)
  - May need to step up recovery work
  - Slow down taper(2→1.5→1→.5 →.25→.25 every other day)
  - THIS PHASE OFTEN TAKES 1-2 YEARS. BE PATIENT

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Slide 47

Case Study: Jack

- Jack is a 26 year old computer programmer who presents for evaluation as a transfer from another buprenorphine provider. He has been prescribed Suboxone® 36 mg. per day for the past 10 months. He reports he isn't sure that medication is working.

Slide 48

Case Study: Jack

- Jack reports that for the first several weeks of treatment, he had been given 16 mg. He used no other opiates during this time. However, 4-5 hours after taking his dose, he would experience shortness of breath, increased heart rate, sweating, edginess.

Slide 49

Case Study: Jack

His MD increased his buprenorphine to 20 mg for 2 days, then 24 mg. per day in a divided dose. He reported good effect, but after 1 week, all of his "withdrawal" symptoms returned, this time 4 hours after each dose. He had no use of other opiates but admitted thinking about it, only to relieve sxs.

Slide 50

Case Study: Jack

Suboxone® increased to 32 mg, then with continuing complaints of withdrawal up to 36 mg. (16mg in the morning, 20 mg in the evening.) After one month, he did try to decrease to 32 mg. but began to worry that his symptoms would come back so his MD increased and kept him at 36 mg.

Slide 51

Case Study: Jack

- Diagnosed with Generalized Anxiety Disorder
- Started on citalopram and gabapentin. Later added propranolol
- Started individual CBT and group therapy. Over past 3 years, Brainspotting.
- After 3 months of above, did decrease buprenorphine to 28 mg. Six years later, dose is 0.5 mg. Seven years later, off.

Matthew Tyson, MD, PhD

Slide 52

Final Thoughts…

- Addiction is a condition of body, mind and soul
- Nearly all individuals who become addicted are trying to numb something, and need our help to learn to feel again
- Medication alone will not solve the issue of substance abuse and addiction but may be one piece of the puzzle

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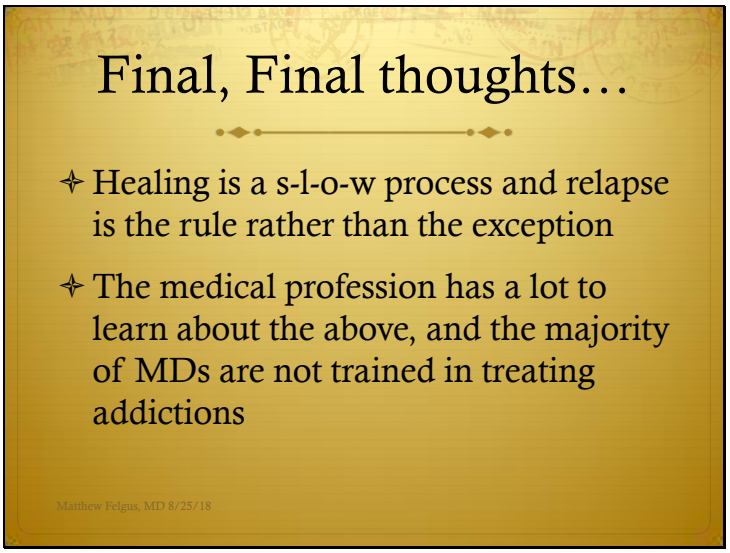
Slide 53


Final, Final thoughts…
Healing is a s-l-o-w process and relapse is the rule rather than the exception
The medical profession has a lot to learn about the above, and the majority of MDs are not trained in treating addictions
Matthew Felgus, MD 8/25/18