2019 Highlands
Opioid Symposium
May 23, 2019
1

WELCOME

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- TRI-COUNTY HUMAN SERVICES, INC. (TCHS)

House Keeping

- **Rest Rooms**
- **Lunch** *(Provided)*
  - 11:45 AM – 12:30 PM *(Video on Naloxone)*
- **Break**
  - 1:30 PM – 1:45 PM
- **Wrap Up**
  - 4:15 PM – 4:30 PM

Understanding Opioid Addiction, Opioid Abuse Impact on Hospital Emergency Rooms, Medication Assisted Treatment and Modalities

Jason Fields, MD

MAT IN FLORIDA

PATHOPHYSIOLOGY OF ADDICTION AND MEDICATION ASSISTED TREATMENT FOR OPIOID USE DISORDER

Prescriber Peer Mentor Training

SPONSORED BY
THE FLORIDA ALCOHOL AND DRUG ABUSE ASSOCIATION (FADAA)
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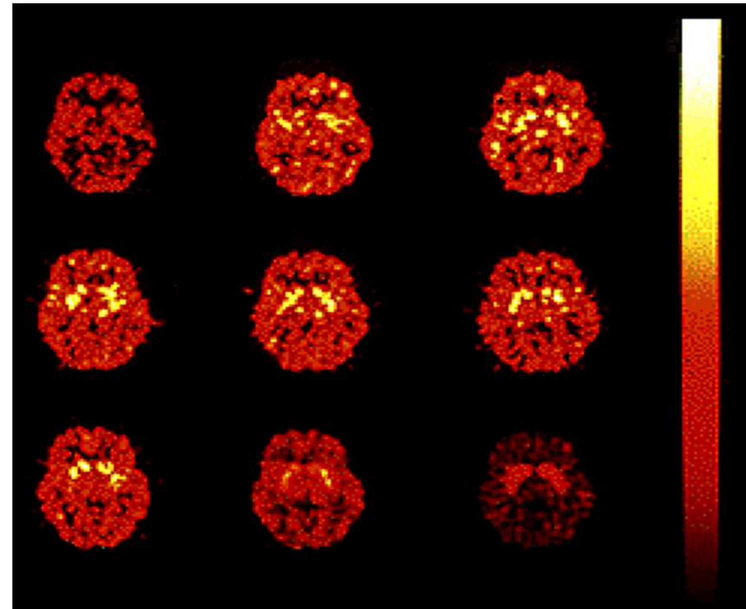
FLORIDA PRESCRIBER PEER MENTORS

- Dr. Eduardo Camps-Romero, Florida International University
- Dr. Jason Fields, DACCO Behavioral Health
- Dr. Jason Hunt, University of Florida
- Dr. Raymond Pomm, Gateway Community Services
- Dr. Courtney Rowling, C.L. Brumback Primary Care Clinics
- Dr. Mark Stavros, Florida State University, & West Florida Hospital
- Dr. Aaron Wohl, Lee Health

Source: Partnership for a Drug-Free America

YOUR BRAIN ON DRUGS IN THE 1980'S

YOUR BRAIN ON DRUGS TODAY!



YELLOW shows places in brain where cocaine goes (Striatum)

Cocaine

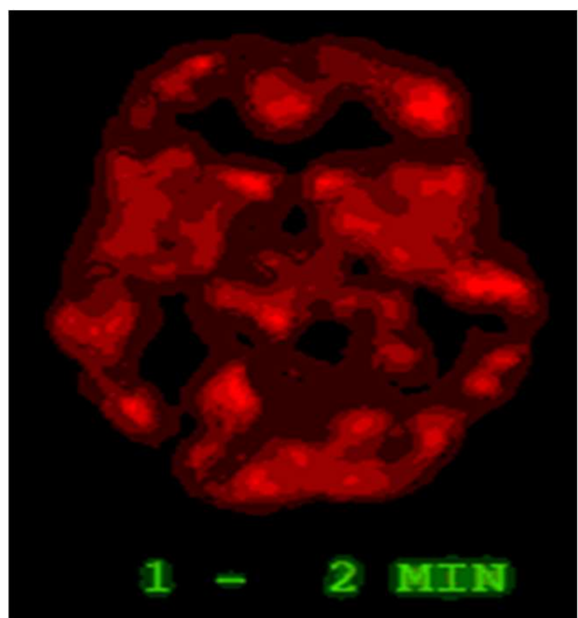


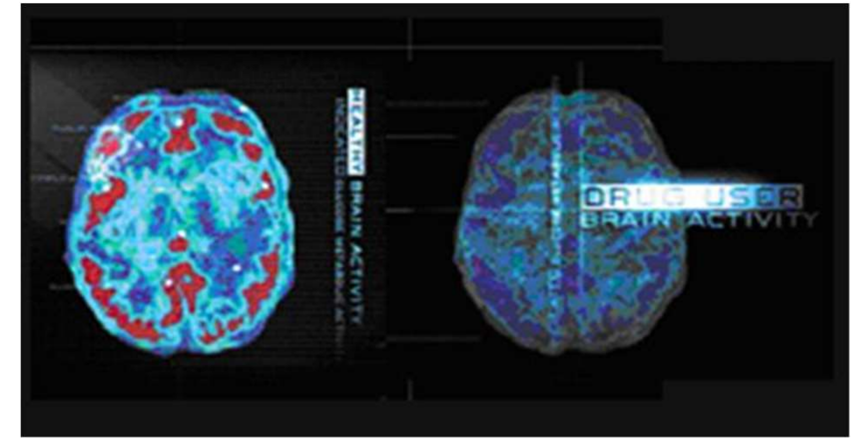
Photo courtesy of Nora Volkow, Ph.D

ADDICTION

WHAT IS ADDICTION?

Addiction is A Brain Disease Characterized by:

- Compulsive Behavior, Loss of Control
- CRAVING
- Continued Use of Drugs Despite Negative consequences
- Persistent Changes in the Brain's Structure and Function



ASAM DEFINITION OF ADDICTION (2011)

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

NIDA DEFINITION OF ADDICTION

- A chronic, relapsing disease characterized by compulsive drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain.

- Brain imaging studies show changes in the brain that are critical for judgement, decision-making, learning and memory, and behavior control.

DEFINITION OF DISEASE

A disease is abnormal condition, a disorder of a structure or function, that affects all (or part) of an organism. Disease is often construed as a medical condition associated with specific symptoms and signs.

A disorder of structure or function in a human, animal, or plant, especially one that produces specific signs or symptoms or that affects a specific location and is not simply a direct result of physical injury.

Pathophysiological = a disease is a cellular defect in an organ or organ system that leads to observable, measurable signs and symptoms

	Diabetes	SUD
Abnormal Condition		
Organ		
Symptoms		

DISEASE CONCEPT OF ADDICTION IS NOT NEW

Dr. Thomas Trotter (1788)

- First to characterize as disease/medical condition

Dr. Benjamin Rush (1808)

- “habitual drunkenness should be regarded NOT as a bad habit but as a disease”

Abraham Lincoln (1842)

- Non-alcoholics have “absence of appetite” rather than “mental or moral superiority”
- “victims of it were to be pitied and compassioned, just as are the heirs of consumption and other hereditary diseases”

From Lincoln's address to the Washington Temperance Society, Springfield, Ill. February 22, 1842

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Neurobiologic Advances from the Brain Disease Model of Addiction

Nora D. Volkow, M.D., George F. Koob, Ph.D., and A. Thomas McLellan, Ph.D.

THIS ARTICLE REVIEWS SCIENTIFIC ADVANCES IN THE PREVENTION AND treatment of substance-use disorder and related developments in public policy. In the past two decades, research has increasingly supported the view that addiction is a disease of the brain. Although the brain disease model of addiction has yielded effective preventive measures, treatment interventions, and public health policies to address substance-use disorders, the underlying concept of substance abuse as a brain disease continues to be questioned, perhaps because the aberrant, impulsive, and compulsive behaviors that are characteristic of addiction have not been clearly tied to neurobiology. Here we review recent advances in the neurobiology of addiction to clarify the link between addiction and brain function and to broaden the understanding of addiction as a brain disease. We review findings on the desensitization of reward circuits, which dampens the ability to feel pleasure and the motivation to pursue everyday activities; the increasing strength of conditioned responses and stress reactivity, which results in increased cravings for alcohol and other drugs and negative emotions when these cravings are not sated; and the weakening of the brain regions involved in executive functions such as decision making, inhibitory control, and self-regulation that leads to repeated relapse. We also review the ways in which social environments, developmental stages, and genetics are intimately linked to and influence vulnerability and recovery. We conclude that neuroscience continues to support the brain disease model of addiction. Neuroscience research in this area not only offers new opportunities for the prevention and treatment of substance addictions and related behavioral addictions (e.g., to food, sex, and gambling) but may also improve our understanding of the fundamental biologic processes involved in voluntary behavioral control.

From the National Institute on Drug Abuse (N.D.V.) and the National Institute of Alcohol Abuse and Alcoholism (G.F.K.) — both in Bethesda, MD; and the Treatment Research Institute, Philadelphia (A.T.M.). Address reprint requests to Dr. Volkow at the National Institute on Drug Abuse, 6001 Executive Bld., Rm. 5274, Bethesda, MD 20892, or at nvolkow@nida.nih.gov.

N Engl J Med 2016;374:363-71.
DOI: 10.1056/NEJMra1511480
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LEADING MEDICAL JOURNALS RECOGNIZE SUBSTANCE USE DISORDER AS A DISEASE

AMERICAN BOARD OF MEDICAL SPECIALTIES RECOGNIZES "ADDICTION MEDICINE"

Contact: Dennis Tartaglia
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For Immediate Release

AMERICAN BOARD OF MEDICAL SPECIALTIES RECOGNIZES THE NEW SUBSPECIALTY OF ADDICTION MEDICINE

Landmark Event Expected to Significantly Increase Number of Physicians Trained to Prevent and Treat Addiction

Bethesda, Maryland – March 14, 2016 – The American Board of Addiction Medicine (ABAM) is pleased to inform you that the American Board of Medical Specialties (ABMS) announced today the recognition of Addiction Medicine as a new subspecialty. The American Board of Preventive Medicine (ABPM), a Member Board of ABMS, sponsored the application for the new field to be a multispecialty subspecialty – meaning that physicians certified by any Member Board of the ABMS can become certified in addiction medicine.

"This is a great day for addiction medicine," said Robert J. Sokol, MD, President of ABAM and The Addiction Medicine Foundation (formerly The ABAM Foundation). "This landmark event, more than any other, recognizes addiction as a preventable and treatable disease, helping to shed the stigma that has long plagued it. It sends a strong message to the public that American medicine is committed to providing expert care for this disease and services designed to prevent the risky substance use that precedes it."

ADDICTION IS A BRAIN DISEASE, NOT A PARTISAN ISSUE

"We have to help our country see that addiction is not a character flaw or moral failing, it is a disease of the brain."
US Surgeon General

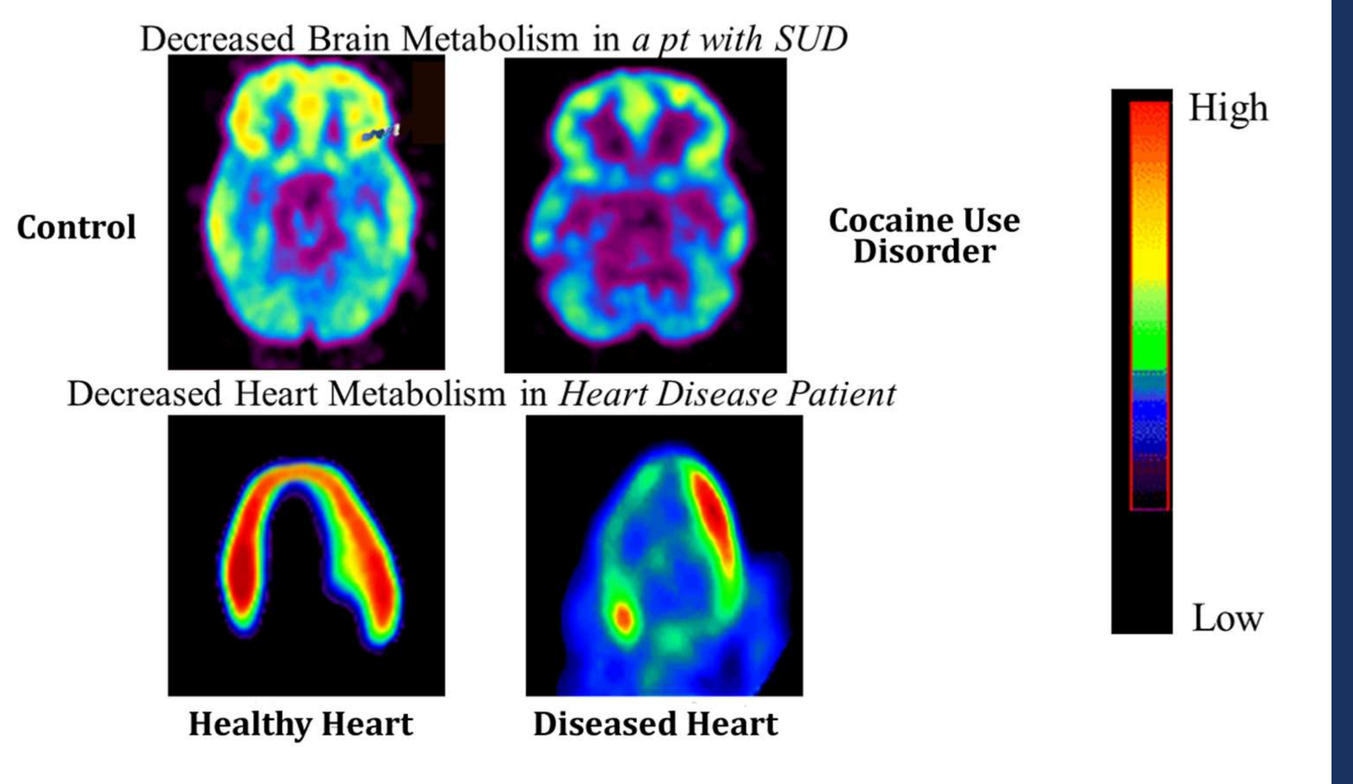
19th US Surgeon General (2014-2017)
Vice Admiral Vivek H. Murthy

20th Surgeon General (Current)
Vice Admiral Jerome M. Adams, M.D., M.P.H.

US Surgeon General at American at the American Medical Association meeting: "As physicians, we must say loudly for all to hear, We will not deny treatment to individuals with the brain disease of addiction."

Photo courtesy of US Department of Health and Human Services

NEUROBIOLOGY

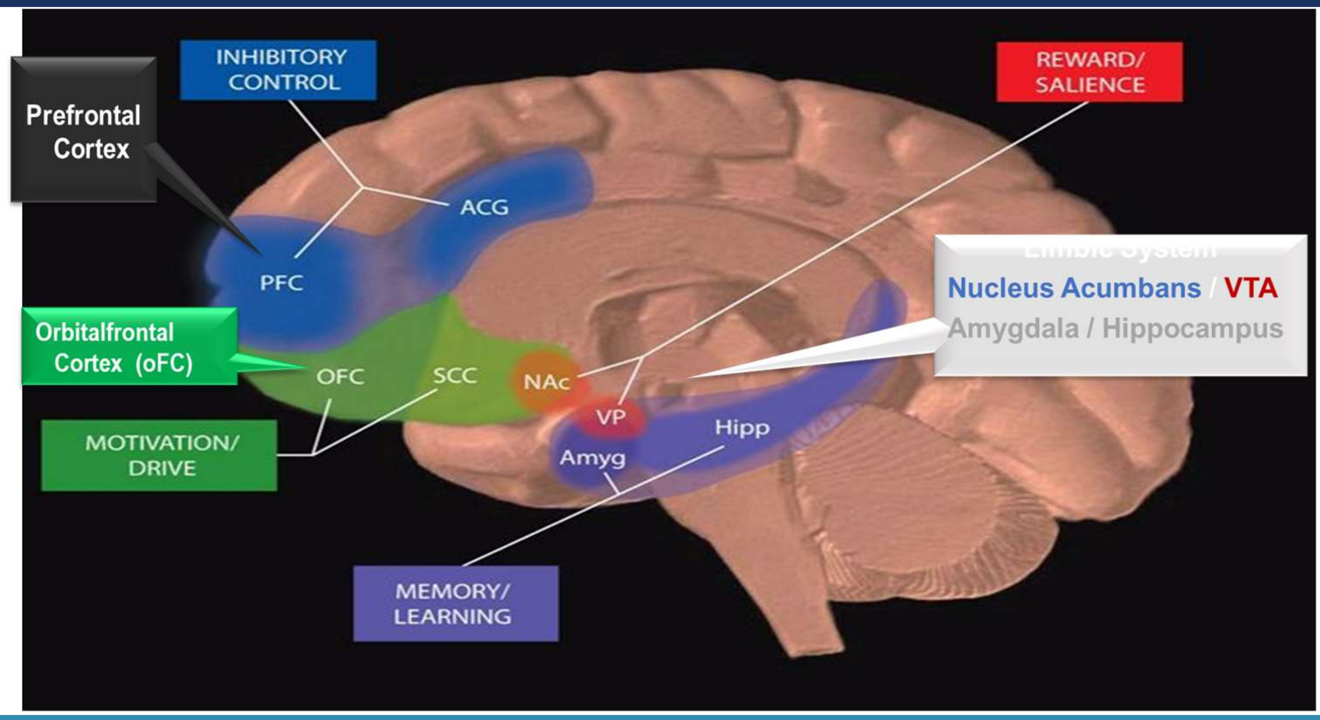


Sources: From the laboratories of Drs. N. Volkow and H. Schelbert

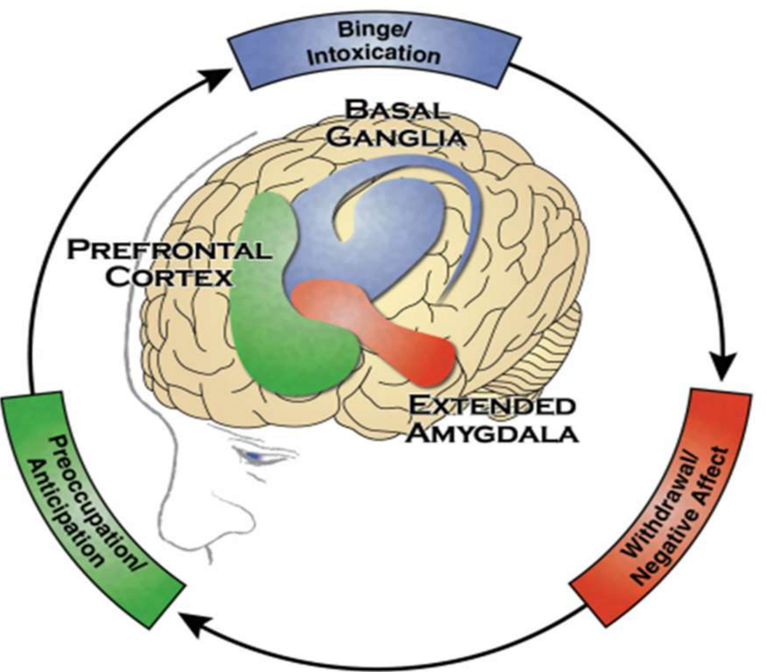
ADDICTION IS A BRAIN DISEASE

JUST LIKE OTHER DISEASES, IT AFFECTS FUNCTION

ADDICTION IS A PRIMARY, CHRONIC DISEASE OF BRAIN REWARD, MOTIVATION, MEMORY AND RELATED CIRCUITRY



THE THREE STAGES OF THE ADDICTION CYCLE AND THE BRAIN REGIONS ASSOCIATED WITH THEM



Source. Surgeon's General Report. 2016

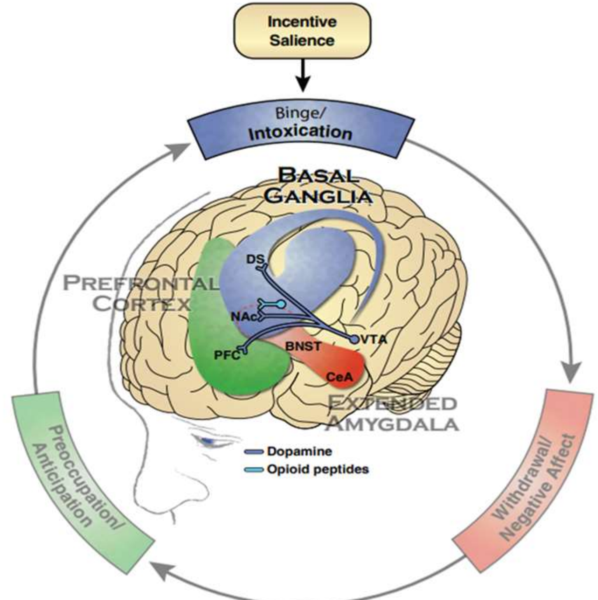
THE BINGE/INTOXICATION STAGE AND THE BASAL GANGLIA

The "reward circuitry" of the basal ganglia (i.e., the nucleus accumbens), along with dopamine and naturally occurring opioids, play a key role in the rewarding effects of alcohol and other substances and the ability of stimuli, or cues, associated with that substance use to trigger craving, substance seeking, and use.

