Pharmacotherapy for Addiction
A Practical Guide

Poll Everywhere
- Text: 22333
- Message: ROBYNJORDAN620

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Assistance Professor of Psychiatry
UNC School of Medicine

Sept 28, 2018

Disclosures

- None

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Objectives

- **Target Audience**: Psychiatrists, Nurse Practitioners, Physician Assistants, anyone interested in learning about medications for substance use disorders
- **By the end of this talk**, the audience will be able to:
  - Identify the indications for three medications used to treat alcohol use disorder.
  - Identify the indications for three medications used to treat opioid use disorder.
  - Reference the guidelines for prescribing and/or administering injectable medications for both alcohol and opioid use disorders.

AGENDA

- Part 1: Alcohol Use Disorder (45 min)
- Part 2: Opioid Use Disorder (45 min)
- Part 3: Putting it together (30 min)

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Part 1: ALCOHOL USE DISORDER

- Diagnosis of Alcohol Use Disorder
- Psychosocial Treatments for Alcohol Use Disorder
- Medications to Help Achieve and Maintain Abstinence

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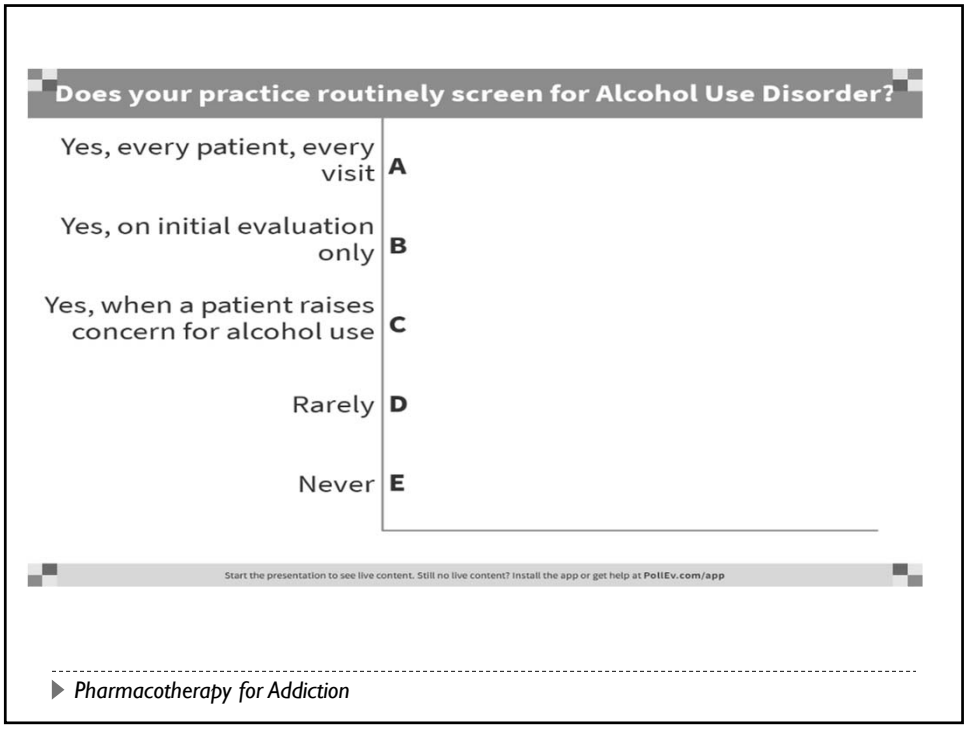
Does your practice routinely screen for Alcohol Use Disorder?
Yes, every patient, every visit
A
Yes, on initial evaluation only
B
Yes, when a patient raises concern for alcohol use
C
Rarely
D
Never
E
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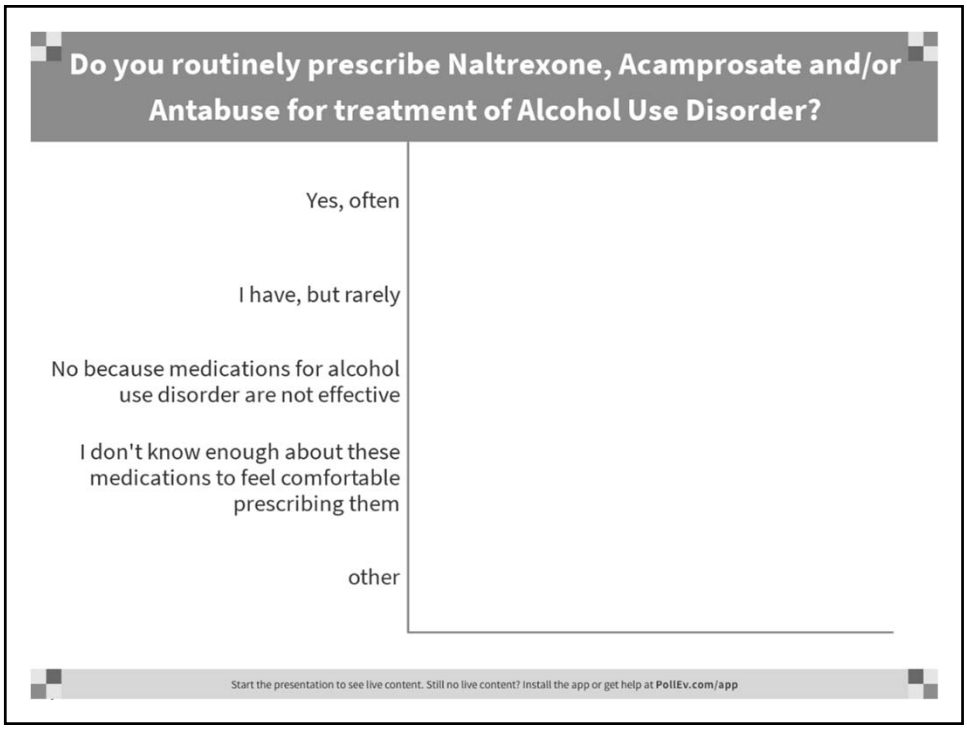
Do you routinely prescribe Naltrexone, Acamprosate and/or Antabuse for treatment of Alcohol Use Disorder?
Yes, often
I have, but rarely
No because medications for alcohol use disorder are not effective
I don't know enough about these medications to feel comfortable prescribing them
other
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Mr. G

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You have been gently encouraging him to address his drinking problem since then. He is finally ready to discuss it, because his friend just died of alcohol-related cirrhosis.

What medication would you consider offering Mr. G?

- Naloxone
- Naltrexone
- Antabuse
- Acamprosate
- None - medications are not helpful for alchol use disorder
- I have no clue - that's why I'm at this workshop

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DSM diagnosis of Alcohol Use Disorder

	DSM-IV Abuse[a]		DSM-IV Dependence[b]		DSM-5 Substance Use Disorders[c]	
Hazardous use	X	≥1 criterion	–		X	≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal[d]	–		X	≥3 criteria	X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

DSM-IV and DSM-5 Criteria for Substance Use Disorders
a One or more abuse criteria within a 12-month period and no dependence diagnosis; applicable to all substances except nicotine, for which DSM-IV abuse criteria were not given.
b Three or more dependence criteria within a 12-month period.
c Two or more substance use disorder criteria within a 12-month period.
d Withdrawal not included for cannabis, inhalant, and hallucinogen disorders in DSM-IV. Cannabis withdrawal added in DSM-5.

