

May 26, 2015

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Murphy:

Thank you very much for the opportunity to testify before your Subcommittee. I am honored to respond to the additional questions that were submitted. Here are my responses to the questions from the following Members:

The Honorable Larry Bucshon

Will you expand on your experience specifically with naltrexone, and how greater access could be helpful across the nation?

We have found naltrexone, particularly the injectable extended-release form known as Vivitrol, to be a potent resource in our treatment approach. We started using it with our opioid-dependent patients in 2012, and consistent with the medical research, have found that it reduces opioid craving and supports abstinence from opioids. If it were more affordable and widely available, that would certainly aid in the nationwide fight against opioid addiction.

Naltrexone reduces cravings and blocks the effect of any opioids. It is available in two forms: a pill that is taken daily, and the extended-release injection (Vivitrol) that is provided once a month. The daily pill option has limitations due to the lack of adherence. If it is provided in a monitored manner to ensure daily use, it is effective; otherwise it is not because people may refuse to take it every day. We seldom use the pill form, but provide the injections regularly. The great benefit of Vivitrol is that the patient only has to make a once-a-month decision to continue therapy, rather than a daily decision.

Patients who take Vivitrol are more likely to remain opioid-free and adhere to other aspects of ongoing treatment like group therapy, individual therapy and Twelve Step meeting attendance. The medication also has little in the way of side effects.

Because people can't get intoxicated while on Vivitrol, it eases concerns of family members, and less monitoring is required. Also, because the injection lasts a month, patients who get sudden urges to use again are compelled to learn other coping skills, which help them get beyond the craving, avoid relapse and establish lifelong recovery practices.

Another advantage of Vivitrol is that it's easy to discontinue once it is no longer necessary. Unlike some other medications, it is not an opioid so there is no withdrawal syndrome.

We have found that if patients suddenly want to stop their Vivitrol injections, especially in early recovery, they are invariably planning a relapse to opioids. That is a strong cue for us to engage their family and all other resources in an attempt to persuade them to remain on the medication and involved in other means of treatment. .

In summary, we have found Vivitrol to be a very effective and essential option for treating opioid use disorders. A downside to its use is that it is expensive, and unfortunately not all insurance companies cover it. Patients must also be abstinent from opioids for 10 to 14 days before Vivitrol can be safely initiated, and this can be difficult to carry out in an outpatient setting. Greater access would certainly result in more people staying abstinent from opioids, thus reducing overdose deaths.

The Honorable Markwayne Mullin

Dr. Seppala, can you speak to the challenges you've seen in treating someone who is addicted to opioids versus other substances, like alcohol, for instance. What are the challenges specifically related to what those people may need once they have left an inpatient program?

Opioid addiction is an especially difficult addiction to treat, when compared with addictions to other substances like alcohol. Individuals dependent on prescription pain medications and/or heroin face unique challenges that can undermine their ability to stay in treatment and achieve long-term abstinence.

They are hypersensitive to pain and more vulnerable to stress. Their anxiety, depression and intense craving for these drugs can continue for months, even years, after getting free of opioid use. They experience a strong desire to feel “normal” again – to escape what seems like a permanent state of dysphoria, which puts them at high risk of relapse. They are also at higher risk of accidental overdose during relapse because they no longer have the tolerance to handle the same doses they were taking prior to treatment. In other words, with opioids – unlike other drugs – relapse often means death.

People with opioid dependence tend to leave treatment early, especially when feeling a bit better right after detoxification. This is a chronic illness and they require long-term care. Unfortunately, insurance often does not allow for the extended period of care needed by these individuals.

Many of these patients are compelled to enter treatment by family and friends through an “intervention,” and have little initial interest in treatment. They have great difficulty recognizing the consequences and problems associated with opioid use, which undermines their ability to begin to engage in treatment. Our challenge is to engage them and help them see this illness for what it is, improving the likelihood they will successfully adhere to treatment recommendations and seek abstinence.

Patients with opioid use disorders can be impulsive, angry and treatment-resistant, which can be a challenge in a group treatment setting. This can undermine the formation of positive relationships, which are so important to recovery. Also, the craving these patients experience is severe and long lasting. They also tend to enter treatment in late stages of addiction, and as with any disease, the late stages are harder to treat. For these reasons, patients need longer periods of treatment and abstinence before they are stable in recovery and able to effectively monitor and structure themselves.

In addition, the stigma of opioids, especially injectable heroin, is worse than other drugs, which can prevent people from seeking treatment and undermine recovery efforts. For example, many sober homes will not accept residents who are taking opioid addiction medications like Suboxone. Some recovery support groups are resistant to accepting these individuals as well.

Another challenge is that opioid-dependent patients have frequently burned bridges with family and friends to such a degree that they have lost the support that is so essential to recovery. They may have gained money for drugs by engaging in behaviors they are ashamed of and reticent to discuss. This burden of shame can undermine treatment, and the behaviors may have placed them at high risk for serious infections like HIV, hepatitis and staph.

Thank you very much for your leadership on these important issues. Please let me know if you need additional information on these specific questions, or if I can ever be helpful to you.

Sincerely,

A handwritten signature in black ink that reads "MD Seppala, MD". The signature is written in a cursive, somewhat stylized font.

Marvin D. Seppala, M.D.
Chief Medical Officer, Hazelden Betty Ford Foundation