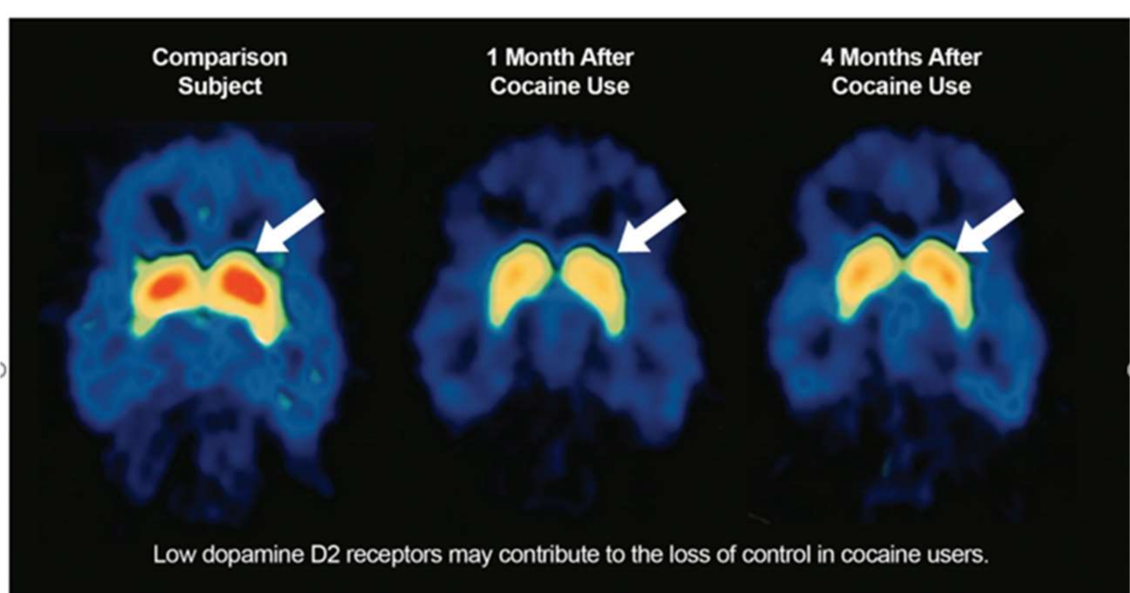
As alcohol or substance use progresses, repeated activation of the "habit circuitry" of the basal ganglia (i.e., the dorsal striatum) contributes to the compulsive substance seeking and taking that are associated with addiction.

The involvement of these reward and habit neurocircuits helps explain the intense desire for the substance (craving) and the compulsive substance seeking that occurs when actively or previously addicted individuals are exposed to alcohol and/or drug cues in their surroundings.

Figure 2.6: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Binge/Intoxication Stage of Addiction



TIME-RELATED DECREASE IN DOPAMINE RELEASED IN THE BRAIN OF A COCAINE USER



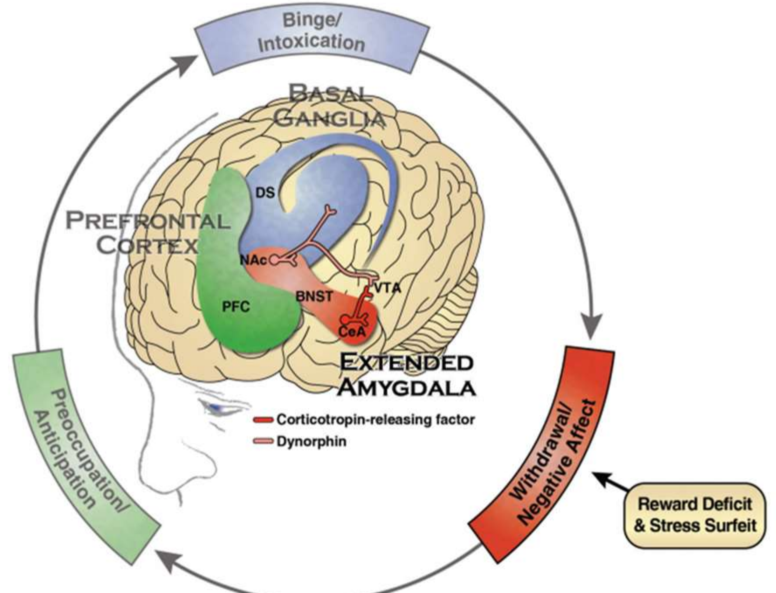
Notes: These fMRI images compare the brain of an individual with a history of cocaine use disorder (middle and right) to the brain of an individual without a history of cocaine use (left). The person who has had a cocaine use disorder has lower levels of the D2 dopamine receptor (depicted in red) in the striatum one month (middle) and four months (right) after stopping cocaine use compared to the non-user. The level of dopamine receptors in the brain of the cocaine user are higher at the 4-month mark (right), but have not returned to the levels observed in the non-user (left).

Source: Modified with permission from Volkow et al., (1993).[29]

THE WITHDRAWAL/NEGATIVE AFFECT STAGE AND THE EXTENDED AMYGDALA

This stage of addiction involves a decrease in the function of the brain reward systems and an activation of stress neurotransmitters, such as CRF and dynorphin, in the extended amygdala. Together, these phenomena provide a powerful neurochemical basis for the negative emotional state associated with withdrawal. The drive to alleviate these negative feelings negatively reinforces alcohol or drug use and drives compulsive substance taking.

Figure 2.9: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Withdrawal/Negative Affect Stage of Addiction

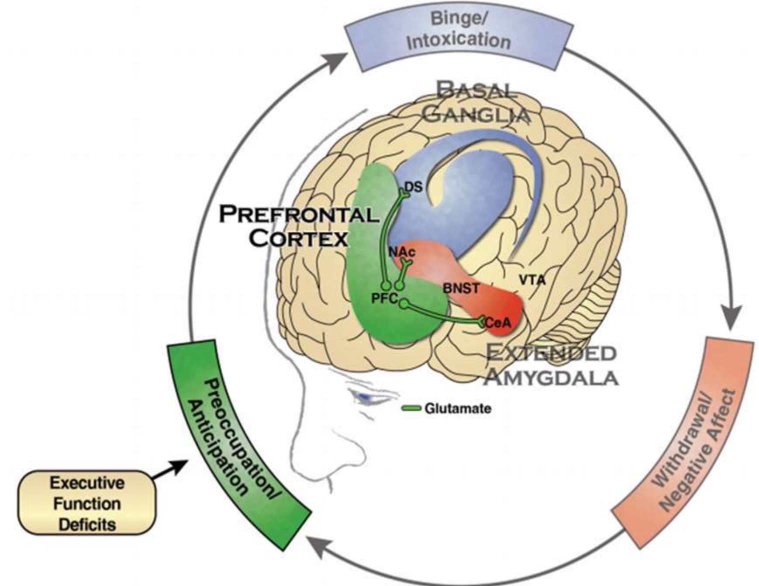


THE PREOCCUPATION/ANTICIPATION STAGE AND THE PREFRONTAL CORTEX

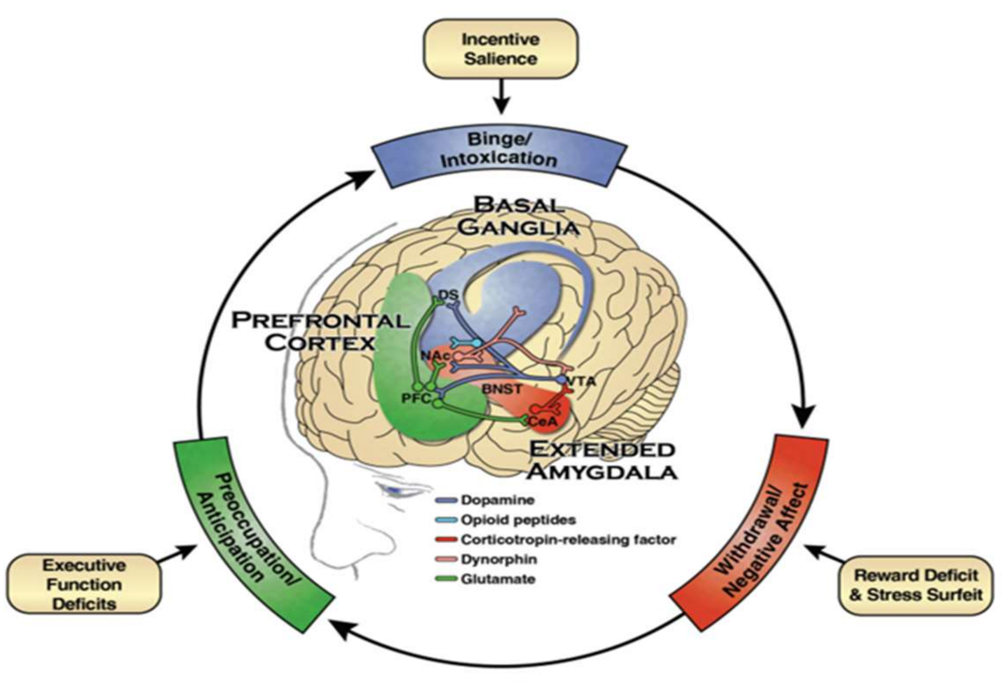
This stage of the addiction cycle is characterized by a disruption of executive function caused by a compromised prefrontal cortex. The activity of the neurotransmitter glutamate is increased, which drives substance use habits associated with craving, and disrupts how dopamine influences the frontal cortex.2

The over-activation of the Go system in the prefrontal cortex promotes habit-like substance seeking, and the under-activation of the Stop system of the prefrontal cortex promotes impulsive and compulsive substance seeking.

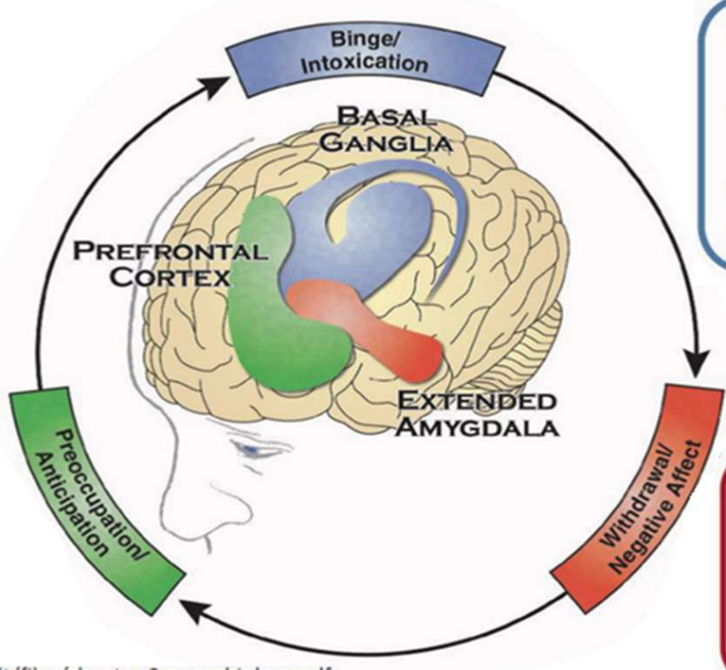
Figure 2.11: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Preoccupation/Anticipation Stage of Addiction



THE PRIMARY BRAIN REGIONS AND NEUROTRANSMITTER SYSTEMS INVOLVED IN EACH OF THE THREE STAGES OF THE ADDICTION CYCLE



ADDICTION IS A PROGRESSIVE BRAIN DISEASE



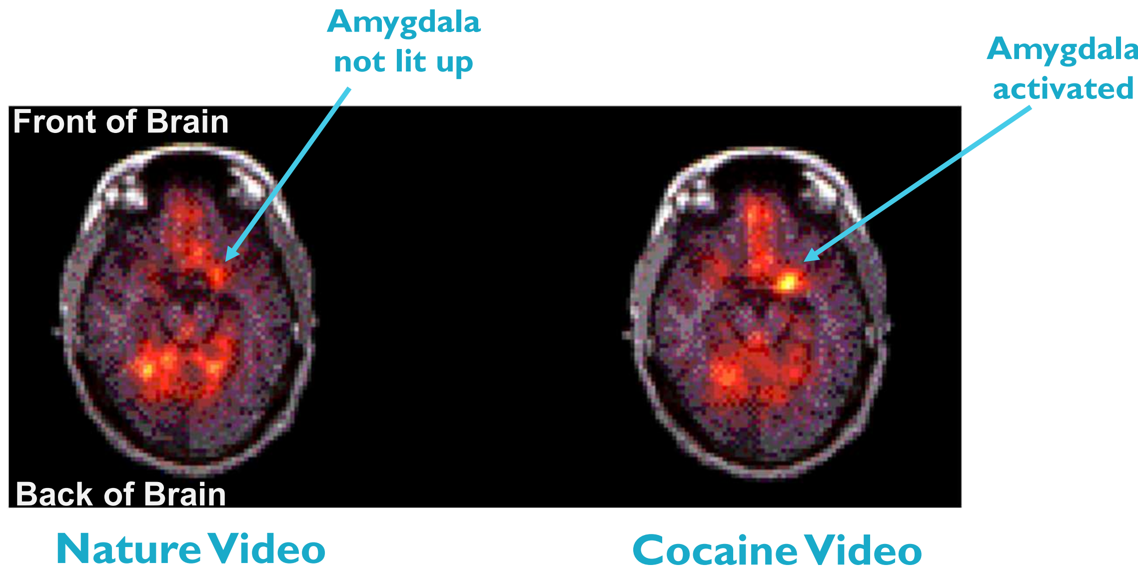
- Diminished response to natural reward
- Increased motivation to seek substance
- Conditioned cravings (triggers)
- Compulsivity

- Cravings
- Altered perception of substance's value
- Impulse control deficit
- Decision making impairments

- Withdrawal symptoms
- Anxiety and agitation
- Excessive stress
- Negative reinforcement (avoiding pain of withdrawal)

https://addiction.surgeongeneral.gov/sites/default/files/chapter-2-neurobiology.pdf

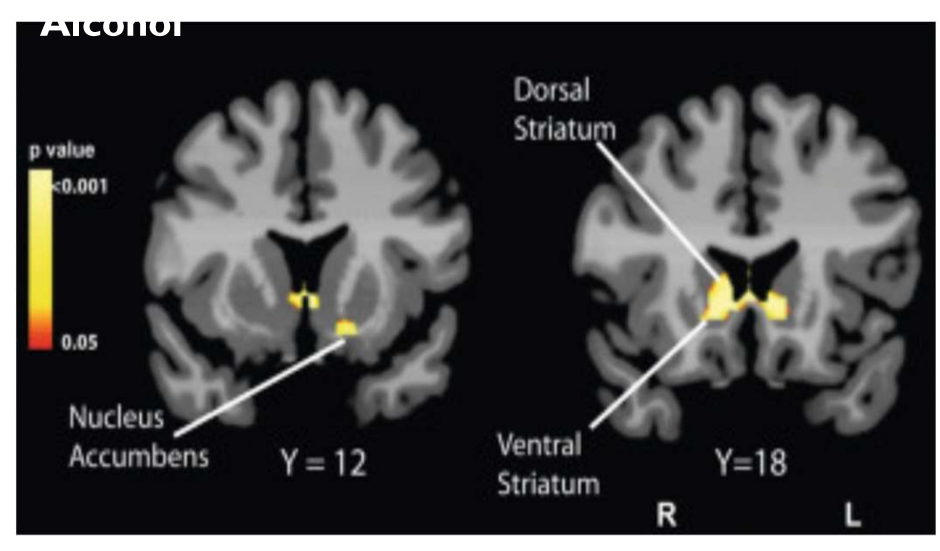
ADDICTION IS A PRIMARY, CHRONIC DISEASE OF BRAIN REWARD, MOTIVATION, MEMORY AND RELATED CIRCUITRY CUE-INDUCED CRAVING - A PATH TO RELAPSE

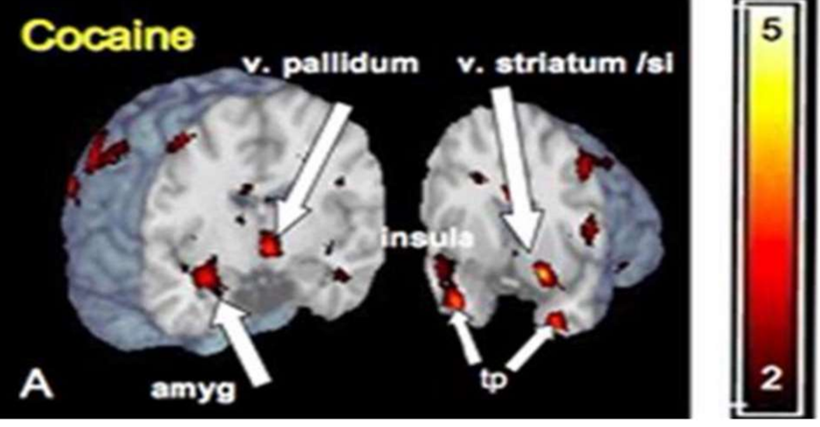


Nature Video **Cocaine Video**

"People, Places & Things"

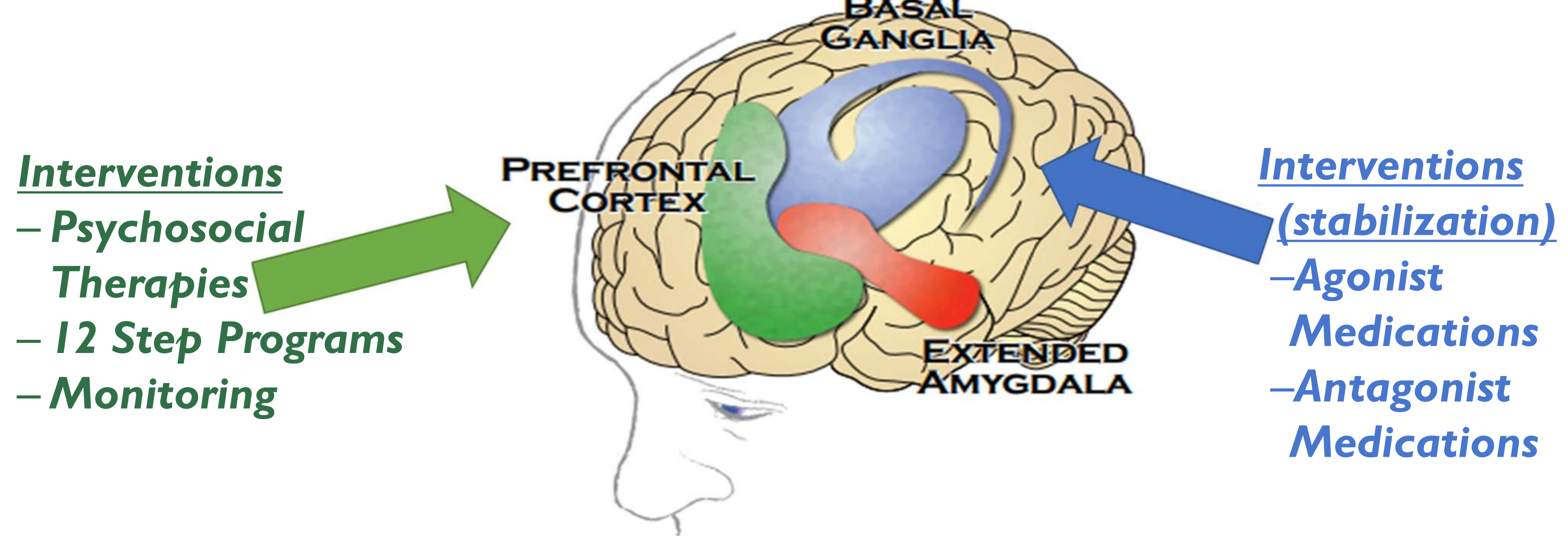
CUES CAN ELICIT BRAIN ACTIVITY (CRAVING)





Brain Regions Activated by 33 millisecond Cocaine Cues (too fast for conscious recognition)
Childress, et al., PloS ONE 2008