Hasan, D. Am J Psychiatry. 2013;170(8):834-851

Identifying "Risky Drinking"

Men < age 65
- more than 14 drinks per week
- more than 4 drinks in any one day

Women (and men >65)
- more than 7 drinks per week
- more than 3 drinks in any one day

If yes: brief intervention

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Psychosocial Interventions for AUD

- Peer support
- Motivational Interviewing
- Cognitive Behavioral Therapy
- "Medication Management" visits

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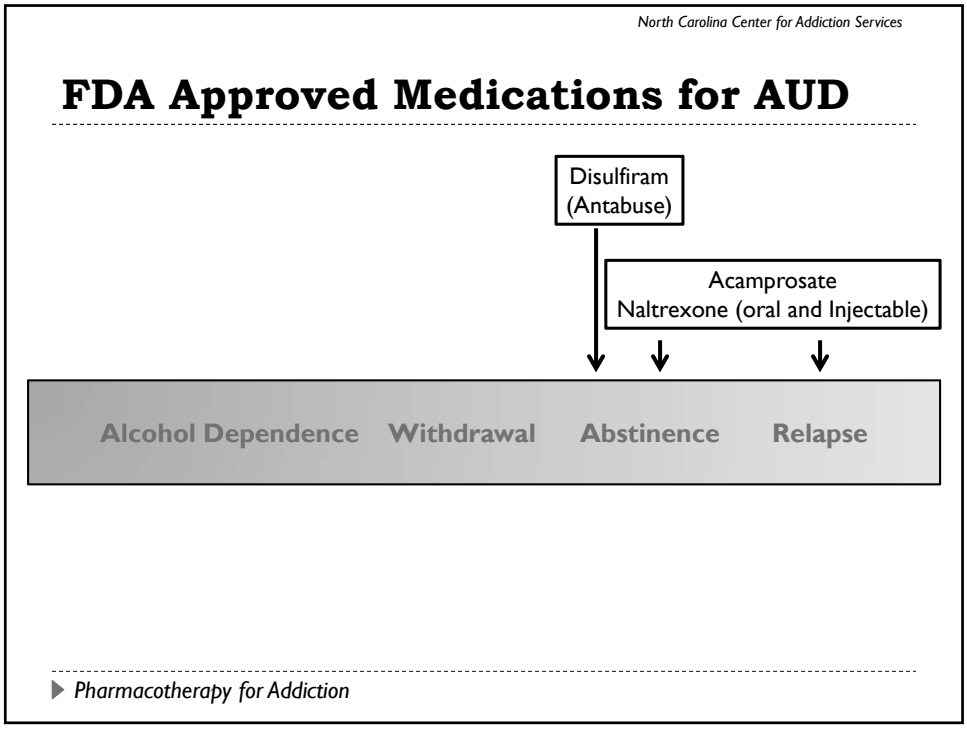
FDA Approved Medications for AUD

- Disulfiram (Antabuse)
- Acamprosate (Campral)
- Naltrexone, oral (Revia)
- Naltrexone, injectable (Vivitrol)


North Carolina Center for Addiction Services
FDA Approved Medications for AUD
Disulfiram
(Antabuse)
Acamprosate
Naltrexone (oral and Injectable)
Alcohol Dependence
Withdrawal
Abstinence
Relapse
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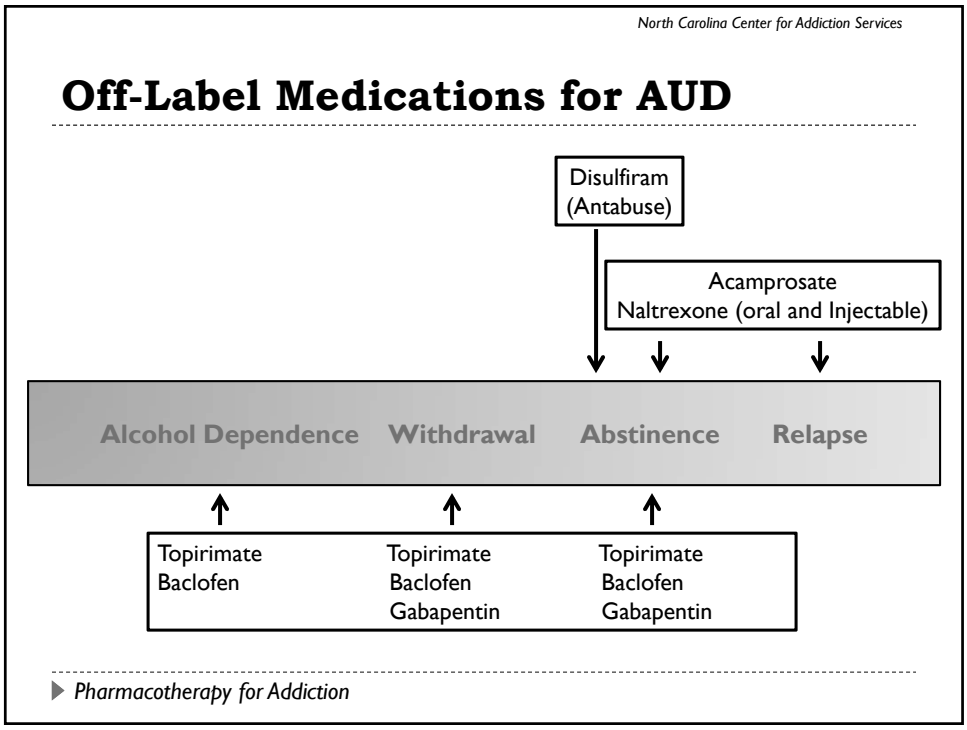
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Off-Label Medications for AUD
Disulfiram
(Antabuse)
Acamprosate
Naltrexone (oral and Injectable)
Alcohol Dependence
Withdrawal
Abstinence
Relapse
Topirimate
Baclofen
Topirimate
Baclofen
Gabapentin
Topirimate
Baclofen
Gabapentin
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Naltrexone

Indication: Alcohol (or opioid) cravings

Dosing: 50mg once daily (potential benefit at 100mg). Can start at 25 mg/day which may reduce risk of nausea.

Details

- Most common side effect is nausea/vomiting, which can lead to discontinuation. Can recommend taking it with food
- Recommend taking it in the morning, as this is when motivation tends to be the highest. Some patients prefer later in the day which may reduce nausea.
- Check LFTs at baseline, after 1 month, and every 6 – 12 months

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Naltrexone

Important consideration: LIVER

Black box warning for liver damage: Initial studies used doses of naltrexone around 300mg and higher and patients were noted to have liver damage (elevated LFTs), leading to a black box warning to naltrexone. Over time, more studies indicated that there was not increased effectiveness with doses greater than 50mg and naltrexone dosed at 50mg tends to not cause liver damage and is much better tolerated. However, naltrexone still carries a black box warning and LFTs should be monitored every 6 – 12 months.

Harm Reduction: Heavy alcohol use leads to liver damage, whereas naltrexone 50mg daily usually does not. If a patient has liver failure, you must consider the risk/benefit ratio.

Naltrexone can be prescribed in patients with mild to moderate liver failure (just make sure to monitor LFTs). Patients in fulminant, stage IV liver failure should consider another medication

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Naltrexone

Important consideration: OPIOIDS

Pt must be opioid free for at least 7 – 10 days prior to starting Naltrexone (longer if the opioid is methadone or suboxone)

- Naltrexone binds the opioid receptor and is thought to block the reward pathway, thereby decreasing cravings.
- Naltrexone binds the opioid receptor with a very high affinity, higher than most other opioids, effectively blocking the opioid receptor and preventing other opioids from binding.
- If a patient is taking naltrexone and has an acute emergency (ie, MVA with broken leg): the patient can still get acute pain relief from opioid management.
- For a patient on standing opioid therapy (ie, chronic pain management or buprenorphine): naltrexone can not be prescribed because it will out-compete the other opioid and cause precipitated withdrawal.

