ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

Alcoholism and Drug Abuse Weekly
Volume 23 Number 27
July 18, 2011

Interview

CRC's Herschman on choosing MAT for opioid addiction

Patients addicted to opioids, in the real world, have a choice of methadone treatment in an opioid treatment program, monthly Vivitrol injections, or buprenorphine prescriptions. At CRC Health Group, the largest substance abuse treatment provider chain in the country, patients have a choice as well. And nobody is better than Philip L. Herschman, Ph.D., returned to his position as chief clinical officer by new CEO Andy Eckert this spring, to talk about how patients are matched to medication-assisted treatment (MAT) for opioid addiction.

"There's not a simple answer," Herschman told ADAW last week. "In terms of real management of opioid dependency, the medication for either detox or maintenance would be methadone, buprenorphine, or Vivitrol."

The most-used medication is methadone, he said. "This is by dramatic orders of magnitude. It's still the least expensive form of treatment. You can get a month's worth of treatment in an OTP, which includes counseling and seeing a physician, for half of what buprenorphine medication alone costs and for a third of the cost of Vivitrol."

But economics aren't the only way the choice is made. "If you put on your clinical hat and talk about which medication might be more appropriate for which population, you would say that methadone is more appropriate for the longer-term heavier user of opioids, and buprenorphine is more effective with the younger population that hasn't been using for very long and whose dosage isn't high." Buprenorphine is also used for detoxification, he said.

CRC last spring launched a program, now called Provita, in which patients are hospitalized for two weeks for detoxification, and then administered their first shot of Vivitrol (see ADAW, February 28). "At this point, you can see that Vivitrol is useful for the physicians, lawyers, and other diversion populations," he said. Because it's an antagonist, with no abuse potential, naltrexone (oral or

Vivitrol) is preferred for many professionals, especially those with access to medications. However, that doesn't necessarily mean it wouldn't be equally efficacious in other populations, he said. "Vivitrol is still sort of an unknown in terms of which populations it's best for," he said, "but the research on it looks really good."

Every kind of MAT has pluses and minuses from the patient viewpoint, as well, he said. "The down side of methadone is that you have to walk into a clinic every day. You can get a prescription for buprenorphine from a doctor, but the down side is that all too often there isn't much counseling. Vivitrol is attractive because you only have to think about it once a month, but the same concern is there — there is not as much counseling going on as there should be."

If patients go to a CRC clinic, they would be given the option of buprenorphine or methadone, but buprenorphine is usually rejected because of the cost, said Herschman. A typical dose for an opioid-dependent patient costs about $500 a month. CRC currently treats 26,000 patients in OTPs, and about 500 of them are maintained on buprenorphine instead of methadone. About 500 injections of Vivitrol were given last month, some for alcohol, but most for opioid dependence. "We were using it for alcohol before we rolled out Provita," said Herschman.

Herschman said Vivitrol will probably be most useful for higher-functioning patients who are going back to strong support systems, have jobs and families, and — this is key — have insurance that covers the medication. □