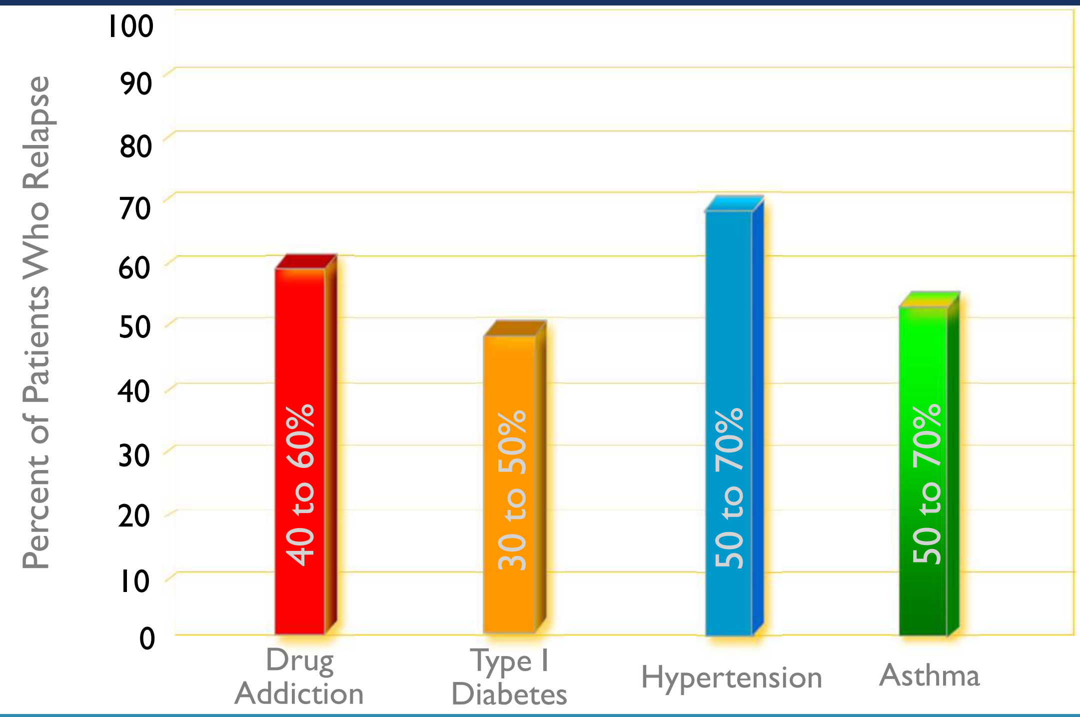
WITHOUT TREATMENT – DIFFICULT TO ATTAIN ABSTINENCE



Interventions
- *Psychosocial Therapies*
- *12 Step Programs*
- *Monitoring*

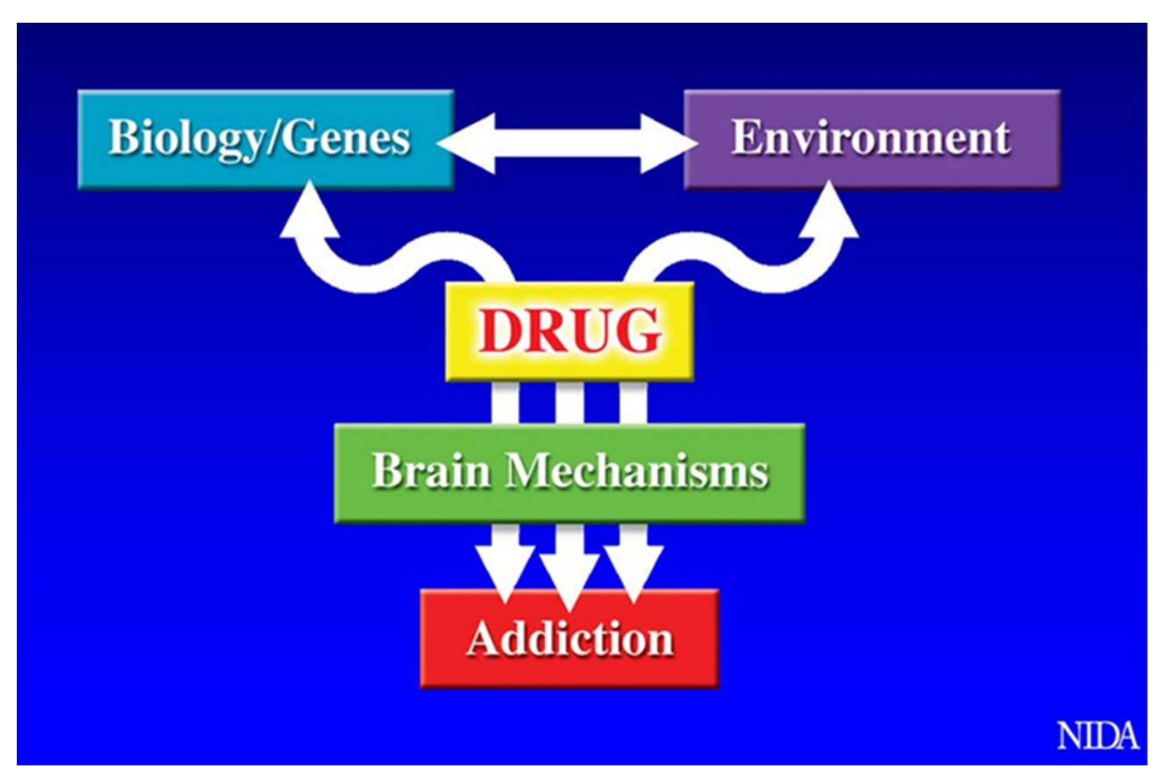
Interventions (stabilization)
- *Agonist Medications*
- *Antagonist Medications*

RELAPSE RATES ARE SIMILAR FOR DRUG ADDICTION & OTHER CHRONIC ILLNESSES



Source: McLellan et al., JAMA, 2000

ADDICTION FACTORS



ADDICTION INVOLVES MULTIPLE FACTORS

WHY DO PEOPLE TAKE DRUGS IN THE FIRST PLACE?

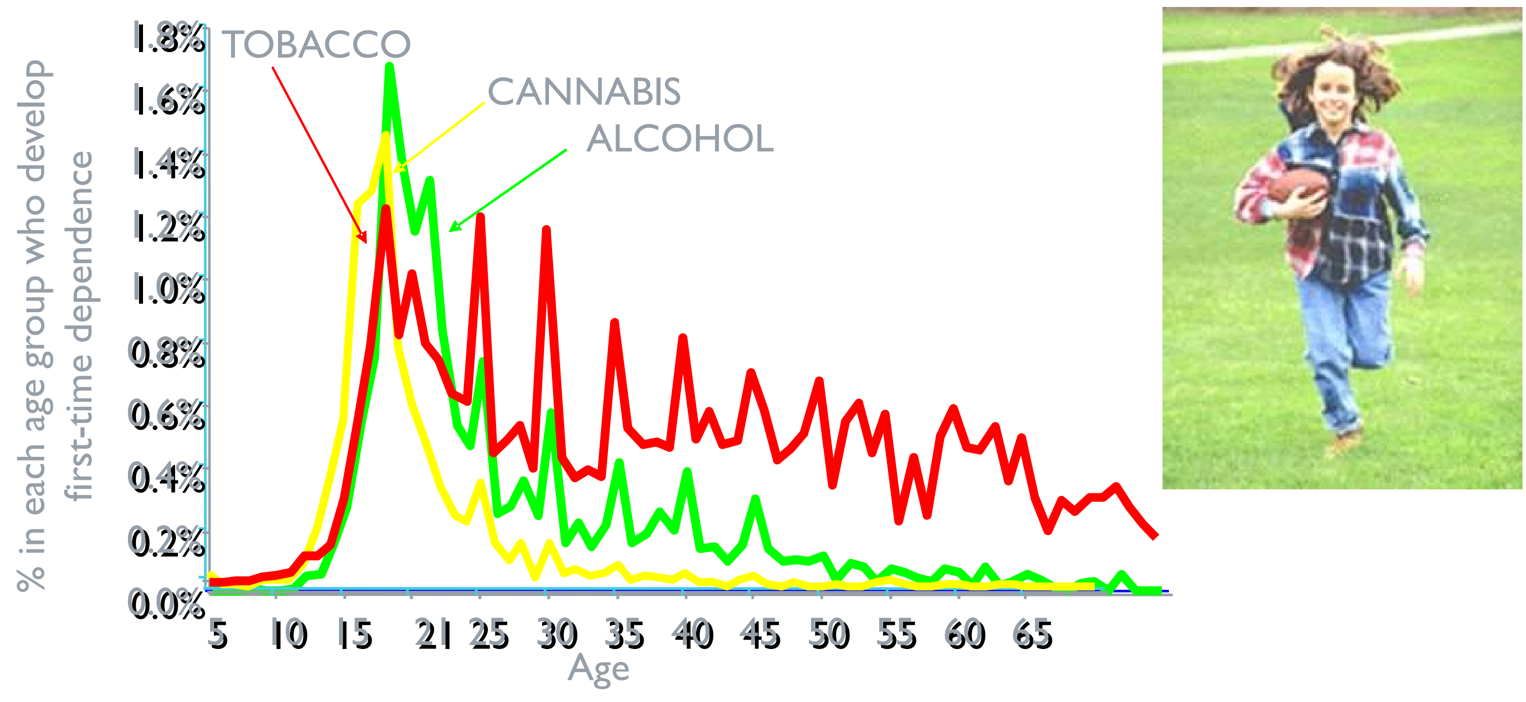
- To fit in, escape, relax, rebel
- Relieve pain, boredom, stress
- To seem grown up, peer pressure
- To experiment, To celebrate
- Enhance work performance or social experiences
- To feel good or to feel better
- To cope with difficult problems or situations, trauma, and symptoms of mental disorders (self-medicate)
- Feeling of hopelessness or feeling unwanted
- To Forget, to deal with conflict

ADDICTION IS A DEVELOPMENTAL DISEASE

- 9 out of 10 people with SUD started using in adolescence
- 7x higher likelihood to develop addiction if 1st use <15yo compared to if 1st use >21yo
- 11% of adolescents in US develop SUD before they reach 18yo
- Earlier onset of substance predicts greater addiction severity

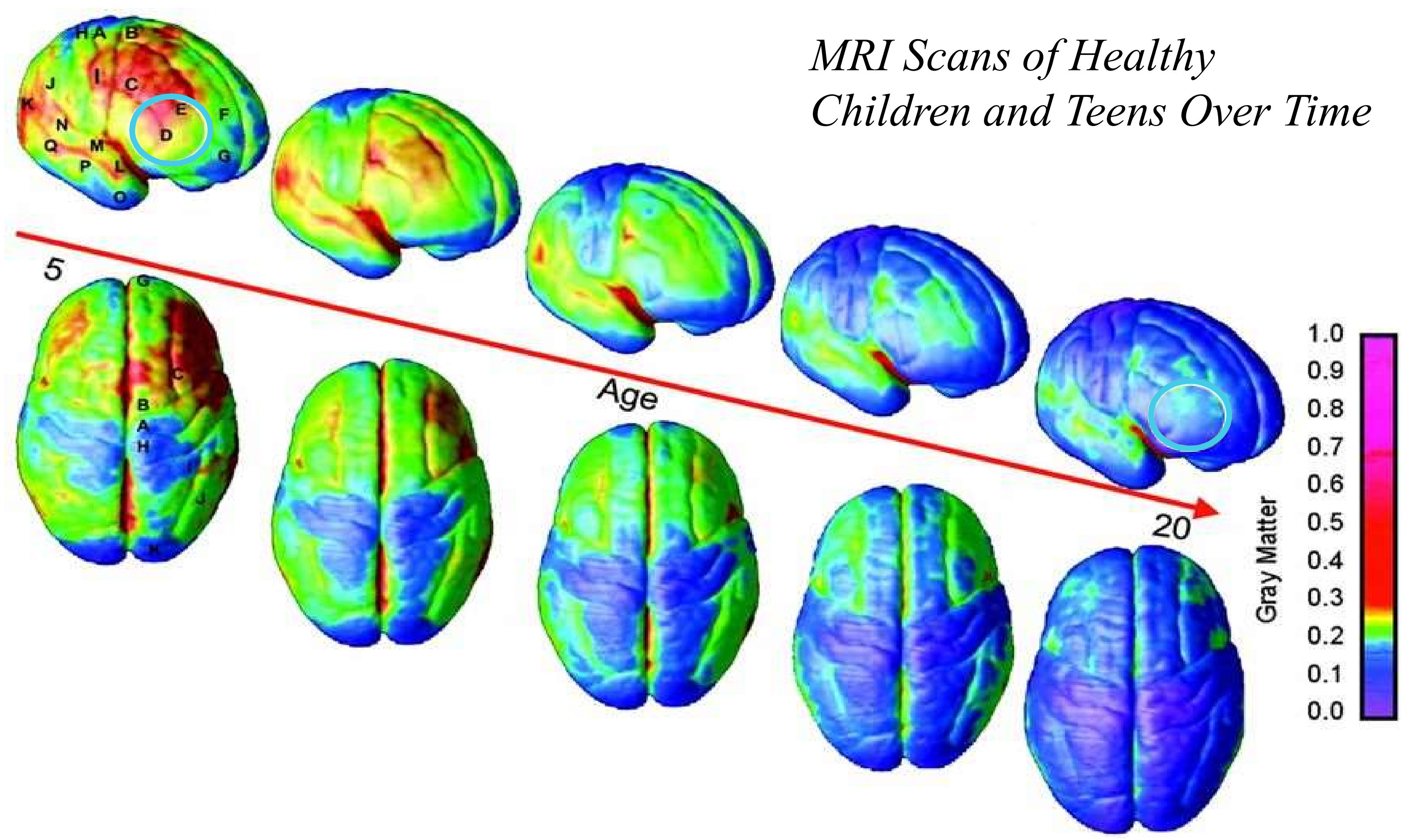
Source. Searcy, L. (2017) J Pediatric Health Care, *31*, 2-4.

Addiction Starts in Adolescence and Childhood



Age at tobacco, alcohol, and cannabis dependence per DSM IV

National Epidemiologic Survey on Alcohol and Related Conditions, 2003.



Copyright ©2004 by the National Academy of Sciences

Gogtay, Giedd, et al. Proc. Natl. Acad. Sci., 2004

VULNERABILITY: "EXAGGERATED RESPONSE"
WHAT DID IT FEEL LIKE THE FIRST FEW TIMES?

- "All my problems disappeared"
- "Felt like I was under a warm blanket"
- "Thought this is how normal people feel"
- "Forgot about all the abuse"
- "Felt like the world was at peace"
- "Totally relaxed"
- "Not shy"
- "Looking at a beautiful sunset"
- "I was energized"

This is a vulnerability (Liking Opioids)

FACTORS THAT INCREASE RISK FOR SUBSTANCE USE, MISUSE, AND ADDICTION

Early Life Experiences

Genetic and Molecular Factors

USE OF MULTIPLE SUBSTANCES AND CO-OCCURRING MENTAL HEALTH CONDITIONS

- Many individuals with a substance use disorder (SUD) also have a mental disorder and some have multiple substance use disorders
- Having a mental disorder increases vulnerability to substance use disorders
- Substance use disorders may increase vulnerability for mental disorders
- The use of marijuana, particularly marijuana with a high THC content, might contribute to schizophrenia in those who have specific genetic vulnerabilities

DEFINING CO-OCCURRING DISORDERS

- Co-Occurring disorder vs. Dual diagnosis
  - Co-Occurring disorder is used because patients often have more than two disorders

- Co-Occurring disorder typically defined as:
  - At least one substance disorder plus
  - At least one major mental disorder (i.e. Major Depression, Bi-polar Mood Disorder, any Psychotic Disorder)

CO-OCCURRING DISORDERS

Mental Disorders

- Major Depressive Disorder
- Bipolar Disorder
- Schizophrenia
- Anxiety Disorders
- Post Traumatic Stress Disorder
- Attention Deficit and Hyperactivity Disorder
- Personality Disorders

Substance Use Disorder

- Alcohol Use Disorder
- Opioid Use Disorder
- Sedative Use Disorder
- Stimulant Use Disorder
- Cannabis Use Disorder
- Hallucinogen Use Disorder
- Tobacco Use Disorder

CO-OCCURRING DISORDERS: POPULATION ESTIMATES

2015 National Survey on Drug Use and Health (NSDUH):

- 20.8 million people aged 12 or older who had a substance use disorder during the past year, about 2.7 million (13 percent) had both an alcohol use and an illicit drug use disorder, and

- 41.2 percent also had a mental illness.

CO-OCCURRING DISORDERS: PREVALENCE

National Co-Morbidity Survey

- 52% of those with alcohol disorders at some point in their lifetime also had a history of at least one mental disorder.

- 59% of those with other drug disorders at some point in their lifetime also had a history of at least one mental disorder.

- 84% of those that experienced a lifetime of co-occurrence report that their mental illness symptoms preceded their substance use disorder (Kessler et al, 1994).

Individuals with co-occurring disorders need to be thought of as the _*Rule*_ not the _*Exception*_.

CO-OCCURRING DISORDERS: RELAPSE FACTORS

- The most common cause of mental illness relapse in co-occurring disorder is substance use. Especially when the drug of choice is alcohol, marijuana, or cocaine.

- The most common cause of relapse with SUD in co-occurring disorder is untreated mental illness (SAMHSA, 1997).

CO-OCCURRING DISORDERS: TREATMENT

- Difficult to find professionals who have experience in both mental health and substance abuse. There is a lack of knowledge stemming from both mental health and SUD in regard to the other discipline.

- Requires a paradigm shift from both disciplines. Treatment providers may find it difficult to adapt to new modalities of treatment (i.e. Harm reduction).

DIAGNOSIS

CASE STUDY

David is a 23-year-old roofer that was injured on his job. His primary care doctor prescribed oxycodone for his pain. After a few months he began taking more medication than was prescribed and was running out of his medication before his scheduled follow up visit. David's doctor discussed the increased drug use and encouraged David to cut down his usage. After David failed to cut down his use, his doctor stopped prescribing oxycodone.

After David ran out of his oxycodone, the next night he was miserable. He woke up sweating profusely, had nausea, diarrhea, anxiety and had severe muscle cramps. He thought he had the flu. He mentioned this to one of his co-workers who gave David a bag of white powder and instructions to snort it. His pain and other symptoms immediately disappeared. When the symptoms returned, he asked his friend for more powder and learned that he was given heroin.

CASE STUDY CONT.

David's heroin use quickly escalated and he began isolating from friends and family. He started to feel more depressed and started to miss work. His employer gave him an ultimatum to get help or lose his job. David started to research addiction treatment and was amazed and overwhelmed at the many choices. He read about detox units, mutual support meetings, methadone treatment, residential treatment, buprenorphine treatment, withdrawal management and naltrexone.

CONFIRM THE DIAGNOSIS OF OPIOID USE DISORDER: DIAGNOSTIC AND STATISTICAL MANUAL (DSM-5)

Opioid Use Disorder Criteria:

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, 4-5 is moderate and 6-7 is severe.

DSM 5 – 11 CRITERIA FOR SUBSTANCE USE DISORDER

1. Taking larger amount or over a longer period of time than intended?
2. Can't cut down or stop using??
3. Spending a great deal of time getting, using, or recovering from?
4. Cravings or urges to use?
5. Problems with work, school, or at home because of use?
6. Recurrent social or interpersonal problems associated with your use?
7. Giving up social activities, recreation, or work because of your use?
8. Recurrent use that leads to potentially dangerous situations?
9. Do you have a psychological or physical problem that is caused by or is worsened by use?
10. Needing more amounts to achieve the desired effect?
11. Withdrawal symptoms or taking the drug to prevent withdrawal?

2-3 Mild. 4-5 Moderate. 6 or more is Severe SUD.

CRITERIA 1

CRITERIA 2

- Wanting to cut down or quit but not being able to do so.
- Have you ever tried to cut down or quit? The patient may say they have tried but "the pain was too bad and I had to go back up."
- The DSM does not specify the reason for the failure of the taper, and this would count as a failed attempt.

CRITERIA 3

- Spending a lot of time obtaining the opioid, under the influence, or recovering from the effects of it.
- Do you have times when you are not very functional, either due to being under the influence of the drug or from not having it available?
- For people using street drugs you can ask, "Do you spend a lot of time and energy obtaining drugs?'

Craving or a strong desire to use opioids.

Do you have cravings or excessive thoughts about the drug especially if you haven't taken it for a while?

If the patient says he/she has never run out, then find out if they spend a lot of time thinking about the medication and watching the clock for their next dosing time.

CRITERIA 4

CRITERIA 5

Repeatedly unable to carry out major obligations at work, school, or home due to opioid use.

Have there been times when you were supposed to be somewhere or do something and you didn't do it because of the drugs?

You can use the example of going to a party or other social function. Anyone who has lost a job due to drug use meets this criteria.

CRITERIA 6

- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use.

- Have the drugs ever affected any relationships – friends, relatives, boyfriends, girlfriends or spouses?

CRITERIA 7

- Stopping or reducing important social, occupational, or recreational activities due to opioid use.
- Have you cut back on social activities or hobbies because of the drugs?
- Are there things you used to do but stopped doing since starting drugs?
- The patient may state that they have cut back on activities but only due to the pain and not due to the medication – that would not qualify for this criterion.

CRITERIA 8

- Recurrent use of opioids in physically hazardous situations.
- Have you ever driven a car when you probably shouldn't have because you were impaired by the drugs?
- Remember that for every Driving Under the Influence (DUI), there are estimated to be 100 times or more when the patient was driving while intoxicated and didn't get caught. Any history of DUIs meet this criterion if the patient has continued to use and drive.

CRITERIA 9

Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids.

Have the drugs ever affected your health in anyway? How about your mental health?