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Vivitrol

(XR Naltrexone, a long acting injectable form of naltrexone)

Indication: alcohol or opioid cravings

Dosing: 380mg IM every 4 weeks

Details

- Same indications and side effects as listed for naltrexone
- If a person has GI upset with naltrexone, they can still use Vivitrol. GI upset is usually lower with Vivitrol given it doesn't have concentration peaks like naltrexone does.
- Vivitrol costs about $1400/injection and is covered by most insurance companies with prior authorization.

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Vivitrol cont.

- Released Spring 2006
- Monthly, sustained release
- Avoids major adherence problems
- Appears to have less liver toxicity, nausea
- Probably more effective than oral naltrexone
- Concern re OD risk after relapse

Lee, J Subst Abuse Treat 2012

Acamprosate

Indication: alcohol cravings, increase likelihood of sobriety

Dosing: 666mg tid (no dose adjustments indicated)

Details

- Makes drinking less pleasurable
- Most common side effect is loose stools, which rarely leads to discontinuation. Overall, well tolerated
- It has low bioavailability so it must be dosed three times a day for best effectiveness.
- It comes in a 333mg pill, which means the patient must take 2 pills 3 times a day (180 pills for 30 day supply).

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Acamprosate cont.

- Due to tid dosing and pill burden, most patients choose to either not take acamprosate or if they do, compliance is often low.
- Excretion is through the kidneys, not metabolized by the liver, making it a good choice for patients with severe liver dysfunction.
- For those with hepatorenal failure, acamprosate can still be used. If there is renal insufficiency, consult with a pharmacist regarding using a lower dose.
- Acamprosate has little drug-drug interactions and is safe to use in most circumstances

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Disulfiram (Antabuse)

"THE MEDICINE THAT MAKES YOU SICK"

BREAKDOWN OF ALCOHOL

STEP 1: Alcohol Dehydrogenase

↓

STEP 2: Aldehyde Dehydrogenase

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BREAKDOWN OF ALCOHOL

STEP 1: Alcohol Dehydrogenase

ANTABUSE ⟶

~~STEP 2: Aldehyde Dehydrogenase~~

Tachycardia
Flushing
Headache
Nausea
Vomiting

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Disulfiram (Antabuse)

Indication: prevention of alcohol consumption (does not treat cravings)

Dosing: 500mg daily for 14 days (to fully inactivate all enzymes), then 250mg daily (no need for dose adjustment once pt is taking 250mg)

Details

- Generally well tolerated, can have mild GI side effects, strange taste, rash
- Often recommend patients take it in the morning, when motivation tends to be the highest

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Disulfiram (Antabuse) cont.

- Recommend family members assist with reminding patients to take it, as long as the family relationship is favorable and not coercive
- Recommend patients use mouthwash without alcohol
- "Normal" amount of hand sanitizer use is not a problem
- Package insert reports Antabuse is effective up to 14 days, but patient's report it's effective for about 1 week.
- Antabuse is not appropriate for the patient who is drinking daily. This either sets the patient up for failure or the patient simply will not fill the prescription.

Disulfiram (Antabuse) cont.

- Antabuse is appropriate for the patient who is able to:
  - maintain sobriety for a few days at a time
  - trying to stop intermittent relapses
  - highly motivated for sobriety
- Antabuse is metabolized through the liver but does not carry the same black box warnings for patients with liver failure. Regardless, it can cause liver damage and LFTs should be assessed 1-2 months after initiation and then again at 6-12 months.

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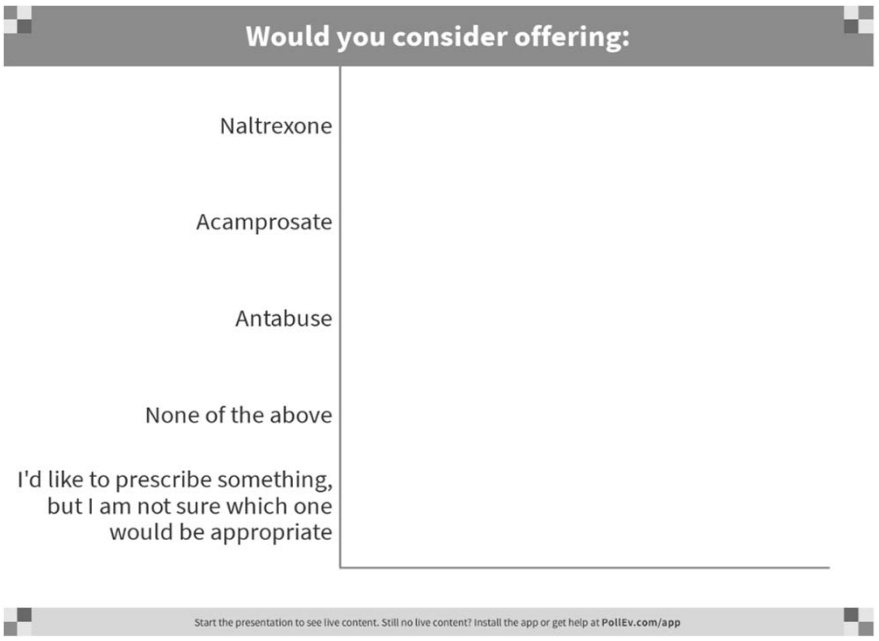
New Patient Evaluation

During a new patient evaluation, a 24 year old male reports that he drinks a 6 pack of beer on 1 or 2 nights per weekend. He recently got a DUI after driving home from his friends house, and now has a suspended license. He makes less money now that he can't make deliveries for work. His wife is annoyed that he still spends money on beer and that she has to drive him to work now

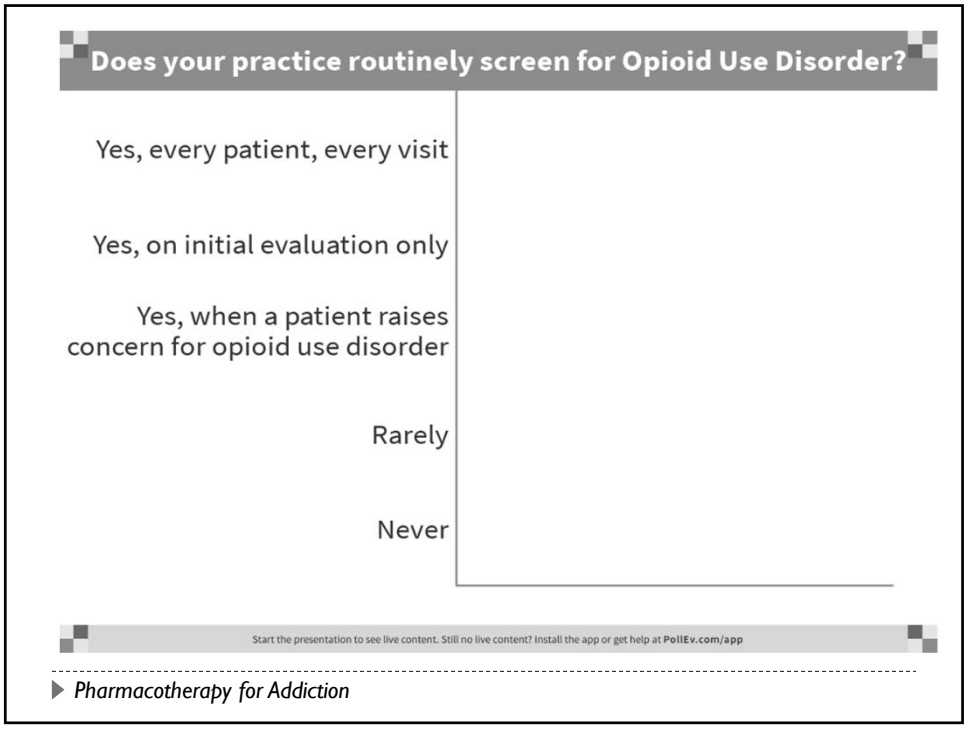
Does this pt meet criteria for:

- Alcohol Use Disorder, Severe
- Alcohol Use Disorder, Moderate
- Alcohol Use Disorder, Mild
- Risky Drinking
- His alchol use is not a problem



Part 2: OPIOID USE DISORDER

- Diagnosis of Opioid Use Disorder
- Review Effectiveness of Medication Assisted Treatment (MAT)
- Medications for Opioid Use Disorder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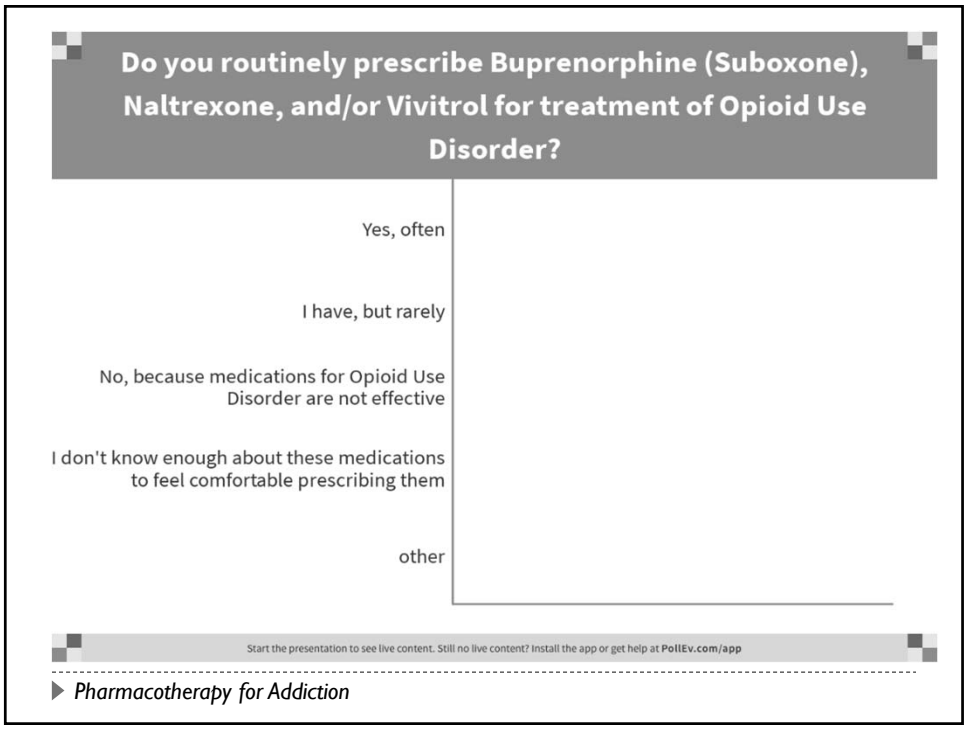
Do you routinely prescribe Buprenorphine (Suboxone), Naltrexone, and/or Vivitrol for treatment of Opioid Use Disorder?
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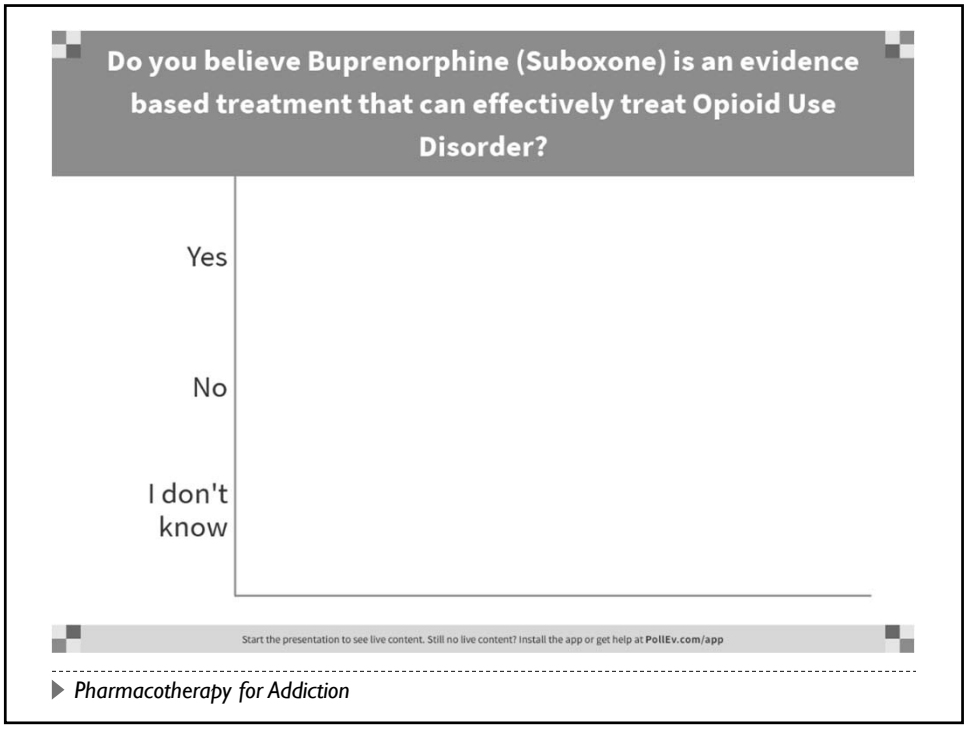
Do you believe Buprenorphine (Suboxone) is an evidence based treatment that can effectively treat Opioid Use Disorder?
Yes
No
I don't know
Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app
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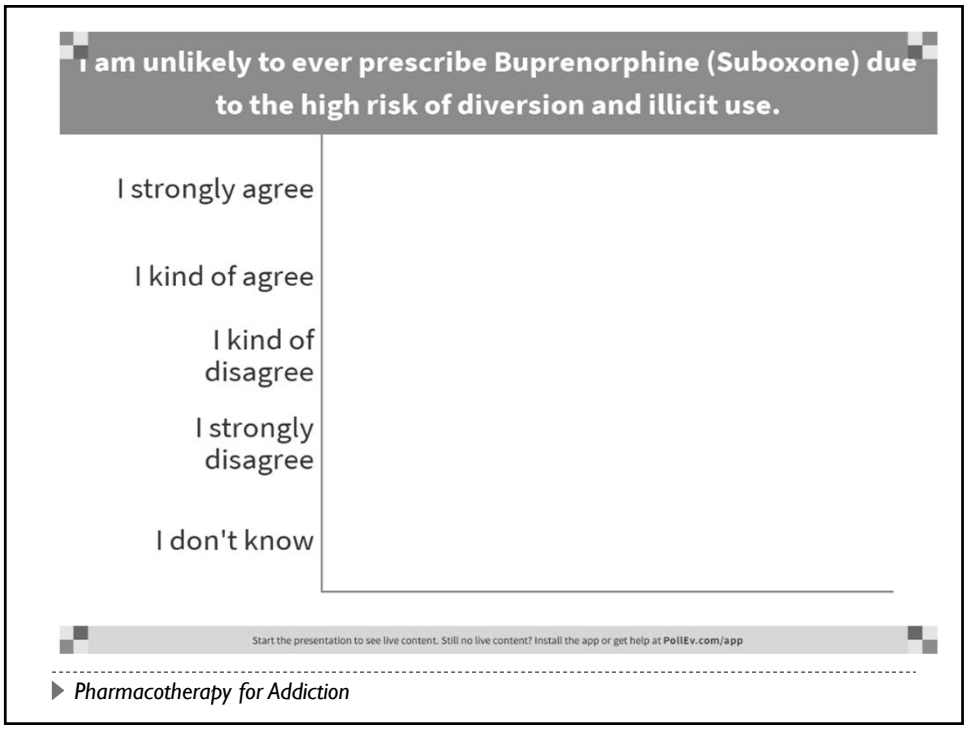
I am unlikely to ever prescribe Buprenorphine (Suboxone) due to the high risk of diversion and illicit use.
I strongly agree
I kind of agree
I kind of disagree
I strongly disagree
I don't know
Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app
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DSM Diagnosis of Opioid Use Disorder

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Hasan, D. Am J Psychiatry. 2013;170(8):834-851

Opioid Use Disorder

Most effective treatment is Medication Assisted Treatment

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How do Opioid Agonist Medications help?