CRITERIA 10

*Tolerance is defined by either a need for markedly increased amounts to achieve intoxication or the desired effect or markedly diminished effect with continued use of the same amount.

You can often determine the presence of tolerance simply by knowing the patient's current daily dosage – if it is well above what could be tolerated by an individual without tolerance.

CRITERIA 11

*Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal.

Virtually all these patients have withdrawal or they wouldn't be seeing us.

*The last 2 criteria are not considered to be met for those individuals taking opioids solely under appropriate medical supervision and who are taking the medication as exclusively prescribed. 10 and11are not counted as positive unless one of the other 9 criteria is met as well.

TREATMENT

NIDA'S 13 PRINCIPLES OF EFFECTIVE TREATMENT

1. No single treatment is effective for all individuals
2. Treatment needs to be readily available
3. Effective treatment attends to multiple needs
4. Treatment needs to be flexible
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness
6. Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction

NIDA'S 13 PRINCIPLES CONT.

7. Medications are an important element of treatment for many patients

8. Addicted individuals with comorbid mental disorder should have both disorders treated in an integrated way
   - Integrated treatment is associated with the following positive outcomes:
     - Reduced substance use
     - Improvement in psychiatric symptoms and functioning
     - Decreased hospitalization, Increased housing stability
     - Fewer arrests and Improved quality of life.

Drake et al.,2001

NIDA'S 13 PRINCIPLES CONT…

9. Medical detox is only the first stage of addiction treatment

10. Treatment does not need to be voluntary to be effective

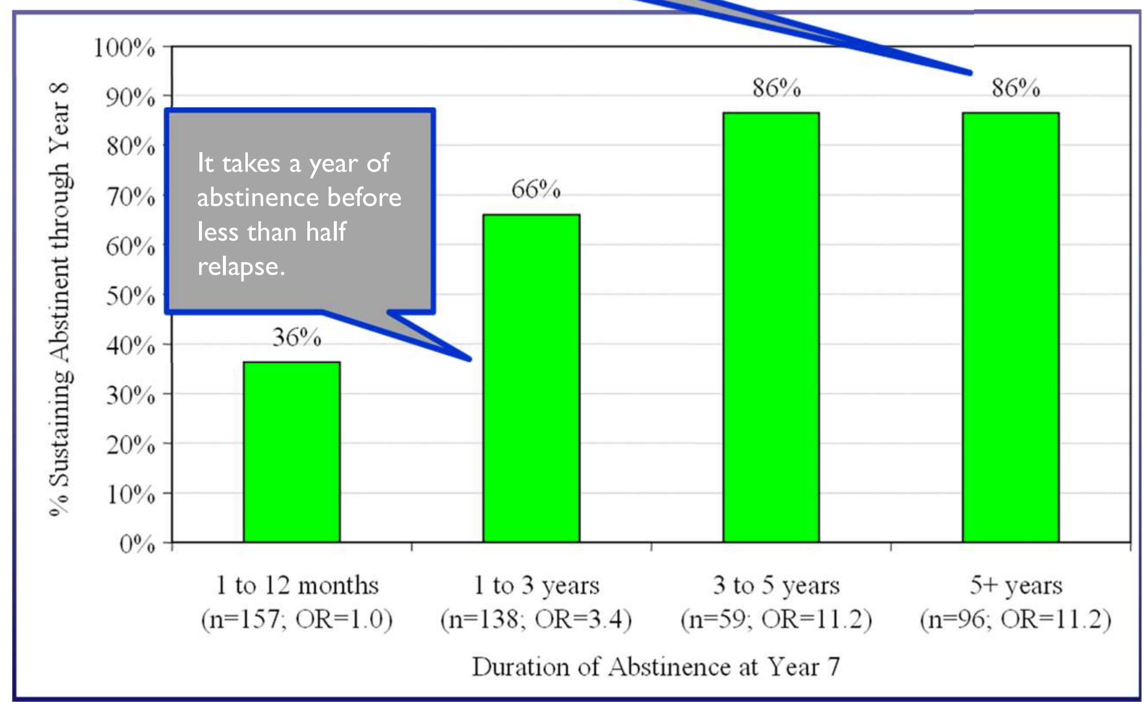
11. Possible drug use during treatment must be monitored continuously

12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases

13. Recovery from drug addiction can be a long-term process

* Of Note: 12-step principles work well for Mental Disorders

EXTENDED TREATMENT / ABSTINENCE IS PREDICTIVE OF SUSTAINED RECOVERY



Dennis et al, Eval Rev, 2007

TREATMENT GOALS

- Must be individualized
- Minimize harm from ongoing use
- Protection against risk of overdose and death
- Reduction or cessation of OUD symptoms
- Learn skills necessary to cope with cravings and life stressors without using drugs inappropriately
- Become responsible for the management of their disease

TREATMENT OPTIONS

Psychosocial/behavioral therapy
- help patients develop skills to cope with cravings and life stressors without drugs

Recovery-oriented activities
-helps patients develop satisfying lives

Self help/mutual help
-from social network supportive of recovery

Medication Assisted Treatment
-uses medication in combination with therapy

TRADITIONAL TREATMENT

Facilities that give psychosocial model involving withdrawal management with or without medications followed by ongoing treatment without medications has been used as 1st line approach for OUD for years.

Success? >85% relapse rate within 1st year

OD rate continues to climb since patients that are detoxed have lost their tolerance to opiates

OPIOID DETOXIFICATION OUTCOMES

- Low rates of retention in treatment
- High rates of relapse post-treatment
  - -<50% abstinent at 6 months
  - -<15% abstinent at 12 months
  - -Increased rates of overdose due to decreased tolerance
  - - "Detoxification may be good for a lot of things; staying off drugs is not one of them" - Walter Ling

O'Conner PG JAMA 2005 Mattick RP, Hall WD. Lancet 1996 Stimmel B et al. JAMA 1977

TREATMENT OF OPIOID SUD (ADDICTION)

- Medication Assisted: Therapy, Treatment, Recovery
- Opioid Agonist Therapy: Methadone, Buprenorphine
- Opioid Antagonist Therapy: Naltrexone Tablets & Depot IM Injection
- +Psychosocial Treatments: generally improved outcomes
- “Drug-Free” “Medication-Free” Recovery, Ambiguous Meaning of “Abstinence-Based Recovery”

MEDICATION ASSISTED ADDICTION TREATMENT

"***All*** *Treatment Works for* ***Some*** *People/Patients*"

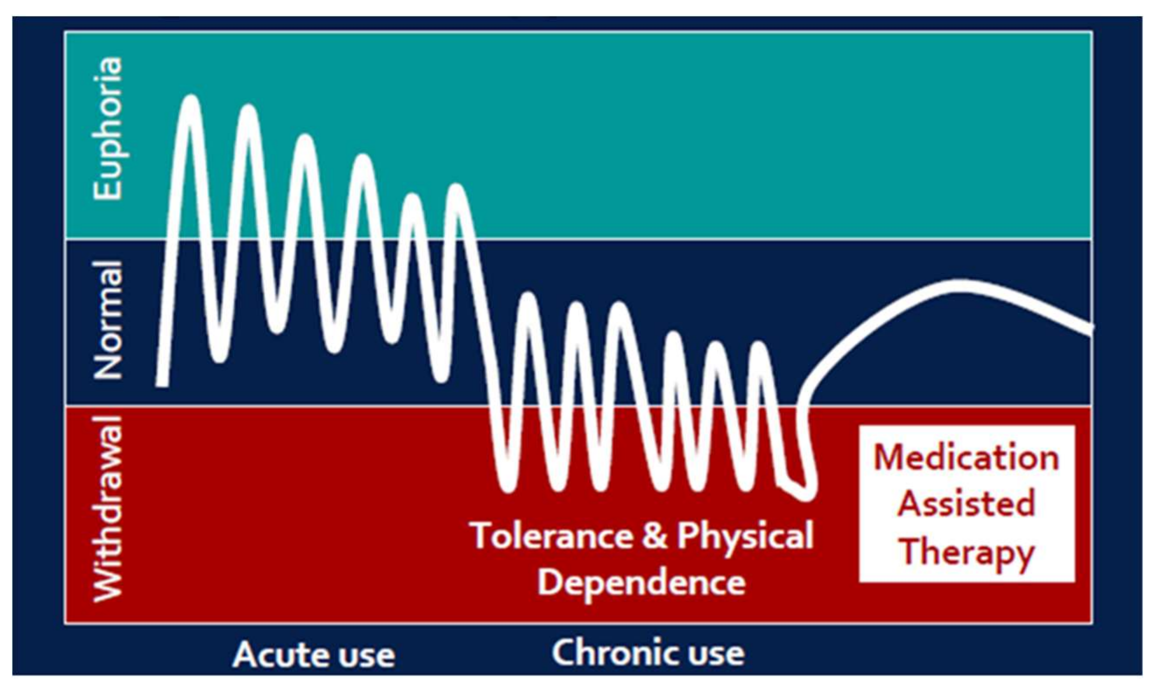
"***No One*** *Treatment Works for* ***All*** *People/Patients*"

Alan I. Leshner, Ph.D.
Former Director, NIDA

ULTIMATE GOAL

To attain long-term recovery maintained with or without medication and provide protection from overdose and death while improving physical, emotional and psychological health.

MEDICATIONS



Source: ASAM. The Review Course in Addiction Medicine

OPIOID AGONIST THERAPY

TABLE 1: MEDICATIONS USED IN ADDICTION TREATMENT

	WHERE IT CAN BE PROVIDED	FDA INDICATIONS	EFFECTIVENESS*	ADMINISTRATION
Methadone	**OUD.** Licensed opioid treatment programs. **Pain.** Any Drug Enforcement Agency (DEA)-licensed prescriber.	OUD and pain management	74% to 80%[12]	**OUD.** Daily pill, liquid, and wafer forms; injectable form in hospitalized patients unable to take oral medications **Pain.** Pill and injectable forms
Buprenorphine and buprenorphine/ naloxone	Prescribed by community physicians and dispensed by pharmacies; available in some opioid treatment programs. Physicians receive federal waivers after eight hours of training; nurse practitioners and physician assistants require 24 hours. Patient panels are capped at 30, 100, and 275 per provider (depending on experience and setting).[13-15] Any DEA-licensed provider can prescribe buprenorphine for pain.	OUD and pain management (depending on formulation and dose)	60% to 90%[16]	**OUD.** Daily sublingual, buccal, film, and tablet, or six-month intradermal device **Pain.** Injectable, transdermal, and buccal film
Naltrexone	No restrictions.	Opioid and alcohol use disorders	**OUD.** 10% to 21%[17]	Daily pill or monthly injectable
Naloxone (used only for overdose reversal, not addiction treatment)	Any setting: prescribed or dispensed by a clinician, furnished by a pharmacy without a prescription (legal in several states), dispensed by lay staff in community settings (by standing order), or carried by law enforcement or other first responders.	To reverse respiratory suppression in suspected opioid overdose	May require high doses for extremely high-potency illicit drug use (e.g., fentanyl and carfentanyl)	Intranasal spray, or intravenous, intramuscular, or subcutaneous injectable

*Retention in treatment at 12 months with significant reduction or elimination of illicit drug use.

Source: California Health Care Foundation

MEDICATION ASSISTED TREATMENT

- Achieve full prevention of both signs and symptoms of withdrawal for 24 hours
- The dose should reduce or eliminate drug hunger or craving
- Block reinforcing effects of illicit opiates: should see significant decrease of opiate positive urine drug screen (UDS)
- Tolerance to any sedative effects of MAT

Methadone

Buprenorphine

Naltrexone

METHADONE

- Schedule II narcotic
- Mu receptor full agonist
- No ceiling effect
- Long half life (24-36 hours on average) but varied 8-59 hours
- Only distributed by federally regulated Opioid Treatment Program (OTP)
- Daily dosing

Admission criteria >1 year OUD -- unless pregnant w/in 6 months release from incarceration, former patient w/in 2 years,
<18 - parental consent, >2 unsuccessful prior treatments

METHADONE MAINTENANCE

- Most successful when used long-term
- Very structured and regulated clinics
- Patients must come everyday to get dosed
- Take home privileges must be earned
- Nurses, doctors, assistant practice clinicians (APCs)
- Psychosocial needs assessment
- Supportive counseling
- Family support resources
- Referrals to community services

IMPACT OF METHADONE MAINTENANCE TREATMENT

- Reduction death rates (Grondblah, '90)
- Reduction of Intravenous Drug Use (IVDU) (Ball & Ross, '91)
- Reduction crime days (Ball & Ross)
- Reduction rate of HIV seroconversion (Bourne, '88; Novick '90; Metzger '93)
- Reduction relapse to IVDU (Ball & Ross)
- Improved employment, health & social function

MAINTENANCE TO ABSTINENCE PATHWAY

- Some patients may need very long-term medication treatment
- Others after more stability/structure may be able to eventually taper off
- Transition to Buprenorphine or Naltrexone

TREATMENT IMPROVEMENT PROTOCOL 63 (TIP 63)

"Methadone retains patients in treatment and reduces illicit opioid use more effectively than placebo, medically supervised withdrawal, or no treatment, as numerous clinical trials and meta-analyses of studies conducted in many countries show."

"Higher methadone doses are associated with superior outcomes. Given the evidence of methadone's effectiveness, the World Health Organization (WHO) lists it as an essential medication."

TIP 63

"Methadone treatment has by far the largest, oldest evidence base of all treatment approaches to opioid addiction. Large multi-site longitudinal studies from the world over support methadone maintenance's effectiveness."

Longitudinal studies have also found that it is associated with:

- Reduced risk of overdose-related deaths
- Reduced risk of HIV and Hepatitis C infection
- Lower rates of cellulitis
- Lower rates of HIV risk behavior
- Reduced criminal behavior

BUPRENORPHINE

- Thebaine derivative
- μ-Partial agonist *K*-antagonist
- High affinity μ receptor > most agonists
- Slow dissociation long T ½ at receptor
- CYP P 450 – 3A4 minimal d/d interactions
- Norbuprenorphine – Active Metabolite
- Biliary (70%) and Urinary (30%) Excretion
- Hemodialysis safe
- Variety of formulations: Bupe/Naloxone preferred vs Mono Tabs (pregnancy)
- Mono formulations: implantable rods, Depot SC Injection

MEDICATION ASSISTED TREATMENT BUPRENORPHINE

Partial opioid agonist
Ceiling effect: much safer, less euphoriant

Higher receptor affinity than almost any other opioid:
Will precipitate withdrawal if not in withdrawal

Less abuse-prone and blocks more abuse-prone opioids

Buprenorphine is uniquely suited to treat opioid addiction: less dangerous, less abuse-prone vs. methadone, more likely to abolish craving, protects users from overdose (OD) by more dangerous opioids

MEDICATION ASSISTED TREATMENT BUPRENORPHINE

Buprenorphine + Naloxone = Suboxone
Naloxone additive is inert unless injected
Naloxone component only prevents IV abuse

Slow acting & long lasting
Reduces abuse potential + ceiling effect = long dosing intervals

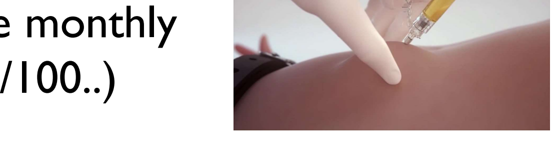
Everyone can use Buprenorphine to treat withdrawal, but an X-waiver is required to prescribe for addiction

BUPRENORPHINE

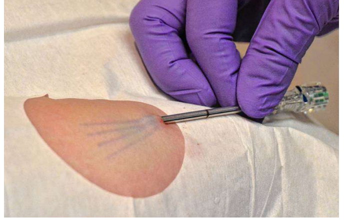
Sublingual films

Sublingual tablets

Injectable monthly (300/300/100..)



Implanted 6 months

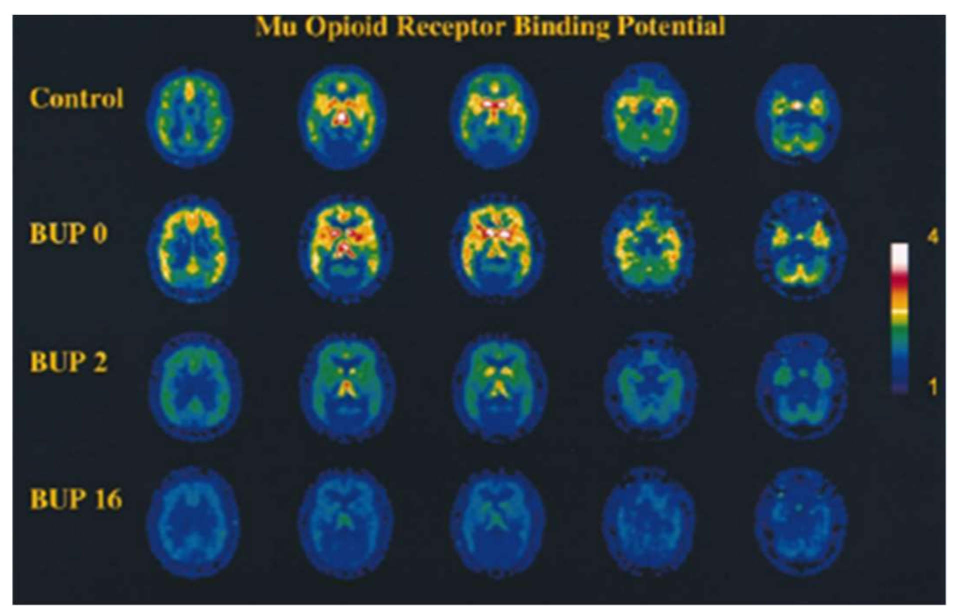


Buccal mucosal film

Source. suboxone.com (film), webmd.com (tablet), sublocade.com (injection), gazettnet.com, (implant) rxlist.com, (buccal)

BUPRENORPHINE BINGING MU RECEPTOR

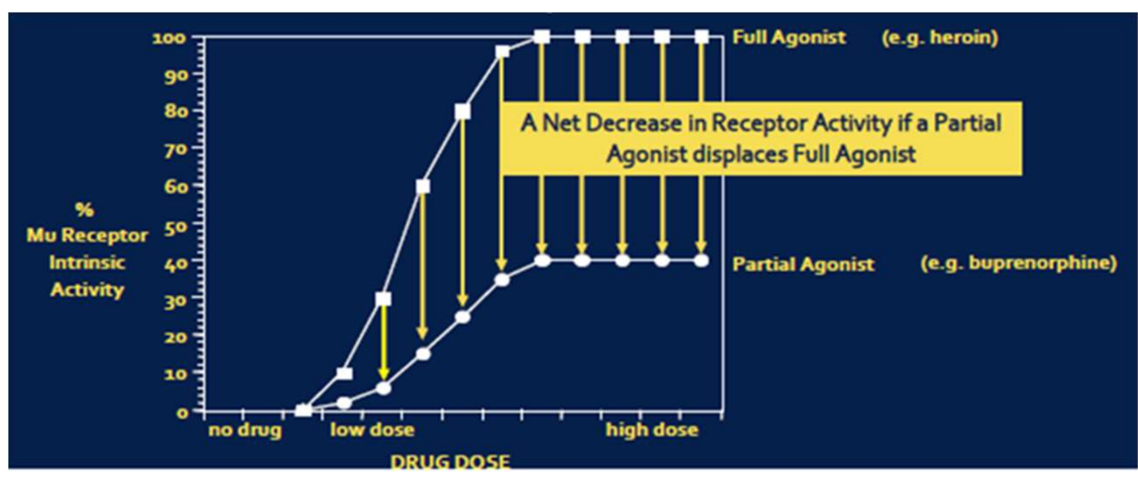
Buprenorphine blocks opioid full mu agonist binding



Zubieta et al [U Mich] Neuropsychopharmacology 23:326-334, 2000

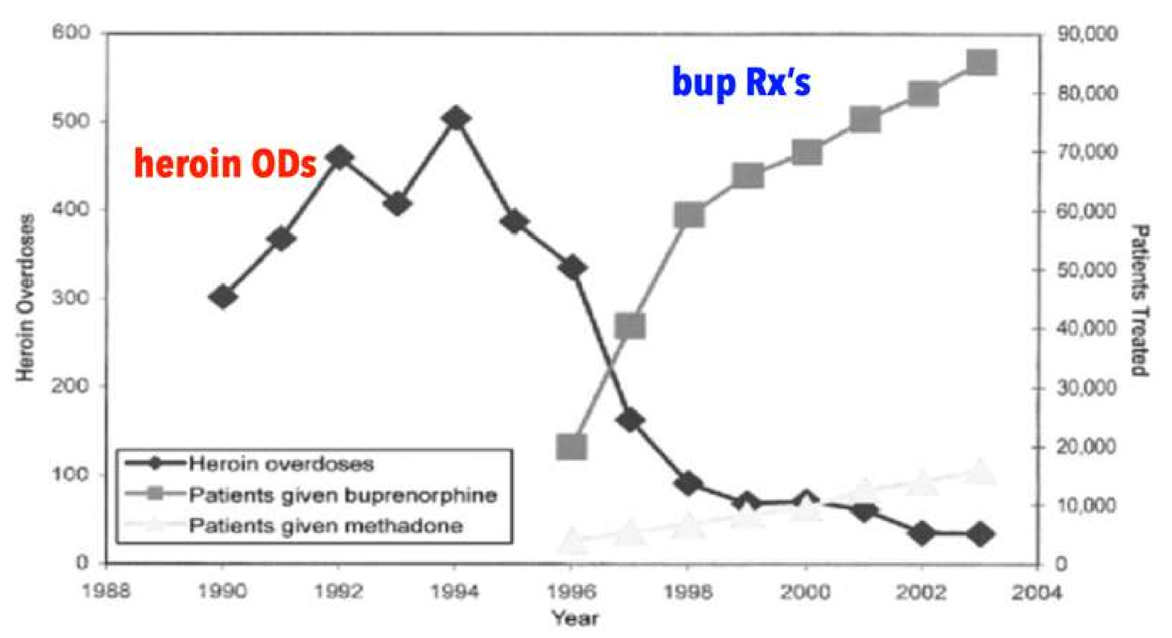
PRECIPITATED WITHDRAWAL

- Buprenorphine will precipitate withdrawal only when it displaces a full agonist off the mu receptors