- Prevent withdrawal from opioids thereby providing physiological stabilization that can allow recovery to take place
- Diminish/eliminate cravings for opioids
- Block euphoric effect of using opioids

Treatment of Opioid Use Disorder is Effective

- Decreases death rate [1]
- Decreases HIV infection [2-3]
- Opioid agonist treatment of injection drug users decreased HIV incidence by 54% [2]
- Decreases crime [4]

1.KreekJ, SubstAbuse Treatment 2002; GuevePN, Addiction 2002
2.MacArthur, BMJ, 2012
3.Metzgar, Public Health Reports 1998
4.Gerstein DR et al, CALDATA General Report, CA Dept of Alcohol and Drug Programs, 1994

Treatment of Opioid Use Disorder is Effective

Maintenance treatment with buprenorphine or methadone cuts the risk of hepatitis C infection by 2/3

K Page, JAMA IM, 2014

Regulatory Background

- FDA approved:
  -methadone for opioid addiction in 1972
  -buprenorphine for opioid addiction in 2002
  -XR-naltrexone for opioid addiction in 2010

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  -Waiver ("X" number) to prescribe buprenorphine in an outpatient clinic
  -Buprenorphine: 30 patients for year 1; 100 patients for at least 1 year; then up to 275 patients if requested.C

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- There are no regulatory requirements for XR-naltrexone (Vivitrol).

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Opioid Agonists

Methadone & Buprenorphine

Methadone

- Full Mu receptor agonist
- Long-acting, half-life 24-60 hours
- Prevents withdrawal symptoms, including craving, without the opioid euphoria if targeted at "right" dose, generally 80-120 mg/day
- Dangerous in overdose and when combined with other sedative medications including benzodiazepines and alcohol

Methadone

- Causes a 2/3 reduction in heroin use; can also be used for pain pill addiction
- Crime decreased 84%, drug selling decreased 86%
- Hospitalization decreased 58%
- Highly cost-effective for society: savings $3-4 for every dollar spent on treatment

Gerstein DR et al, CALDATA General Report, CA Dept of Alcohol and Drug Programs, 1994

Who is appropriate for methadone?

- Long history and high level of opioid dependence
- Need for greater structure for social stabilization as will need to go to clinic daily to get medication
- Significant concerns about diversion
- Do poorly on buprenorphine or naltrexone

Opioid Treatment Program (OTP)

- Methadone can only be prescribed in a federally-regulated OTP when used for treatment of addiction
- Directly observed therapy
- Exposure to other drug users

Salsitz, Mt Sinai J of Medicine, 2000

Concerns about Methadone

- Sedation, "high"
- High doses required to be effective
- Difficult withdrawal
- Overdose potential
- "diversion"
- Stigma

Opioid Agonists

Methadone & Buprenorphine

Buprenorphine is Effective

	Buprenorphine	Placebo
Retained at 1 year	70%	0
Died	0	20%

- 40 young heroin users
- Buprenorphine 16 mg/day vs
- taper + placebo
- All received counseling, groups
- Followed for 1 year
- UDM entirely negative in about 75% of bup recipients

Kakkoet al, Lancet 2003

MAT is Evidence Based

Author, Journal	Year	"n"	Setting	% still participating in treatment
Fudala, NEJM	2003	461	Multicenter research trial	57% @ 6 months
Alford, JGIM	2006	85	Acad med Ctr/ Community clinic; ½ patients homeless; nurse case mgr	81% @ 12 months
Mintzer, Ann Fam Med	2007	99	4 primary care practices	54% @ 6 months
Cunningham, Fam Med	2008	41	Urban community health center	71% @ 3 months
Soeffing, J Subst Abuse	2009	255	Urban academic health center	57% @ 12 months

Starting MAT in the Hospital

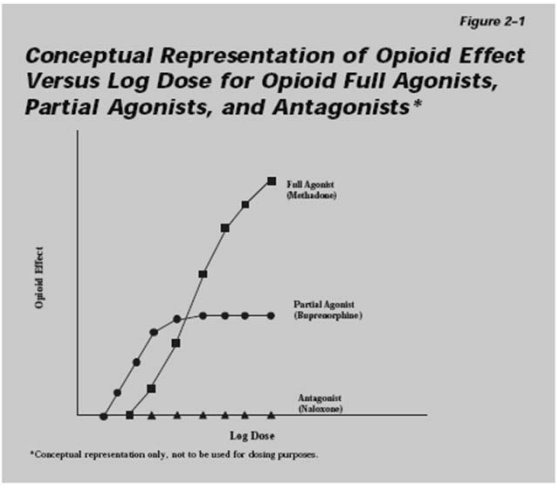
72% of inpatients randomized to maintenance buprenorphine with linkage to outpatient buptreatment successfully entered maintenance outpatient treatment, vs. 12% of inpatients randomized to 5 day buptaper.

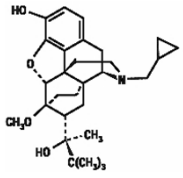
LiebschutzJ, JAMA IntMed 2014

Formulations of buprenorphine

- **Subutex** - sublingual buprenorphine alone
- **Suboxone, Zubsolv, Bunavail –** sublingual or cheek patch of buprenorphine plus naloxone (naloxone activated if tampered)
- **Generic buprenorphine +/- naloxone** available, quality varies
- **Probuphine -** 320 mg given as 4 subdermal implants in the inner upper arm. Lasts 6 months.
- **Sublocade** - New subcutaneous formulation of buprenorphine for 4-week administration

Buprenorphine
A Partial μ-opioid Receptor Agonist





Advantages:
-Very low lethality
-Improved side-effect profile
-Less diversion liability but still significant

Buprenorphine

- Active metabolite, norbuprenorphine
- Long-acting, half-life ~ 30 hrs and 40 hrs for norbup
- Binds strongly to u-opioid receptor but partial agonist activity makes it MUCH SAFER than full agonist
- Some increased opioid sensitivity when stopped which can increase overdose risk to heroin, oxycodone, etc.

What does Suboxone look like?

Suboxone 8mg tablet

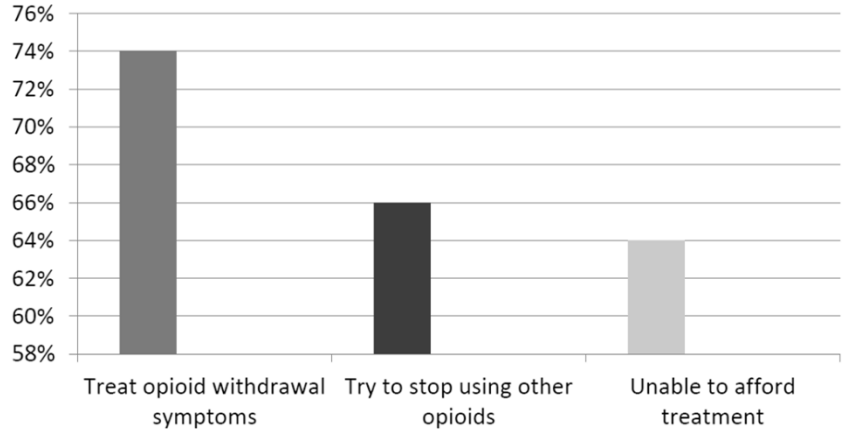

Suboxone 8mg film

Diversion

- 2010 Harvard study of people seeking treatment concluded: ***"illicit buprenorphine rarely represents an attempt to attain euphoria. Rather, illicit use is associated with attempted self-treatment of symptoms of opioid dependence, pain, and depression."***
- •Interestingly, although absolute numbers of diverted tablets are increasing, diversion has remained relatively steady as a proportion of prescribed tablets

Schuman-Olivier, JSAT, 2010
Johanson, Drug Alcohol Dep, 2012

Reasons for Illicit Use of Buprenorphine



Bazazi, J Addict Med 2011

Sublocade

- SUBLOCADE contains buprenorphine, a partial opioid agonist, and is indicated for the treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a transmucosal buprenorphine-containing product, followed by dose adjustment for a minimum of 7 days.
- SUBLOCADE should be used as part of a complete treatment program that includes counseling and psychosocial support.

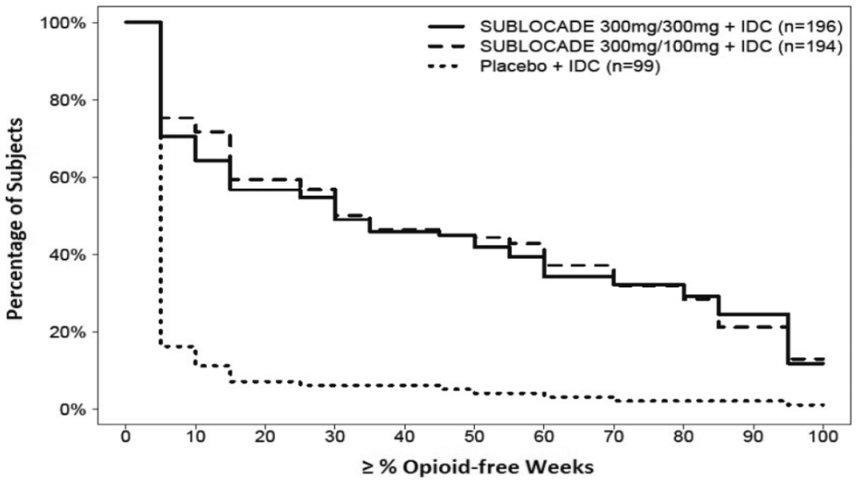
Sublocade
Abdominal Subcutaneous Injection

2.2 Important Dosing and Administration Information

FOR ABDOMINAL SUBCUTANEOUS INJECTION ONLY. DO NOT ADMINISTER SUBLOCADE INTRAVENOUSLY OR INTRAMUSCULARLY *[see Warnings and Precautions (5.1), Dosage and Administration (2.6)]*.

- Only healthcare providers should prepare and administer SUBLOCADE.
- Administer SUBLOCADE monthly with a minimum of 26 days between doses.
- Initiating treatment with SUBLOCADE as the first buprenorphine product has not been studied. Initiate SUBLOCADE treatment only following induction and dose-adjustment with a transmucosal buprenorphine-containing product *[see Dosage and Administration (2.4)]*.
- Administer each injection only using the syringe and safety needle included with the product *[see Dosage and Administration (2.6)]*.

Figure 12. Subjects Achieving Varying Percentages of Opioid-Free Weeks



Pharmacotherapy for Addiction

Buprenorphine

Buprenorphine is an effective treatment that can help your patients who are dependent on pain pills or other opioids.

Pharmacotherapy for Addiction

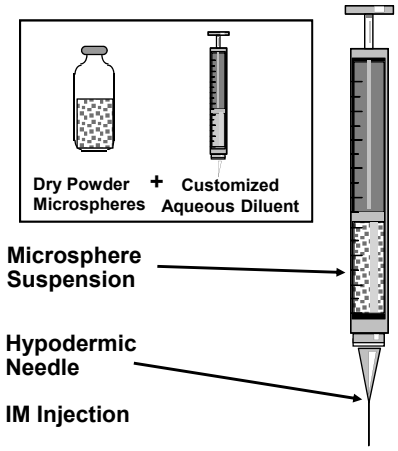
Opioid Antagonists

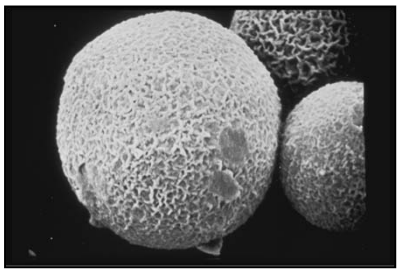
Naltrexone and XR-Naltrexone (Vivitrol)

Naltrexone and XR-Naltrexone (Vivitrol)

- Full antagonist given orally or intramuscularly
- Oral form has half-life ~ 24hrs; XR-Naltrexone is a monthly injection
- Individual cannot get "high" while on naltrexone though may continue to use drug out of habit.
- When stopped there can be increased sensitivity to opioids and thus risk for overdose.

XR-Naltrexone Delivery System





Scanning EM of microspheres

Once Monthly Dosing

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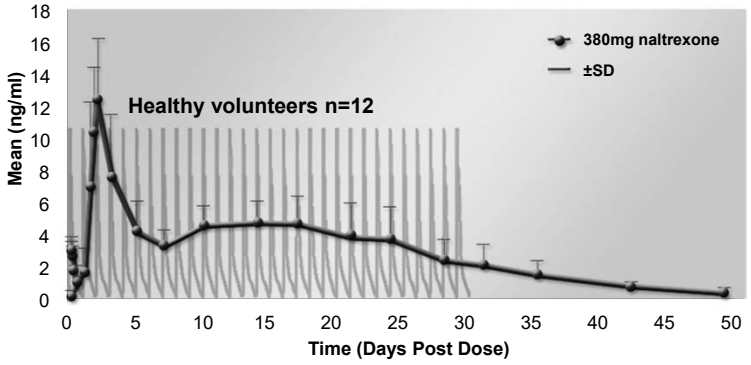
Naltrexone Concentrations Following a Single Long-Acting Naltrexone Injection



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Long-Acting Naltrexone and Opioid Dependence

Primary Trial: Krupitsky et al, Lancet 2011; 377: 1506–13

- Approved by FDA for opioid dependence in 2010. Monthly injection, 380 mg
- Need to be opioid free for 7-10 days prior to injection
- Consider transitioning buprenorphine patients to Vivitrol as it allows the brain to become opioid free while protecting the patient

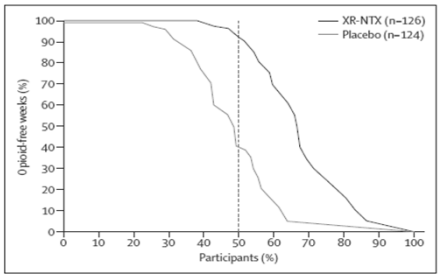

Figure 2: **Percent of confirmed opioid-free weeks (cumulative) among participants treated with XR-NTX compared with placebo**
XR-NTX=extended-release naltrexone.

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Buprenorphine vs Naltrexone

Lancet Nov 2017

- 570 patients in multiple US community programs
- From inpatient detox, randomized to bupe vs naltrexone
- Followed for 6 months
- Primary outcome: rate of opioid relapse

RESULTS

- 28% of naltrexone arm unable to tolerate induction
- As a result, buprenorphine was more effective in intention-to-treat analysis
- If only included those who successfully inducted, both treatments were similar in rate of opioid relapse as well as OD events

Take Away

- Naltrexone can be an effective treatment, but is likely more appropriate
- for patients with lower severity disease and who can tolerate induction

Pharmacotherapy for Addiction

Question

- Mr. R is a 24 y/o man who started taking opioid pain pills after a sports injury. He has progressed to snorting the pills, and then smoking them. He buys the pills from several physicians. He recently lost his management job after his boss found him sleeping at his desk and required a drug test, which showed opioids.
- Mr. R comes to see you to talk about how he can get a handle on this problem. He states that he does not think he is really addicted because he just smokes the pills and does not inject.