- Buprenorphine only partially activates the receptors, therefore a net decrease in activation occurs and withdrawal develops

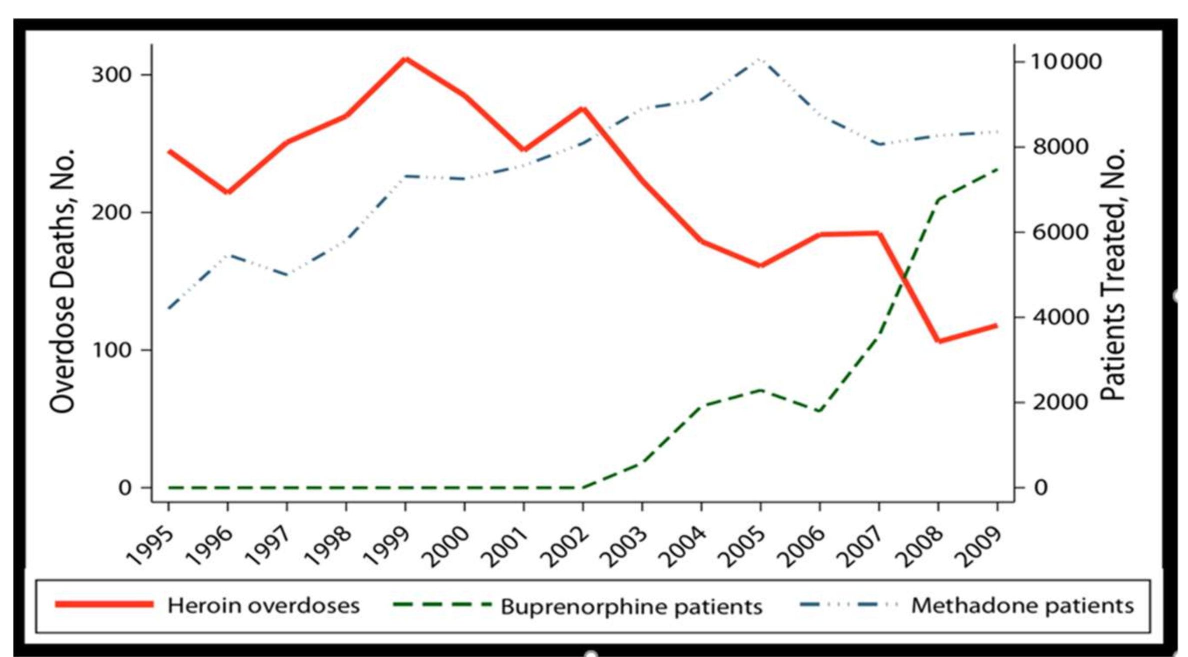
Wright, T. ACOG & ASAM Buprenorphine Course. 2016



Emmanuelli, J Descnclos JC. Harm reduction interventions, behaviors and associated outcomes in France, 1996-2003, Addiction, 2005, vol. 100 (pg. 1690-1700)

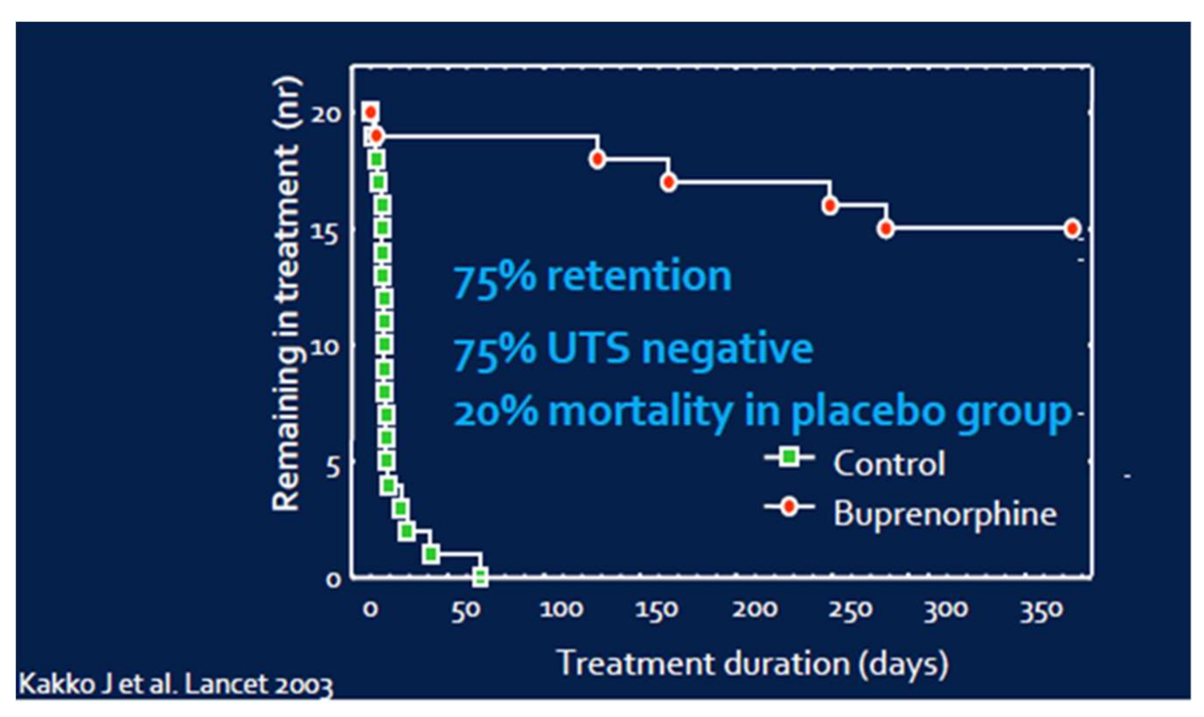
IN 1996, FRANCE RESPONDED TO IT'S HEROIN OVERDOSE BY TRAINING/LICENSING GENERAL PRACTITIONERS TO PRESCRIBE BUPRENORPHINE

HEROIN OVERDOSE DEATHS AND OPIOID AGONISTS TREATMENT BALTIMORE, MD 1995-2009



Schwartz, Robert P., et al. Opioid agonist treatments and heroin overdose deaths in Baltimore Maryland, 1995-2009. American journal of public health 103.5 (2013): 917-922

BUPRENORPHINE MAINTENANCE VS DETOX



NALTREXONE (NTX)

- Effective in specialized populations; e.g. impaired professionals
- Early drop out is common: Hx. With po tabs
- I.M. Naltrexone Depot – 30-day duration, less overall exposure to NTX, no black box for liver function tests (LFTs)
- Off opioids for 7-10 days, Naloxone challenge
- Strategies to shorten "off opioid interval"*
- Loss of Tolerance: OD Concerns, Duration of treatment, Impact on Mortality Reduction

POTENTIAL NALTREXONE CANDIDATES

- Occupational Obstacles: e.g., HCPs
- Not Interested/Failed Agonists
- High Motivation for AA Model of Recovery
- Currently Abstinent: High Risk for Relapse
- Younger, Lower Duration of OUD
- Don't Want to be Physically Dependent
- Tired of Regulations, Stigma, and SO Pressure

Courtesy Adam Bisaga, M.D.

INJECTABLE NALTREXONE (XR-NTX)*

- Multicenter (13 sites in Russia)
  -DB RPCT, 24 weeks, n=250 w/ opioid dependence
  -XR-NTX vs placebo, all offered biweekly individual drug counseling
  -Increased weeks of confirmed abstinence (90% vs 35%)
  -Increased patients with confirmed abstinence (36% vs 23%)
  -Decreased craving (-10 VS +0.7)

- Two recent studies showed similar effectiveness for XR-NTX and daily buprenorphine naloxone (BUP-NX)
  -More difficult to start patients on XR-NTX than BUP-NX

*No black box LFT Warning Label for Intramuscular (IM) formulation

Krupitsky E et al. Lancet 2011

Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): A multicenter, open-label, randomized controlled trial. Lee J.D. et al. (2017) The Lancet

NALTREXONE: BENEFITS

- Benefits
- Good for patients who do not want agonist or partial agonist therapy
- No risk of diversion (not a controlled substance)
- No risk of overdose by drug itself
- Can be administered in any setting (OBOT or OTP)
- Long-acting formulation
- Treats both opioid use disorder and alcohol use disorder

Kampman, K. et al. (2015). The ASAM National Practice Guideline for the use of medications in the treatment of addiction involving opioid use. Retrieved from http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn-24

NALTREXONE: LIMITATIONS

- Ease of starting-must be fully withdrawn from opioids
  -Short-acting (6 days)
  -Long-acting opioids (7-10 days)

- Not recommended for pregnant women

  -Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine (mono formulation for now)

- Diminished tolerance to opioids, unaware of consequent increased sensitivity to opioids if they stop taking naltrexone

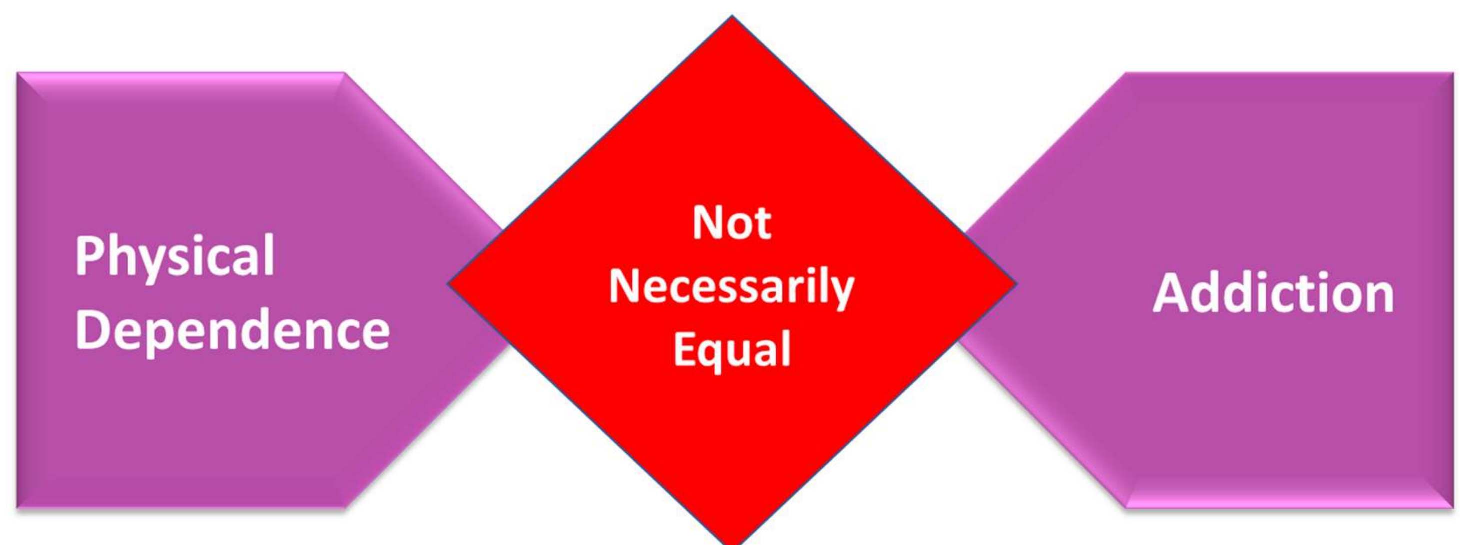
- Head to head studies buprenorphine versus IM naltrexone equally effective if able to start IM Naltrexone

Kampman, K. et al. (2015). The ASAM National Practice Guideline for the use of medications in the treatment of addiction involving opioid use. Retrieved from http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn-24

INTRAMUSCULAR INJECTION FORMULATIONS

Vivitrol
- Opioid antagonist, non-addictive and non-narcotic
- 380 mg intramuscular, extended-release formulation of naltrexone
- Delivered via injection into buttocks once a month, alternating sides each month

Sublocade
- Opioid partial agonist
- 100-300 mg subcutaneous, extended-release formulation of buprenorphine
- Delivered via injection into stomach area once a month


Physical Dependence
Not Necessarily Equal
Addiction

CHOOSING MEDICATION

WHICH OPTION TO CHOOSE?

There are tools for determining the most appropriate placement, i.e. ASAM criteria.
Focus should be on choosing the most appropriate MAT for the patient.

- Patient choice
- Stability/severity of abuse
- Risk of diversion
- Patient past treatments
- Affordability
- Co-occurring psychiatric disorders
- Co-occurring medical disorders
- Overdose liability
- Pregnancy
- Social support
- Employment
- Contraindications to certain MAT

CHANGING BETWEEN MEDS

Buprenorphine to Methadone:
Fairly easy - - 8mg bup day 1, 30 mg methadone day 2 & titrate up from there
16mg bup = 60 mg, some mild w/d symptoms

Methadone to Buprenorphine:
More of a challenge - - precipitated withdrawal

Taper to 30 mg or less of methadone and stay there for 1 week,
Skip one day dosing then start Buprenorphine,
If withdrawal symptoms, add more Buprenorphine,
Best if done in the clinic

CHANGING FROM BUPRENORPHINE OR METHADONE TO INJECTABLE NALTREXONE

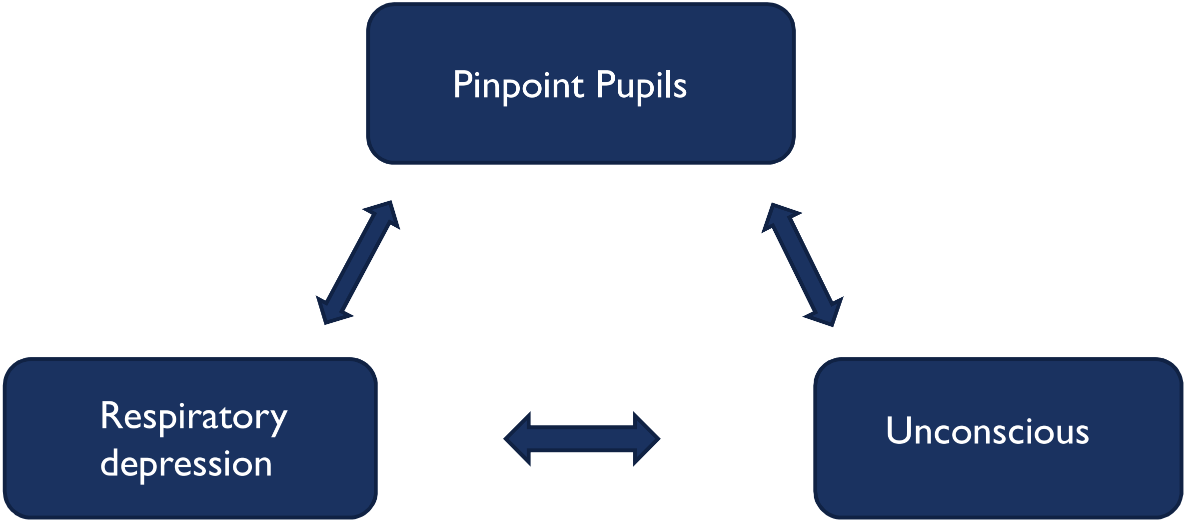
- Wash out period usually takes 10-14 days or longer
- Need pregnancy test
- Naloxone/Naltrexone 50 mg po challenge

SIGNS OF OPIOID EXCESS THAT MAY PROGRESS TO OVERDOSE

Unusual sleepiness or drowsiness
Mental confusion, slurred speech, intoxicated behavior
Slow or shallow breathing
Pinpoint pupils
Slow heartbeat, low blood pressure
Difficulty waking the person from sleep

Substance Abuse and Mental Health Services Administration, (SAMHSA) Opioid Overdose Prevention Toolkit Information for Prescribers. HHS Publication No (SMA) 13-4742 Rockville, MD Substance Abuse and Mental Health Services Administration, 2016

OVERDOSE TRIAD



NALOXONE

NALOXONE (NX) HISTORY

- Approved by the FDA for the treatment of overdose in 1971
- On the WHO essential medicines list
- Historically, primarily available in emergency services
- Currently available in take-home formulations

NALOXONE PHARMACOLOGY

Non-selective competitive opioid antagonist
Poor oral bioavailability (≥2%)[1]

Typically injected (IV, IM, SC), but also IN
Short T ½ (~60) & duration of action (~45 min) ➡ May need to give another dose

Retrospective study of patients with opioid toxicity in the emergency room:
1/3 that responded to naloxone had recurrence of toxicity[2]

High dose and repeat doses needed for longer acting and high potency opioids like methadone or fentanyl

IV = Intravenous, IM = Intramuscular, sC = subcutaneous. IN = intranasal. T ½ = elimination half-life, C max = peak concentration 1. Smith, Hopp, Mundin, Bond, Bailey, Woodward, Bell (2012) Int J Clin Pharmacol Ther. 50: 360-367. 2, Watson, Steele, Muellman, Rush (1998) Clinical Toxicology, 36: 11-17

DIFFERENT ROUTES OF ADMINISTRATION

- IV: rapid onset of action ~ 1 min
  -Rapid overdose reversal + opioid withdrawal
  -Can take time to establish IV access
  -Potentially risk for needle stick
  [1]
- SC/IM: Reaches C max at ~12 min and IN: ~6-9 min
  -Easier to administer
  -No needle with IN

1. Dowling, Isbister, Kirkpatrick, Naidoo, Graudins (2008) Ther Drug Monit, 30: 490-496

NALOXONE AUTO-INJECTOR

- FDA approved 2014
- Voice instructions are provided to guide the user through the rescue
- Intramuscular injection into thigh
- Single-use unit (0.4 mg Naloxone HCl)
- Price: High (≤$500)

NALOXONE NASAL SPRAY

- FDA approval Nov 2015 4 mg in 0.1 mL
- Single dose, one nostril
- Very rapid delivery
- Repeat within 2-3 minutes as needed

Price: low (<$100, 2 pack) & free or insurance covered in many states

PSYCHOSOCIAL TREATMENT

EVIDENCE-BASED PSYCHOLOGICAL-BEHAVIORAL TREATMENTS

- Motivational Interviewing (MI)/Motivational Enhancement Therapy (MET) (Miller & Rollnick)
- Cognitive Behavioral Relapse Prevention, Coping skills, Matrix model (Marlatt & Gordon, Carroll, Rawson)
- Twelve Step Facilitation (Donovan)
- Individual Drug Counseling (Woody)
- Medical Management
- Community Reinforcement Approach (Meyers)
- Contingency Management (Higgins, Stitzer, Iguchi, Silverman Preston)
- Network Therapy (Galanter)
- Family Therapy (Szapocznik, Liddle, Henggeler)

MOTIVATIONAL INTERVIEWING (MI)/ MOTIVATIONAL ENHANCEMENT THERAPY (MET)

- MI is arguably the essential skill for working with substance use disorder patients

  - It's about how to ask, how to talk to patients about substance abuse, especially resistant patients
  - Foster empathy and treatment alliance
  - Collaborative, evocative style
  - Open questions and reflections
  - Goal setting

- Precursor to other treatments

(Source. Miller & Rollnick, 2002, 2013 Guilford Press)

COGNITIVE BEHAVIORAL RELAPSE PREVENTION (CBT-RP)

- A family of approaches emphasizing *cognitive behavioral* and *coping skills* training
- *Cognitive-Behavioral Approach:* treatment model based on assumption that the development and continuation of use is based on a learning process
- Introduces and rehearses *coping skills* to promote the "unlearning" of maladaptive behavioral patterns and feelings and cognitive beliefs
- Structured, time-limited, and goal-oriented
- Flexible approach that can be adapted for a variety of individual obstacles, skill deficits, settings, and formats
- Synergize with any medication; coping skills may be focused on medication adherence

Source. Marlett & Gordon, 1985; Carroll et al., 1994

GOALS OF CBT-RP

- Recognize triggers
- Avoid high risk situations
- Cope with cravings
  - -drug refusal skills
  - -decision delay
  - -"talking through" cravings with others

CONTINGENCY MANAGEMENT (AKA VOUCHER INCENTIVES)

- Provides contingent reinforcement, or incentives for positive change in treatment (e.g., abstinence)

- Target behavior

-drug negative urine
-treatment plan adherence (e.g. attending sessions, or taking medication)

- Reinforce target behavior with voucher points (a.k.a. incentives)

-immediate reinforcement

- Schedule of reinforcement

- often escalating schedule – e.g. the more consecutive negative urines the greater the reward value (voucher value)

Source. Higgins, Stitzer, Iguchi, Silverman, Preston

12-STEP FACILITATION MODEL

- 12-step (Alcoholics Anonymous, Narcotics Anonymous, others) conceptualizes drug and alcohol dependence as a *spiritual* and *medical* disease
- Spiritual component encourages acceptance, turning self and addiction over to a *higher power*
- Manual guided intervention with emphasis on 12 steps providing *tools* for recovery
- Emphasis on connection with recovering person, or *Sponsor*, in fellowship
- Emphasis on *abstinence*

ALCOHOLICS ANONYMOUS (AA.ORG)

- "An international fellowship of men and women who have had a drinking problem"
  - Non-professional, self-supporting, apolitical
- Membership: "open to anyone who wants to do something about his or her drinking problem"
- Other 12-step meetings
  - Narcotics Anonymous
  - Cocaine Anonymous
  - Crystal Meth Anonymous
  - Gamblers Anonymous

NIAAA PROJECT MATCH

- Randomized trial of treatments for alcohol dependence
  -Motivational Enhancement Therapy (MET)
  -Cognitive Behavioral Therapy (CBT)
  -12-Step Facilitation (12-step)

- Aftercare (N = 774) and outpatient samples (N = 952), 3-year follow-up

- A prior treatment matching hypotheses

FAMILY SYSTEMS THERAPY

- Addiction in identified patient distorts the family system
- Restore family system functioning
- Strong evidence of efficacy
- Not widely used
  - therapist training
  - large blocks of time for longer sessions
  - logistics of gathering the family for sessions

Source. Szapocznik, Liddle, Henggeler

NETWORK THERAPY
(GALANTER, AJP 1993)

- Involves one or more non-drug-using significant others in therapy sessions
- Review and rehearsal of CBT-RP skills
- Supports integrity of network by improving communication, diffusing interpersonal conflict, and praising drug avoidance skills
- Significant other monitors adherence to medication (e.g. naltrexone, buprenorphine, disulfiram)

Source. Galanter, American Journal of Psychiatry, 1993

MORE BEHAVIORAL APPROACHES

- Psychodynamic Psychotherapy
  -Evidence for treating substance use disorder treatment is limited

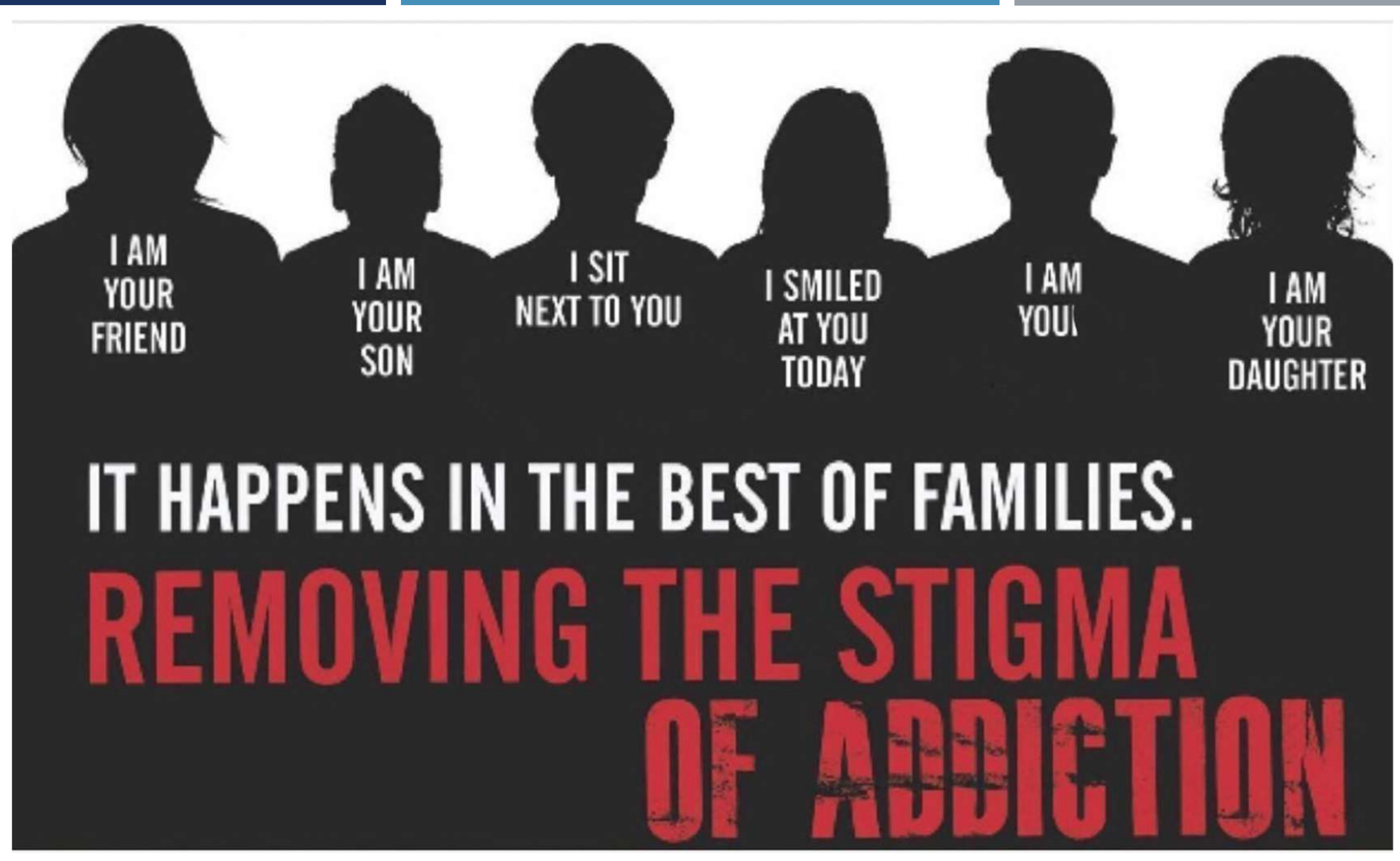
- SMART Recovery
  -Pragmatic self-help approach (“AA without God”)
  -Supporting evidence is limited

- Exercise
  -Some empirical support for smoking cessation
  -Large CTN clinical trial for cocaine dependence was negative

SUMMARY

- Psychosocial/behavioral strategies for treatment of substance use disorders
  - Motivational Interviewing (MI)/Motivational Enhancement Therapy (MET) (Miller & Rollnick)
  - Cognitive Behavioral Relapse Prevention, Coping skills, Matrix model (Marlatt & Gordon, Carroll, Rawson)
  - Twelve Step Facilitation (Donovan)
  - Individual Drug Counseling (Woody)
  - Medical Management
  - Community Reinforcement Approach (Meyers)
  - Contingency Management (Higgins, Stitzer, Iguchi, Silverman Preston)
  - Network Therapy (Galanter)
  - Family Therapy (Szapocznik, Liddle, Henggeler)
- Evidence of effectiveness
- Require training to deliver correctly

STIGMA



I AM YOUR FRIEND
I AM YOUR SON
I SIT NEXT TO YOU
I SMILED AT YOU TODAY
I AM YOU
I AM YOUR DAUGHTER
IT HAPPENS IN THE BEST OF FAMILIES.
REMOVING THE STIGMA OF ADDICTION

For People with Other Illnesses

For People with Addiction

STIGMA – LANGUAGE MATTERS!

Medically Incorrect Terminology
Addicted babies
Dependence is not synonymous with addiction
Disparaging language referencing methadone/buprenorphine
boston.com
Cleaning up 'Methadone Mile' and other drug havens
NBC NEWS
STORYLINE › ONE NATION OVERDOSED
Born Addicted: The Number of Opioid-Addicted Babies Is Soaring

THE ADDICTIONARY: CHANGE LANGUAGE TO IMPROVE CARE

Avoid	• "dirty," "clean," "addict," "abuse," and "abuser"
Consider changing	• Medication *Assisted* Treatment
Medications for addiction treatment	• are life-saving similar to insulin for diabetes, • not called "insulin assisted treatment" despite importance of behavioral interventions with diabetes care

STIGMA - MORE THAN SEMANTICS

Professionals more likely to view patient as deserving of punishment if described as a "substance abuser"

Stigma increases if person described as "drug addict" vs "person with an opioid use disorder"

People with more stigmatizing views of addiction more likely to support punitive rather than public health policies.

KNOW SCIENCE NO STIGMA

Treat
Addiction
Save
Lives

While Science has taught us that Addiction is a hijacking of the brain, Recovery must involve healing of the Heart and Soul.

SAMHSA TIP 63
Medications for Opioid Use Disorder
TREATMENT IMPROVEMENT PROTOCOL
For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

https://store.samhsa.gov/system/files/sma18-5063fulldoc.pdf

TIP 63 MEDICATIONS FOR OPIOID USE DISORDER

Treatment Improvement Protocol 63

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

This TIP reviews three Food and Drug Administration-approved medications for opioid use disorder treatment—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support people in recovery.

TIP Navigation

Executive Summary
For healthcare and addiction professionals, policymakers, patients, and families

Part 1: Introduction to Medications for Opioid Use Disorder Treatment
For healthcare and addiction professionals, policymakers, patients, and families

Part 2: Addressing Opioid Use Disorder in General Medical Settings
For healthcare professionals

Part 3: Pharmacotherapy for Opioid Use Disorder
For healthcare professionals

Part 4: Partnering Addiction Treatment Counselors With Clients and Healthcare Professionals
For healthcare and addiction professionals

Part 5: Resources Related to Medications for Opioid Use Disorder
For healthcare and addiction professionals, policymakers, patients, and families

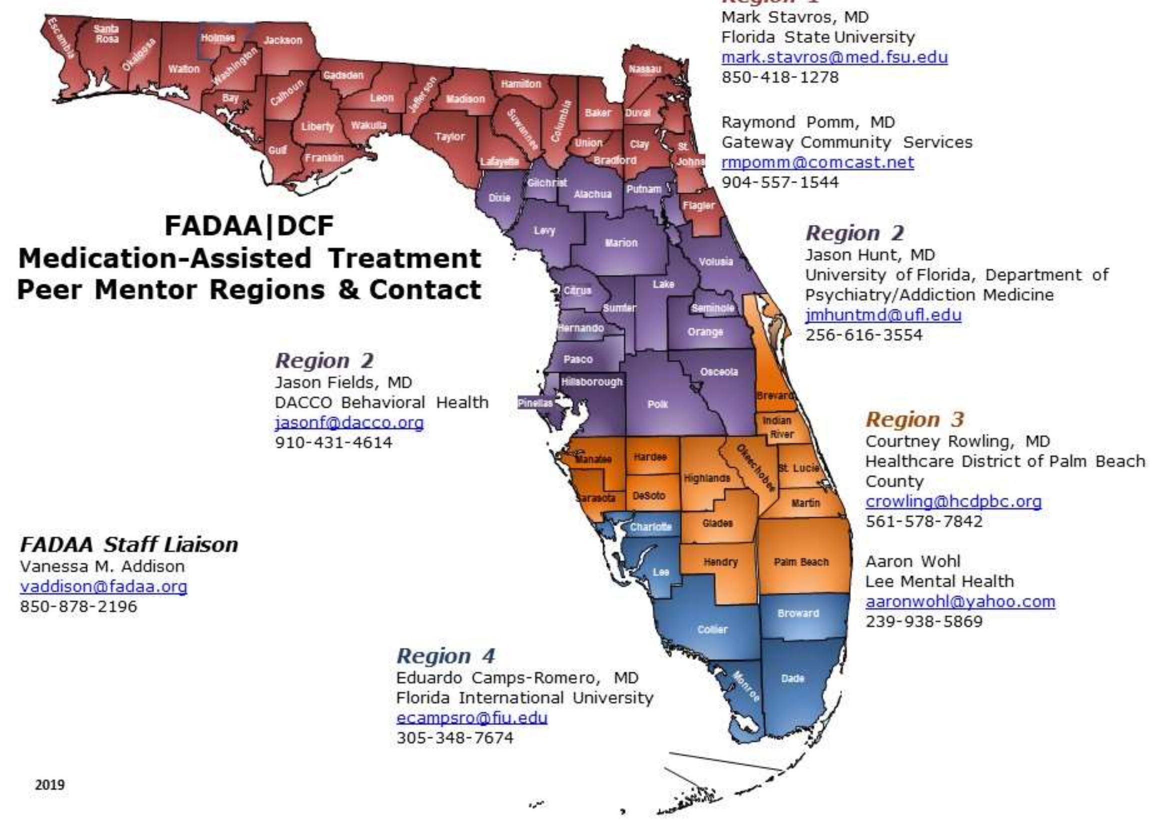
National Institute on Drug Abuse (NIDA)

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)

Last Updated January 2018

https://www.drugabuse.gov

https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/675-principles-of-drug-addiction-treatment-a-research-based-guide-third-edition.pdf


FADAA|DCF
Medication-Assisted Treatment
Peer Mentor Regions & Contact
Region 1
Mark Stavros, MD
Florida State University
mark.stavros@med.fsu.edu
850-418-1278
Raymond Pomm, MD
Gateway Community Services
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904-557-1544
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Region 2
Jason Fields, MD
DACCO Behavioral Health
jasonf@dacco.org
910-431-4614
Region 3
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Healthcare District of Palm Beach County
crowling@hcdpbc.org
561-578-7842
Aaron Wohl
Lee Mental Health
aaronwohl@yahoo.com
239-938-5869
FADAA Staff Liaison
Vanessa M. Addison
vaddison@fadaa.org
850-878-2196
Region 4
Eduardo Camps-Romero, MD
Florida International University
ecampsro@fiu.edu
305-348-7674
2019

FADAA
FLORIDA ALCOHOL & DRUG ABUSE ASSOCIATION

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Lunch & Video Provided

11:45 AM - 12:30 PM
Next presentation - 12:30 PM

Naloxone Video

https://youtu.be/tGdUFMrCRh4

Recognizing and Effectively Intervening/Client Retention

Leeann Irving, MA, CAP, CMHP

PROPER INTERVENTION & RETENTION

Leeann Irving, MA, CAP, CMHP

We're in the midst of an opioid epidemic. How did this happen?

- According to the NIH, in the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers. The rate of prescription increased.
- The inherent qualities of opioids can easily contribute to misuse.
- These qualities include inducing feelings of euphoria and stress relief, as well as side effects such as tolerance and withdrawal.
- Even when taken as prescribed patients may still become addicted, but not all patients take opioids as prescribed.
- In 2015, the International Narcotics Control Board reported that Americans represented about 99.7% of the world's hydrocodone consumption.
- In 2017, an estimated 1.7 million people in the U.S. suffered from substance use disorders related to prescription opioid pain relievers.
- Opioid overdose rates increased 30% from July 2016 through September 2017 in 45 states. Opioid overdoses in large cities increased by 54% in 16 states.
- In 2017, more than 47,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin, and illicitly manufactured fentanyl.

Effective Interventions for Healthcare Professionals

1. **Data, analytics and best practices can be used to identify opportunities for improvement and drive the prevention of opioid misuse and overdose.**

   - Payers have access to rich data that can be evaluated and provider-specific data shared with individual prescribers.
   - Physicians may receive notification if patients are taking more than three opioids, or if they have multiple providers.
   - Physicians may receive date allowing them to analyze their prescribing patterns relative to their peers and adjust where appropriate. Adjustments may include avoiding long-acting opioids; prescribing less than 20 opioid pills per prescription; limiting duration to less than five days, unless it is determined that the injury or medical condition may last longer.

Effective Interventions (con't.)

2. Adopt prescription drug monitoring programs to prevent misuse.

- States can increase the availability of Prescription Drug Monitoring Programs (PDMPS) and availability of the data from other state PDMPS.
- State regulatory boards can help communicate evidence-based dosing guidelines, increase education opportunities and ongoing education requirements for prescribers.
- PDMPS help providers identify patients who might be misusing their prescription drugs.
- Use of the PDMPS prior to prescribing has resulted in a significant decrease in patient who were seeing multiple prescribers to obtain the same drugs.

Effective Interventions

3. **Adopt Evidence-Based Guidelines.**

   - Implementation of evidence-based dosing guidelines, including a dosing threshold trigger for consultation with pain specialists, criteria to considered a pain specialist, elements for patient evaluation, periodic review of the patient's treatment plan, exemptions for special circumstances, and continuing education requirements.
   - When prescribing opioids, prescribers need to check PDMP, use the lowest possible effective dose and start with immediate release opioids rather than long-acting opioids. The quantity prescribed should align with the expected duration of the pain.
   - When prescribing an opioid pain reliever, the prescriber may refer to the CDC Guideline for Prescribing Opioids for Chronic Pain.
   - For individuals receiving prescriptions for high dosages of opioid pain relievers, physicians should consider also providing a prescription for naloxone and provide education to the patient and their support system regarding naloxone's purpose and how it works.

Effective Interventions

4. Promising State Strategies For Dealing With Prescription Opioid Overdose

Implementation of these strategies, which will help to address the opioid epidemic and improve patient care, need the support of healthcare providers.

- States can use data from PDMPS, Medicaid, workers' compensation programs, and state-run health plans to identify pain clinics that may be prescribing opioids in ways that are risky to patients.
- Many states may also need to increase access to substance abuse treatment services and medication-assisted treatment services.
- Healthcare providers can support layperson administration of naloxone and can encourage bystanders to be good Samaritans and summon emergency response for someone who has overdosed.
- Increase availability of naloxone and promote education regarding it's use.

Additional Intervention Strategies

- Physicians must insure that they are appropriately educated regarding addiction.
- Rather than prescribing opioid pain relievers when pain may be of an extended duration, physicians may consider utilizing alternative pain management strategies.
- Physicians should educate their patients regarding the potential for addiction when taking prescriptive opioid pain relievers.
- Physicians should maintain an open dialogue with patients receiving opioid pain relievers in order to facilitate discussion regarding addiction and intervention options.
- Physicians should be aware of available community resources which may be accessed in order to help the patient address his or her addiction.
- Once a physician has identified a patient who is misusing opioid pain relievers, he or she should discuss intervention options, including addiction treatment, participation in the MAT program (opioid replacement medications) and the benefits of combining MAT and traditional addiction treatment. The physician should provide appropriate referrals.
- The State of Florida enacted the Marchman Act which, under civil court order, forces an individual to participate in a substance abuse evaluation and complete treatment if such is recommended.
- Hospital Emergency Rooms and Tri-County Detox (Mary Lyons Center) are available 24/7.

Strategies for Patient/Client Retention

- Identify and implement alternative pain-management strategies.
- Encourage participation in substance abuse and/or co-occurring treatment.
- Encourage regular participation in peer support groups, such as Alcoholics Anonymous, Narcotics Anonymous and/or Celebrate Recovery. Provide the patient with a list of local meetings.
- Be aware of treatment options, discuss those options with the patient, and provide the patient with appropriate referrals.
- Educate the patient's family and support system regarding addiction in order to increase their understanding of the disease and minimize enabling. Encourage participation in Al-Anon or Nar-Anon.
- Provide unconditional support, encouragement and acceptance as the patient works to reclaim his/her life. Avoid blame, criticism, frustration, anger.
- If unsure how to effectively intervene, contact Tri-County Human Services for assistance.

OPIOID SYMPOSIUM
Intervention and Retention

Thank you for spending this time with me. I welcome your questions, concerns and/or comments. I hope that I've left you with valuable information, new ideas or, possibly, confirmed old ones, and an even firmer commitment to continue reaching out to those afflicted with opioid addiction.

Together we're an army.

Break

1:30 AM - 1:45 PM

Next presentation – 1:45 PM

Prevention Activities

Ivy Gonzalez

Opioid Prevention

What we do, and how we do it

Education

It is crucial that we begin to educate our children on the dangers of substance abuse at the elementary grade level or younger.

Why is this important?

Toddlers begin imitating the people around them therefore, if substance abuse is prevalent in the household at a young age a child could view this as a normal behavior .

Opioids

True or False

- Combining Opioids with Alcohol can lead to overdose and / or death?

- Physical dependence can involve painful withdrawal symptoms when the drug is no longer being used?

- Opioids are prescribed to treat ___________________?

We must learn to speak the language and stay current as on the new drug names when we work in the schools.