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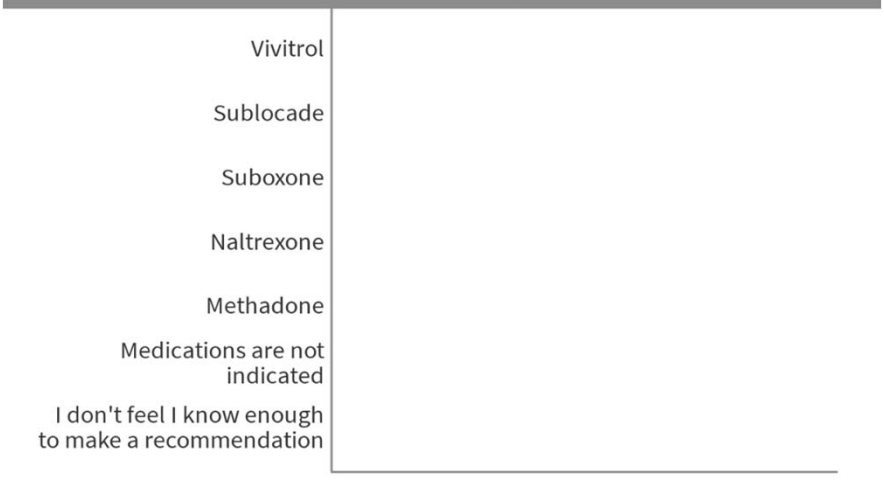
You recommend to Mr. R that he may have Opioid Use Disorder. What medication would you consider?



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Question

- **Ms. A is a 49 year old woman who is enrolled in a program designed to help "super-utilizers" of medical care. She was diagnosed with Idiopathic Pulmonary Fibrosis and is on high-flow oxygen.**
- **At the time of enrollment she was receiving high-dose benzodiazepines and opioids to treat anxiety and pain in her chest. She spent most of her time in bed, had a pulmonary embolus, was hospitalized every 2-6 weeks for pneumonia and respiratory decompensation, and walked with a walker.**
- **After several months of working with the team she was willing to consider that her frequent hospitalizations could be due to sedation and respiratory suppression. She agreed to taper off of benzodiazepines, which she did over 2 months. Then she was transferred to buprenorphine/ naloxone.**
- **Although she reports ongoing anxiety and chest pain, she has been able to turn down her oxygen from 6 to 2 liters. She has stopped using a walker, swims every day, and has not been hospitalized in the 6 months since switching to buprenorphine. She says she feels more "alive" than she has in years.**

Now that Ms. A is doing better, when would you recommend stopping suboxone?

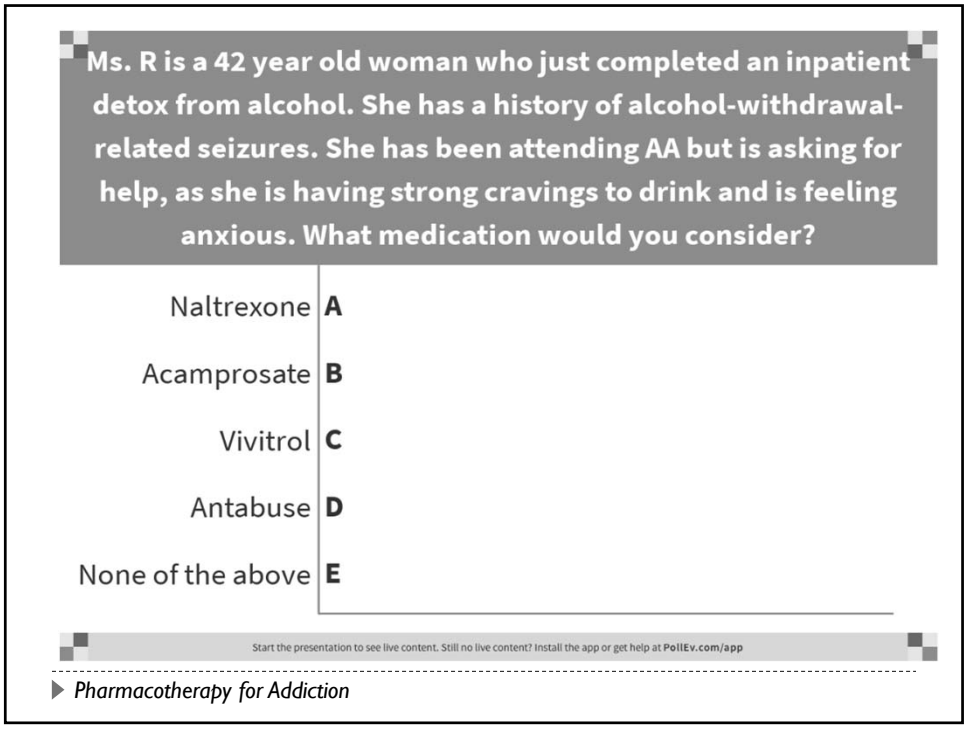
Taper and d/c in 3 months	A
Taper and d/c over the next year	B
Continue MAT treatment as long as it's indicated, indefinitely if needed	C

Integrating Buprenorphine, Methadone and Naltrexone (Vivitrol) in Clinical Practice

- Majority of opioid dependent patients coming to an outpatient setting are most likely to be buprenorphine candidates
- Patients with heavy opioid use and long duration and/or with social chaos/diversion concerns may do best in a methadone program if available
- Patients with limited but concerning opioid use and able to be opioid free for 7-10 days may be good XR-Naltrexone candidates if affordable

Part 3: Putting it all Together

- Diagnosing patients with Alcohol and/or Opioid Use Disorders
- Choosing Appropriate Medications
- Where to go for more Information


Ms. R is a 42 year old woman who just completed an inpatient detox from alcohol. She has a history of alcohol-withdrawal-related seizures. She has been attending AA but is asking for help, as she is having strong cravings to drink and is feeling anxious. What medication would you consider?
Naltrexone A
Acamprosate B
Vivitrol C
Antabuse D
None of the above E
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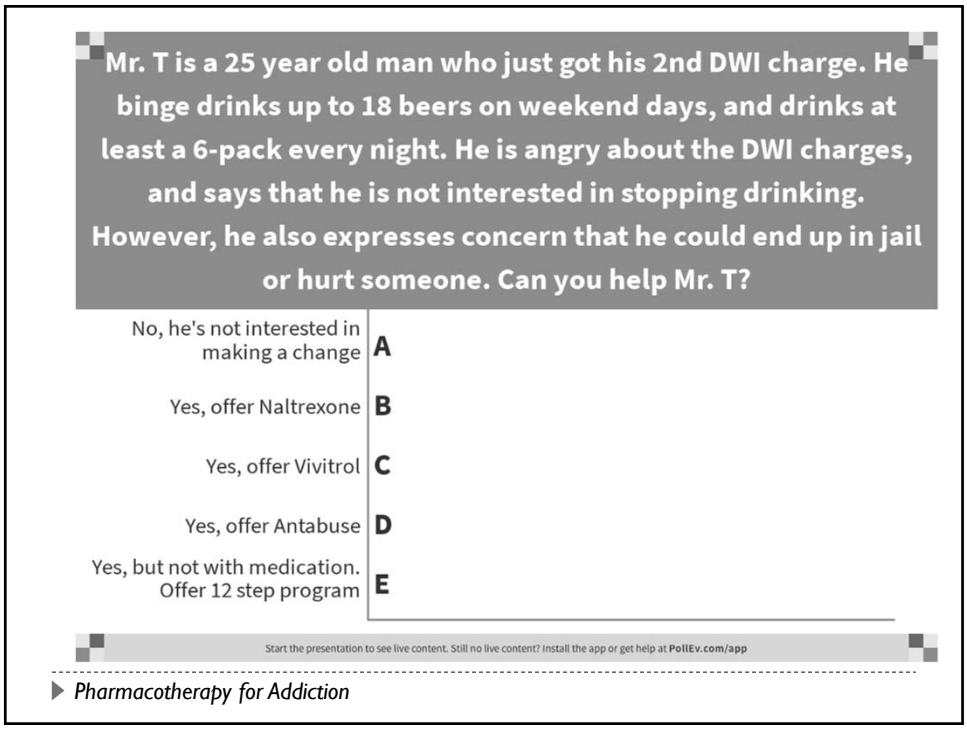
Pharmacotherapy for Addiction