- **Fentanyl** (fentanyl extended-release transdermal system)
- **Methadone hydrochloride** (methadone hydrochloride tablets, methadone hydrochloride oral solution)
- **Morphine sulfate** (morphine sulfate extended-release capsules, morphine sulfate extended-release tablets)
- **Oxymorphone hydrochloride** (oxymorphone hydrochloride extended-release tablets)

Street names: Captain Cody, Cody, Schoolboy, Doors & Fours, Pancakes & Syrup, Loads, M, Miss Emma, Monkey, White Stuff, Demmies, Pain killer, Apache, China girl, Dance fever, Goodfella, Murder 8, Tango and Cash, China white, Friend, Jackpot, TNT, Oxy 80,Oxycat , Hillbilly heroin, Percs, Perks, Juice, Dillies

“Use Only as Directed Campaign”

“Use Only as Directed” is a media and education campaign that is designed to prevent and reduce the misuse and abuse of prescription pain medications (Opioids) in Utah by providing information and strategies regarding safe use, storage and disposal. Efforts include a paid media campaign, online presence, local community outreach and nontraditional public relations events.

DON'T ADD
ADDICTION TO INJURY
Not all #fails need opioids.
USE ONLY AS
DIRECTED
Reagan

NOT ALL #FAILS
NEED OPIOIDS
Don't add addiction
to injury.
USE ONLY AS
DIRECTED

WE NEED TO TALK

AN OPIOID PROBABLY ISN'T THE ANSWER.

The CDC now recommends opioids be reserved for cancer and end-of-life care. Other pain can often be better treated with the right combinations and doses of safer alternatives.

IT'S NO SECRET
SPEAK OUT
Opioids can cause physical dependence after just seven days of use. Talk to your doctor about possible opioid alternatives.
USE ONLY AS DIRECTED

THERE'S NO SUCH THING AS SAFE LEFTOVERS

Leftover prescriptions are responsible for much of Utah's opioid abuse. Use the hospital pharmacy's drop box to safely dispose of leftover medications.

BEFORE YOU TAKE AN OPIOID, TAKE A MOMENT TO ASK YOUR DOCTOR:

1. Am I at risk for addiction?
2. Will something else work?
3. How long will I be taking them?
4. Are you prescribing the lowest possible dose?
5. What's the plan to taper me off?

SPEAK OUT

Our Programs

- Positive Action Club at All Middle and High School in Highlands County
- Peers educating peers
- Our 4 campaigns a year
- Bullying
- Marijuana and other substances
- Tobacco & Juuling
- Alcohol

The Prevention unit of Tri-County Human Services, Inc. would like to offer to provide our evidenced-based programs to all Elementary, Middle and High schools in Hardee, Highland, and Polk County. All the programs are **free of charge**. Please see the program descriptions listed below.

Botvin Life Skills

This program includes such topics as: self-esteem, communication skills, and social skills as well as information on alcohol, tobacco and drugs. The program is tailored for many age levels from 3rd thru 12th grade, this is an 8 to 12 session program.

New Horizons

This is a 16 session program that includes such topics as: goal setting, stress and the effects on the body, anger management, communication skills, media literacy, as well as alcohol, tobacco and drug education. The program is for students from 3rd thru 12th grades.

Wise Owl and Life Skills for Kindergarten – 3rd grade

Wise Owl is a Bullying information and healthy choices 6 session program.

Strengthening Families:

SFP is delivered in 14 weekly sessions. Sessions begin by sharing a meal (provided by TCHS) and then are followed by 1-hour parents' and children's classes and ending with a 30 to 45-minute family class. The parenting sessions review appropriate developmental expectations, positive interactions with child, active listening, effective and consistent discipline, social rewards for good behavior, as well as other positive skills.

Children's skills training includes communications skills to improve parent, peer and teacher relationships, resilience skills, problem solving, peer resistance, anger management and coping skills. The family sessions allow parents and children to practice what they learned in their individual sessions. This is also time for group leaders to coach and encourage family members for improvements in parent/child interactions. The major skills taught are child play, family meetings, and problem solving and planning.

To learn more or register for programs please contact:
Ivy Gonzalez, Prevention Supervisor
863 385-0513 Office or 863-241-2389 Cell

Our Future Plans

- Working with Drug Free Hardee on an Opioid Prevention Grant
- Parent Resource Center
- Gaming Club with Adult Supervision
- Working with the Courts on Substance Abuse Diversion Programs and Parenting Programs
- Maintain and enhance our presence in the schools.
- Grow our Afterschool programs
- Set up Social Media Page for PAC at Our Summer Workshops.
- Set up an QR code to be printed on our giveaways that will direct students and public to our webpage.
- Summer programs in Polk, Highlands and, Hardee Counties

Local Challenges regarding Drug Use & Abuse

Panel:

Becky Razaire, LMHC – TCHS

Lena Lyall, CCHP

Highlands Sheriff Department

Legislative Wrap-Up

Representative Cary Pigman, MD

2019 Legislative Session

Review of Key Issues

New Governor and Cabinet

Governor

Ron Desantis

Lt. Governor

Jeanette Nunez

Ashley Moody
Attorney General

Jimmy Patronis
Chief Financial Officer

Nikki Fried
Commissioner of Agriculture & Consumer Services

PRIORITIES OF GOVERNOR AND CABINET

- Hurricane Michael recovery
- Prescription drug import plan
- Smokable medical marijuana
- School choice expansion
- Environmental resources

- Access to the PDMP
- Opioid Task Force

- Cancer presumption for firefighters
- Assignment of Benefits (AOB) reform

- State Industrial Hemp Program

House Leaders

Speaker

Jose Oliva
(R-Dade)

Speaker
Pro-Tempore

Mary Lynn Magar
(R-St. Lucie)

Majority
Leader

Dane Eagle
(R-Ft. Myers)

Appropriations

Travis Cummings
(R-Orange Park)

Health & Human Services

Ray Rodrigues
(R-Ft. Myers)

Minority Leader

Kionne McGhee
(D-Cutler Bay)

HOUSE PRIORITIES

Goal:
To shake up health care in Florida

✓ **Certificate of Need Repeal**
- Applies to General and Tertiary Hospitals
- Directs AHCA to review CON process and make recommendations for repeal of children's and specialty hospitals

✓ **Expansion of Telehealth**
- For out-of-state providers
- Payment parity not included
- Authorizes contracts with health plans for telehealth, may deviate standard reimbursement rate upon mutual agreement

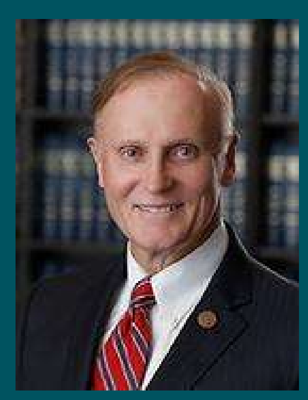
✓ **Canadian Drug Importation**
- For Medicaid
- AHCA must develop plan
- Must seek federal approval

✓ **Ambulatory surgical center overnight stays**

Senate Leaders

President

Bill Galvano
(R-Bradenton)



President Pro-Tempore

David Simmons
(R-Longwood)

Majority Leader

Kathleen Passidomo
(R-Naples)

Appropriations

Rob Bradley
(R-Jacksonville)

Health Policy

Gayle Harrell
(R-Port St. Lucie)

Children & Families

Lauren Book
(D-Plantation)

Minority Leader

Audrey Gibson
(D-Jacksonville)

SENATE PRIORITIES

Goal:

To prepare Florida for population growth

✓ **Infrastructure Development**

- Polk to Collier
- Citrus to Jefferson
- Turnpike to Suncoast

✓ **Massive K-12 Education Overhaul**

- Expansion of vouchers for private/charter schools
- Expansion of Guardian Program for schools
- Increases in teacher salary

✓ **The Environment: Clean Water Initiatives**

- Red Tide
- Northern Water Storage
- Septic to Sewer Conversions
- Reservoir/North Lake Okeechobee

POLICY and BUDGET

2019 Legislative Session

HEALTH CARE/ACCESS

Health Plans
SB 322 (Simpson)

Requires each insurer or HMO in Florida to offer at least *one* comprehensive major medical policy or contract that does not limit, exclude, deny, or delay coverage for preexisting conditions.

Effective date: Upon becoming law

Patient Savings Act
HB 1113 (Renner)

Authorizes health insurers and HMOs to create a shared savings incentive program for Florida policy holders inside and outside of Florida.

Effective date: July 1, 2019

Direct Health Care Agreements
HB 007 (Duggan)

Expands current law related to direct primary care agreements to all direct healthcare by physicians, chiropractors, dentists, and nurses. Psychologists or clinical therapy are not included.

Effective date: July 1, 2019

HEALTH CARE/CHILDREN

Mental Health
SB 1418 (Powell)

- Encourages schools districts to adopt standardized suicide assessment tool to implement prior to initiation of involuntary examination
- Increases number of days from next working day to 5 working days a receiving facility has to submit forms to DCF
- Requires providers share information to law enforcement when a patient makes a specific threat to another

Effective date: Upon becoming law

Child Welfare
HB 7099 (Stevenson)

Authorizes psychiatric nurse to prescribe psychotropic medication to dependent minors; obtain consent from legal guardians, and advise court and DCF on any continued need for psychotropic medications or services.

Effective date: July 1, 2019

OPIOIDS

Opioid Task Force Executive Order 19-97

- Attorney General Ashley Moody, Chair
- Evaluate cost/impact to state local governments
- Identify available programs that have been successful in combating opioid abuse
- Explore need for additional regulatory activity
- Evaluate and identify ways to reduce the demand for opioids and decrease the supply

Office of Drug Control Executive Order 19-97

- Coordinate with state and local agencies and communities to identify drug trends
- Identify federal funding sources
- Collaborate with other states
- Develop a plan to address addiction

Non-opioid Alternatives HB 451 (Plakon)

- Requires DOH to develop advance directives for non-opioid alternatives prior to surgery or during the recovery process
- This bill was included as part of the recommendations of the Advance Directives workgroup

Effective date: July 1, 2019

OMNIBUS RECOVERY LEGISLATION

PEER SPECIALISTS

- Promotes the use of peer specialists in behavioral health care
- Requires that peer specialists who are reimbursed through DCF or Medicaid funding be certified
- Codifies existing training and certification requirements for peer specialists

RECOVERY RESIDENCES

- Requires treatment programs licensed as a day/night with community housing overlay to be certified (programs under contract with managing entities are exempt)
- Requires owners, directors, and CFOs to pass Level 2 background screening under both 435.04, F.S. and 408.809, F.S.
- Exempts landlord tenant laws
- Exempts Oxford House model from required certification
- Authorizes use of Chapter 120 hearing for disputed decisions on suspension/revocation of certification
- Clarifies patient brokering laws, in that it is not superseded by federal Anti-Kickback Statute

OMNIBUS RECOVERY LEGISLATION

BACKGROUND SCREENING (Current law or practice)

- Chapter 397, substance abuse is subject to Level 2 background screening under Chapter 435.04. Generally, these are various crimes against individuals but also include theft, robbery, prostitution, arson, etc.
- Chapter 394, mental health is subject to Level 2 background screening under Chapter 435.04 and 408.809. Generally, these are the financial crimes including bad checks, fraudulent use of credit cards, Medicaid fraud as well as patient brokering.
- Managing entities require each provider be co-occurring capable. Thus, most providers screen to the higher standard.
- Most MMA plans require screening (to the higher standard) as part of credentialing process
- Disqualifying offenses must have exemptions from appropriate agency (DCF/397; AHCA/394)
- Only those who have had 3 years post completion of all court ordered sanctions are eligible for exemption. If there are outstanding fines, you can pay that off and then apply.
- In DCF you must have certified copies of arrest reports, court dispositions, proof of completion, application, letters of reference, demonstration of rehabilitation

OMNIBUS RECOVERY LEGISLATION

BACKGROUND SCREENING **(NEW LAW, if approved by Governor)**

- All persons working within substance abuse or mental health must pass a Level 2 background check at the higher standard (Chapters 408.809 and 435.04)
- Once an application has been completed, DCF must make their determination within 60 days
- DCF and AHCA may grant exemptions to work solely in substance abuse, mental health or recovery settings
- Individuals may work under direct supervision for up to 90 days while they await the determination
- If 5 years or more have elapsed (3 years for peers), certain common 3rd degree offenses and their related crimes may receive a "fast pass" to an exemption, though not mandated on DCF
    - Prostitution
    - Burglary
    - Theft
    - Forgery
    - Uttering forged documents

JUSTICE

Justice Reform
HB 7025 (Daniels)

- Requires OSCA to submit annual reports/data on problem-solving courts
- Raises threshold for retail felony theft from $300 to $750
- Raises weight threshold on trafficking hydrocodone
- Requires DOC to publish directory of community resources for offenders upon release
- Authorizes probation officer to impose non-court sanctions for violators
- Authorizes educational scholarships for inmates after completion of their sentence

Effective date: October 1, 2019

Public Records/OGSR
HB 7025 (LaMarca)

Removes scheduled public records exemption repeal date for participants of treatment-based drug court programs.

Effective date: October 1, 2019

JUSTICE

Needle Exchange
SB 366 (Braynon)

- Authorizes local governments to establish needle exchange programs with consultation from the health department
- May be established through hospitals, clinics, medical schools, ARFs, or HIV programs
- Cannot use public funds
- Exchange must be a 1:1 ratio
- Must offer HIV screening, information on treatment

Effective date: July 1, 2019

Good Samaritan Act
HB 595 (Silvers)

- Adds alcohol to substances individual may have prosecutorial immunity from when calling EMS for overdose
- Will now apply to individuals on probation
- Emergency calls resulting in potential overdose by a minor, the caller must remain at the scene

Effective date: July 1, 2019

OTHER

“UBER” for Medicaid
SB 302 (Brandes)

- Authorizes use of ride-sharing transportation methods (such as UBER or Lyft) for Medicaid patients
- Unlike traditional use of ride-sharing through an app, the Medicaid patient must arrange the transportation through their MMA plan
- Ride sharing must be a second option for MMA plans when choosing transportation methods

Effective date: July 1, 2019

Public Records
HB 838 (Powell)

- Exempts from public records court documents related to involuntary examinations
- Release may only be through court order to petitioner, patient, DCF, physician/psychiatrist of record or DCF

Effective date: Upon becoming law

FY2019-2020 BUDGET HIGHLIGHTS

Department of Children & Families

- $2.5 million NR – increased efforts to address opioid crisis
- FIT funding ($12.9 million) shifted to all *recurring*
- $1.021 million NR for long-acting naltrexone (DCF) in FY18-19 was *not replaced*
- $3.5 million NR to modernize BH
- MRT + CAT fully funded

Justice/ Juvenile Justice

- $2.5 million NR for long-acting naltrexone (OSCA) in FY18-19 was *not replaced*
- $6 million for MAT (OSCA) was maintained *plus* carry-over
- $3 million community and transition cut in DOC for SAMH was replaced
- Expansion of juvenile non-secure residential commitment (+$2.179 million)
- $750,000 NR retention bonus for direct care workers (-$1.25 million)
- $11.289 million Problem solving courts (+$2.36 million)

Education & Housing

- $6.7 million R Mental Health Awareness training (+$1.2 million)
- $75 million R Mental Health Assistance Allocation (+$5.76 million)
- ~$100 million increase for supportive and affordable housing

THANK YOU!

Questions?

Building Recovery Networks Developing Connections with Community Partners

Ginny LaRue, MNM

Ivy Gonzales - TCHS

Opioid Symposium

Highlands & Polk Counties

Building the Voice of Recovery Community Organizations (RCOs)

A Toolkit for RCO Development

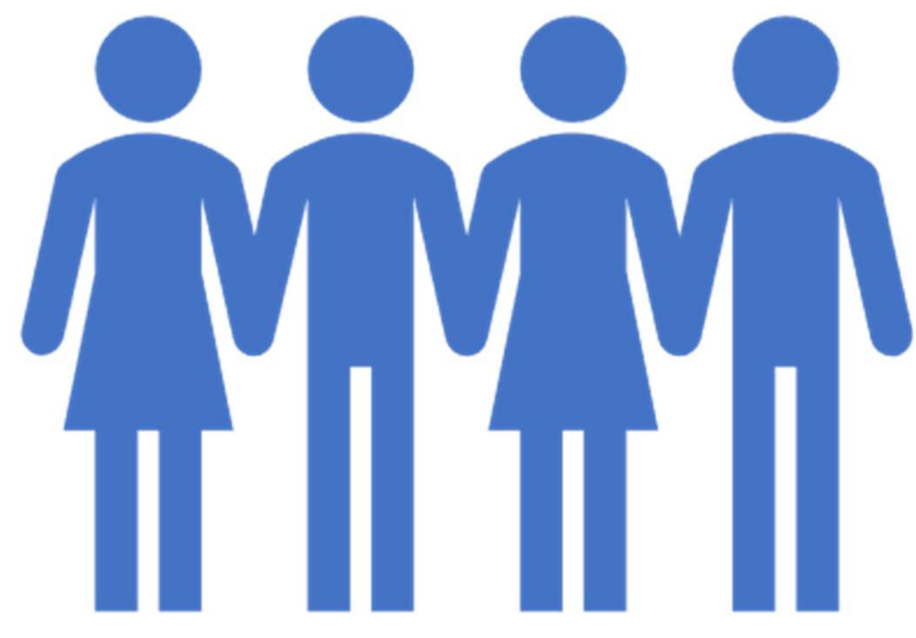
Presented by: Ginny LaRue, MNM

Director - Recovery Project

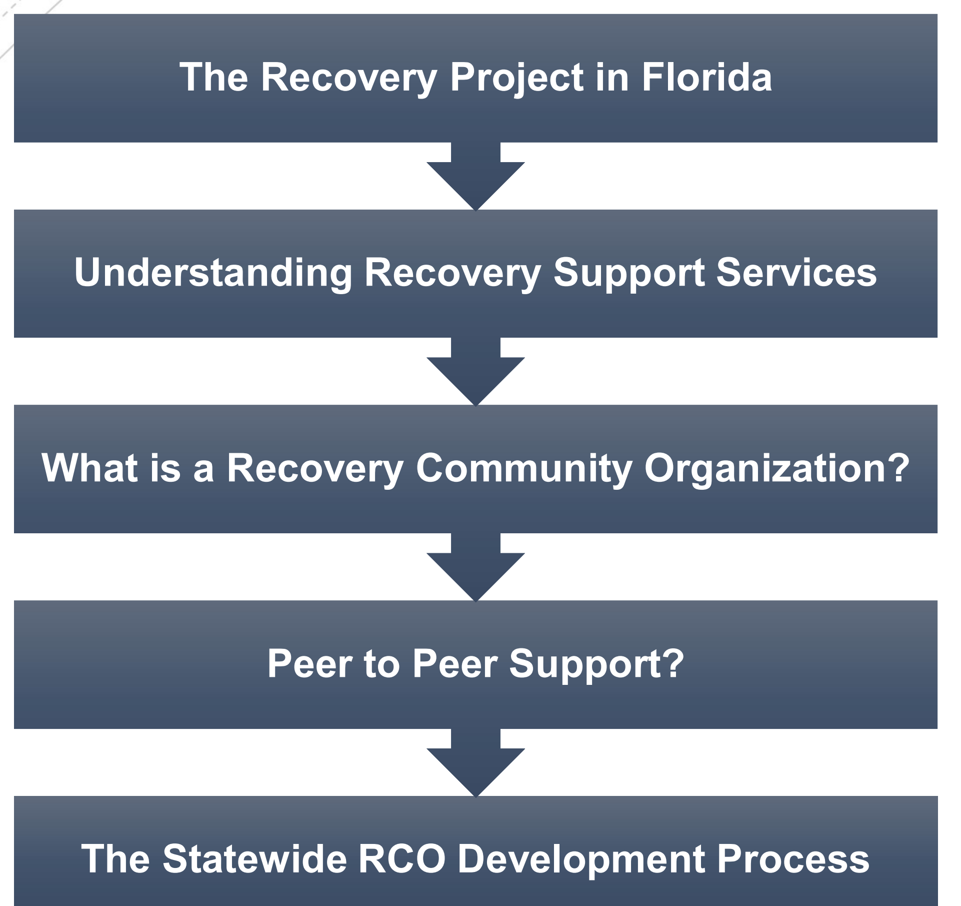
All in for Recovery: A Recovery Project

What Recovery Has Done for Me

What's Right With You Today?



Objectives



All in for Florida: A Recovery Project

The “All in for Florida: A Recovery Project" is a three-year initiative with the broad goal of building recovery groups across Florida into sustainable Recovery Community Organizations (RCOs) that utilize Certified Recovery Peer Specialists (CRPS) to enhance recovery support services within the local recovery network consistent with the guiding principles of a Recovery Oriented System of Care (ROSC).