Mr. T is a 25 year old man who just got his 2nd DWI charge. He binge drinks up to 18 beers on weekend days, and drinks at least a 6-pack every night. He is angry about the DWI charges, and says that he is not interested in stopping drinking. However, he also expresses concern that he could end up in jail or hurt someone. Can you help Mr. T?
No, he's not interested in making a change A
Yes, offer Naltrexone B
Yes, offer Vivitrol C
Yes, offer Antabuse D
Yes, but not with medication. Offer 12 step program E
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JV

- JV is a 40 year old man with history of chronic back pain after he sustained a work injury a few years ago.
- PMH of alcohol use disorder now in remission.
- Initially prescribed oxycodone/acetaminophen 10 mg q4-6 hours
- After 4 months of medication prescribed by a PCP, JV reports pain is not controlled at this dose and requests a dose increase which his PCP does not authorize.
- JV escalates his own dose and takes 2 pills q 4-6 hours and runs out in two weeks.
- He then presents to the ER 3 days after running out of medication with abdominal pain, diarrhea, sleep disturbance and requesting an increase pain medication

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Does JV meet criteria for Opioid Use Disorder?

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JV

- After ED visit, patient discharged with twenty tablets of oxycodone/acetaminophen and told to follow up.
- Started buying medication from a friend at work
- Initially taking medication orally
- Started using intranasally up to 180 mg daily
- Spending a great deal of time using the drug and trying to obtain it.
- He promptly switched to heroin use intranasally daily and after three months began using up to 5-10 bags of heroin IN daily.

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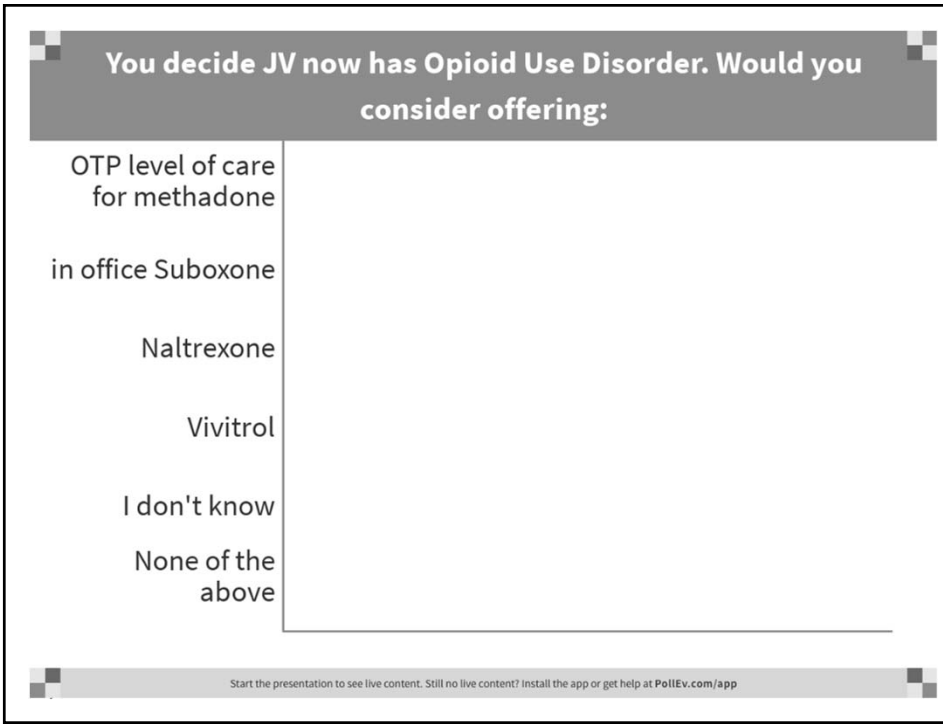

Ms. L is a patient who has been stable on buprenorphine for 6 months and inquires about coming off the medication. What do you recommend?

- stopping buprenorphine is not recommended
- Ok, but this will require a long, slow taper
- Ok, but you should consider transitioning to naltrexone

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Mr. W

Mr. W has been a patient in your clinic for 5 years and is undergoing treatment for opioid use disorder, depression and anxiety. He has been stable on suboxone for about 4 years with no relapses. You've been treating his depression and anxiety, which had worsened over the past year. You've learned that he is now drinking alcohol, to the point of meeting criteria for moderate alcohol use disorder. He is drinking daily and appears to have dependence on alcohol.

Pharmacotherapy for Addiction

How to Learn More about MAT

UNC ECHO

FOR MEDICATION ASSISTED TREATMENT

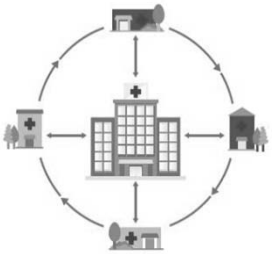
Project Sponsored by AHRQ and NC DHHS
Principle Investigator: Sherri Green

UNC ECHO for MAT

MISSION: Project ECHO® (Extension for Community Healthcare Outcomes) is a movement to demonopolize knowledge and amplify the capacity to provide best practice care for underserved people all over the world.

Moving Knowledge, Not Patients

Through telementoring, ECHO creates access to high-quality specialty care in local communities.



Hub and spoke knowledge-sharing networks create a learning loop:

Community providers learn from specialists.

Community providers learn from each other.

Specialists learn from community providers as best practices emerge.

Goals of UNC ECHO for MAT

1. Disseminate best practices information to clinicians so they are better prepared to provide evidence based Medication Assisted Treatment (MAT).
2. Increase knowledge and self-efficacy related to MAT through case-based education and mentorship.
3. Improve utilization and access to Substance Use Disorder Resources in the practitioners community.

ECHO is Tele-Mentoring
ECHO is NOT Tele-medicine

Upcoming Waiver Trainings

- **Tuesday, Nov 6th 8:00am – 12:30pm at UNC Chapel Hill Campus**
  Half and Half Waiver course sponsored by ASAM and UNC ECHO for MAT
  9 hours CME creidt
- **Providers Clinical Support System (PCSS)**
  www.pcssnow.org
  SAMHSA sponsored program in response to the opioid epidemic
  No upcoming events in NC
- **American Society of Addiction Medicine (ASAM)**
  Education → "Live and Online CME" → Waiver Qualifying Training
  No upcoming events in NC
- **Buppractice.com**
  Online course for $199
  9 hours CME credit

Resources

UNC ECHO for MAT
www.echo.unc.edu

The American Psychiatric Association
Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder

Provider Clinical Support System (PCSS)
www.pcssnow.org

Acknowledgments

- James C. Garbutt, MD
- Miriam Komaromy, MD
- ECHO Project

Thank you!

QUESTIONS?

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