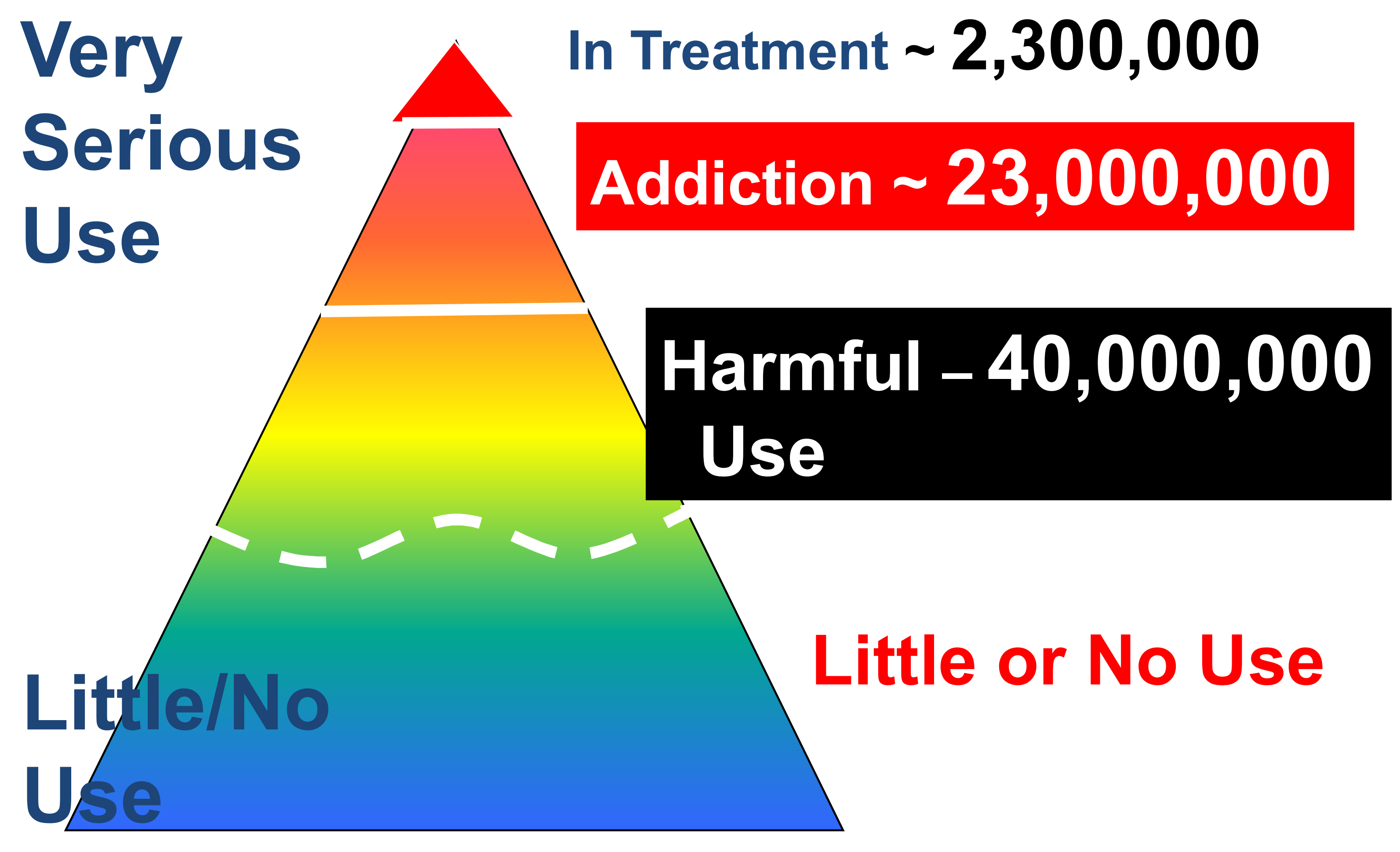
Goals of Recovery Project

- Address the nationwide opioid epidemic by cultivating recovery champions in Florida communities through ***Appreciative Inquiry*** model to guide cultivation of recovery champions.
- Build sustainability with RCO Development through community listening sessions, symposiums, and visioning sessions.
- Utilize peer to peer support services within each local recovery network

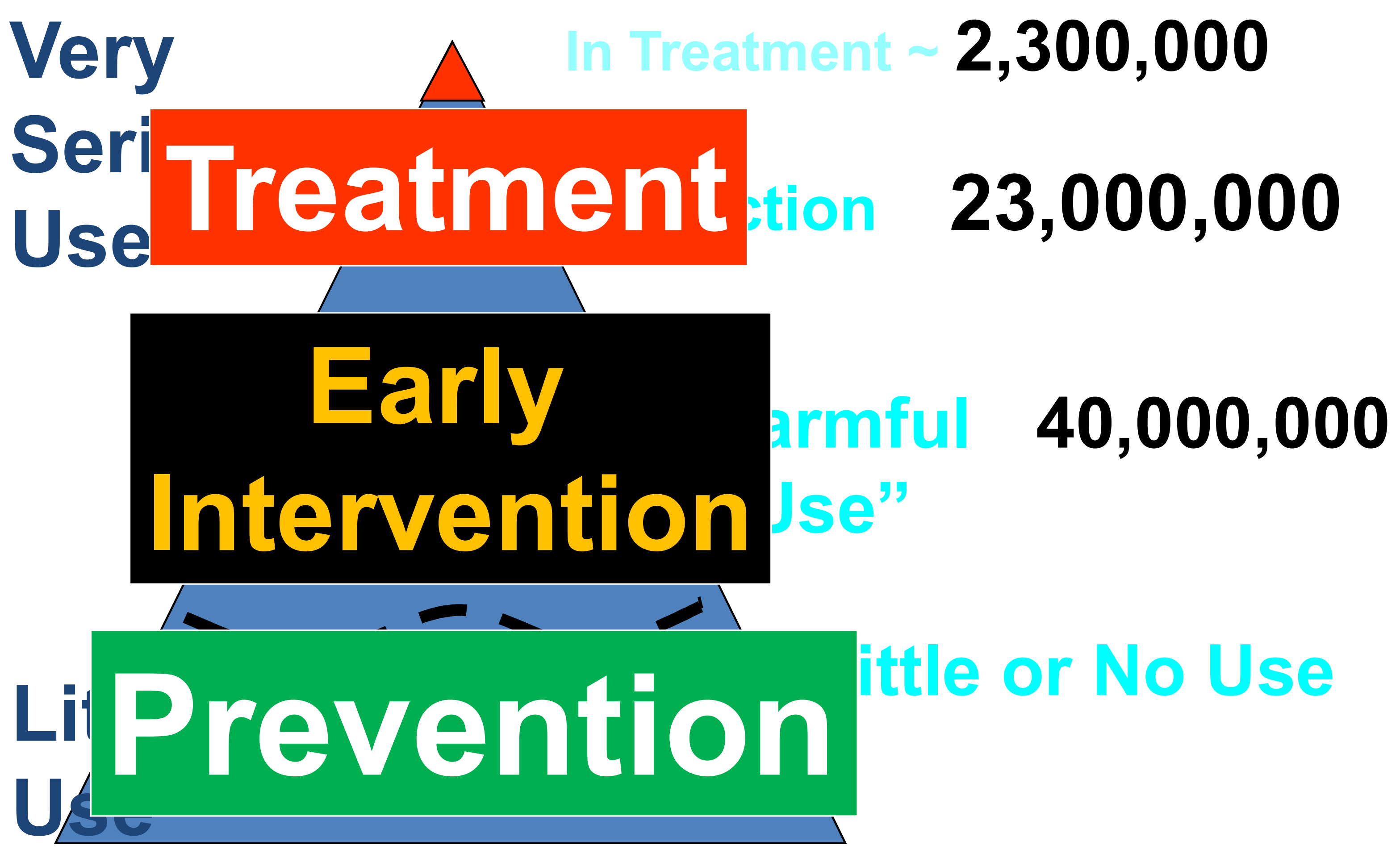
Statewide Partnerships

- Department of Children & Families SOR grant to assist with Project:
  - Faces & Voices of Recovery
    - RCO Bootcamp
    - Recovery Launch Pads
    - CAPRSS Training
- Peer Coalition of Florida:
  - Provide peer workforce training
- Floridians for Recovery – Statewide RCO to continue TA for further development

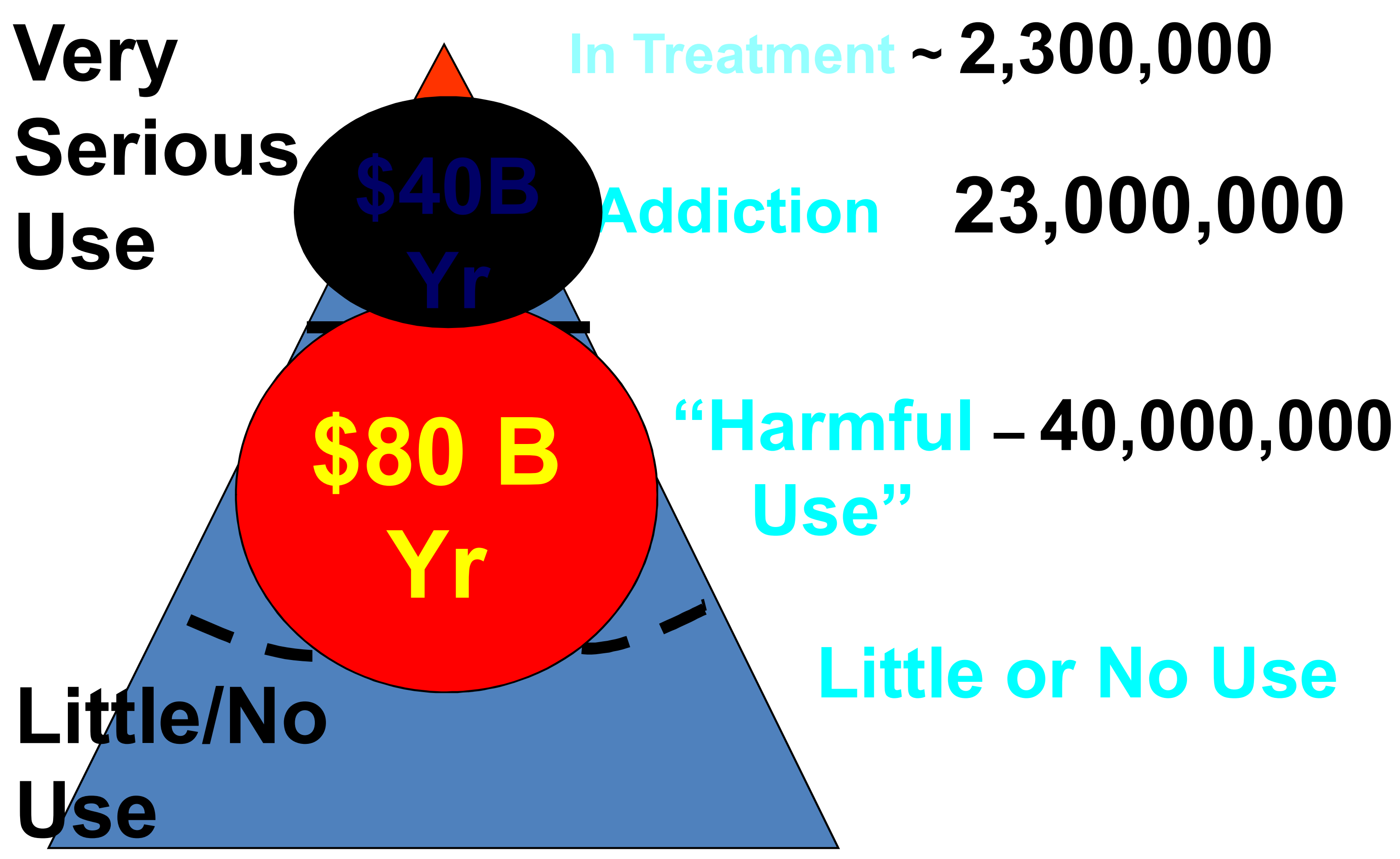
Substance Use Among US Adults

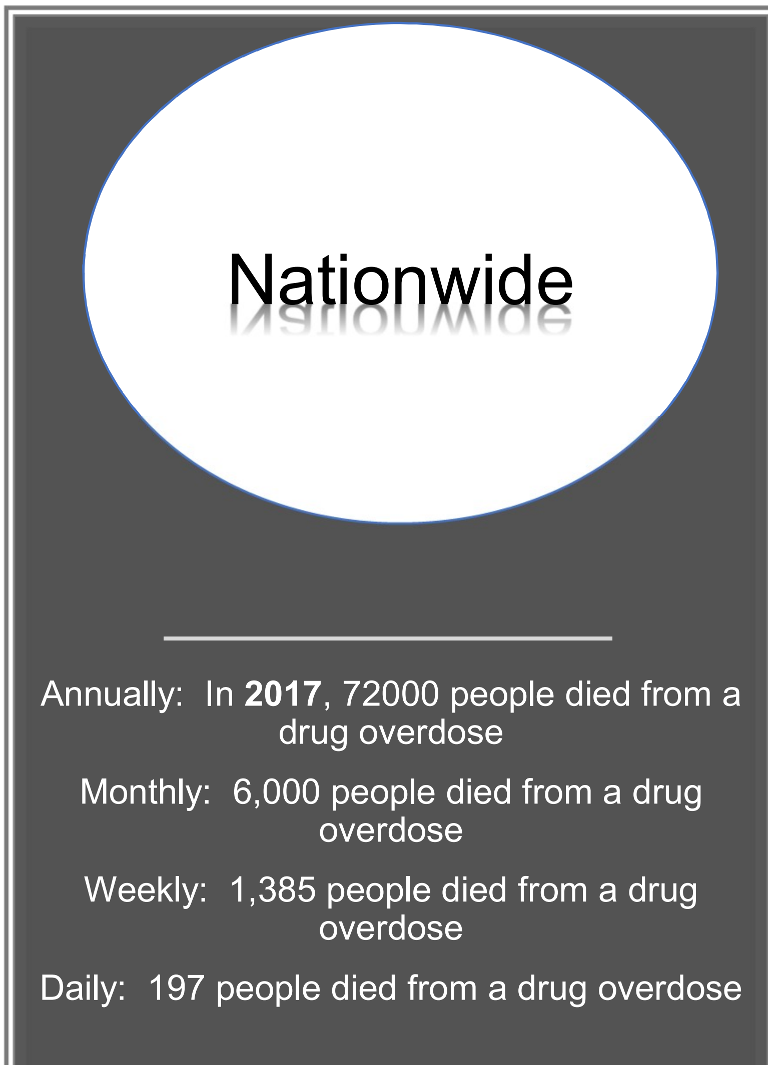


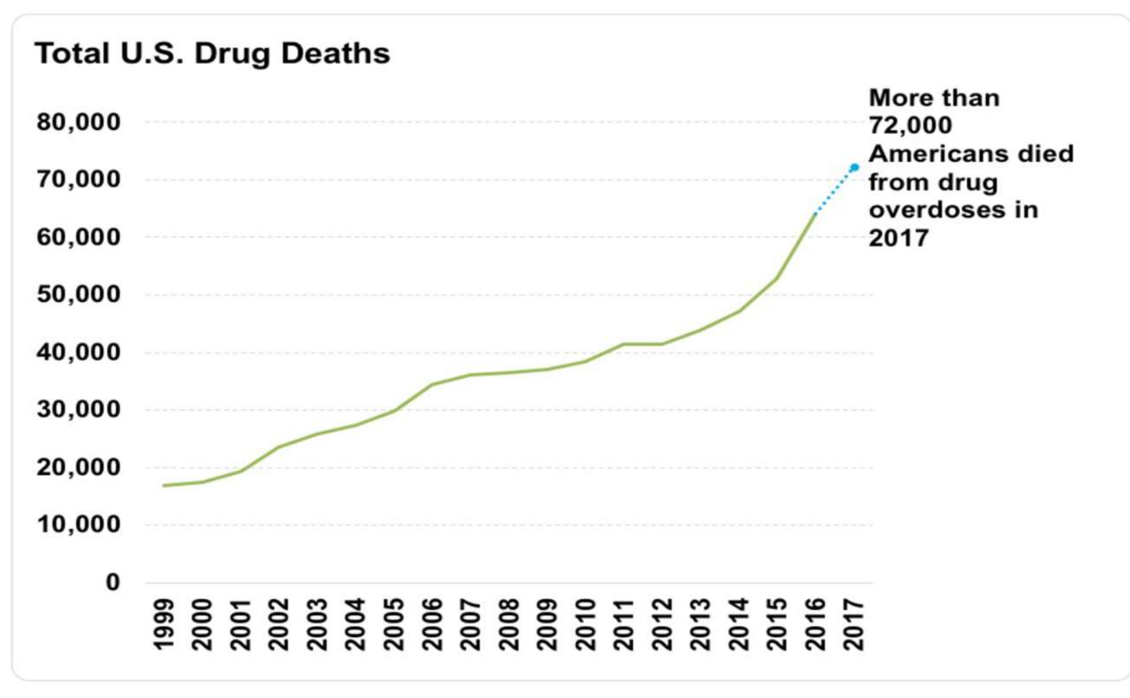
Substance Use Among US Adults



Substance Use Cost in Healthcare







https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

MANY PATHWAYS to RECOVERY
Recovery is the Solution

Definition of Recovery SAMSHA

A process of change through which individuals improve their health and wellness, live a self directed life, and strive to reach their full potential.

https://www.samhsa.gov/newsroom/press-announcements/201112220300

Recovery Guiding Principles

Emerges from Hope	Person-Driven
Multiple Pathways	Holistic
Supported by Peers	Supported through relationships & social networks
Culturally-Based & Influenced	Addresses Trauma
Involves Individual, Family, & Community	Based on Respect

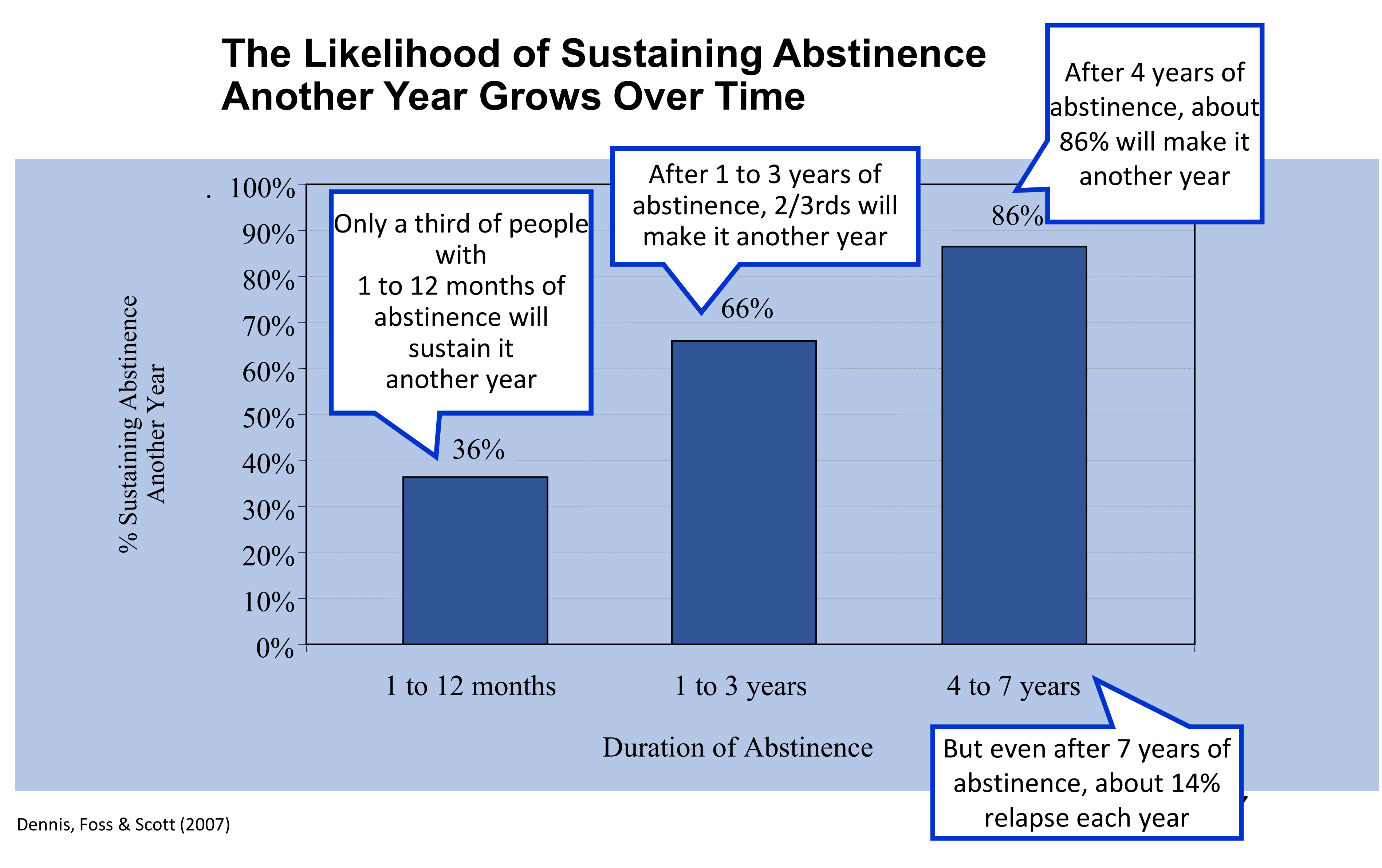
https://store.samhsa.gov/system/files/pep12-recdef.pdf

Dyad

Person A – Tell a story of how you overcame an obstacle or bounced back from something difficult. What helped you in doing so?

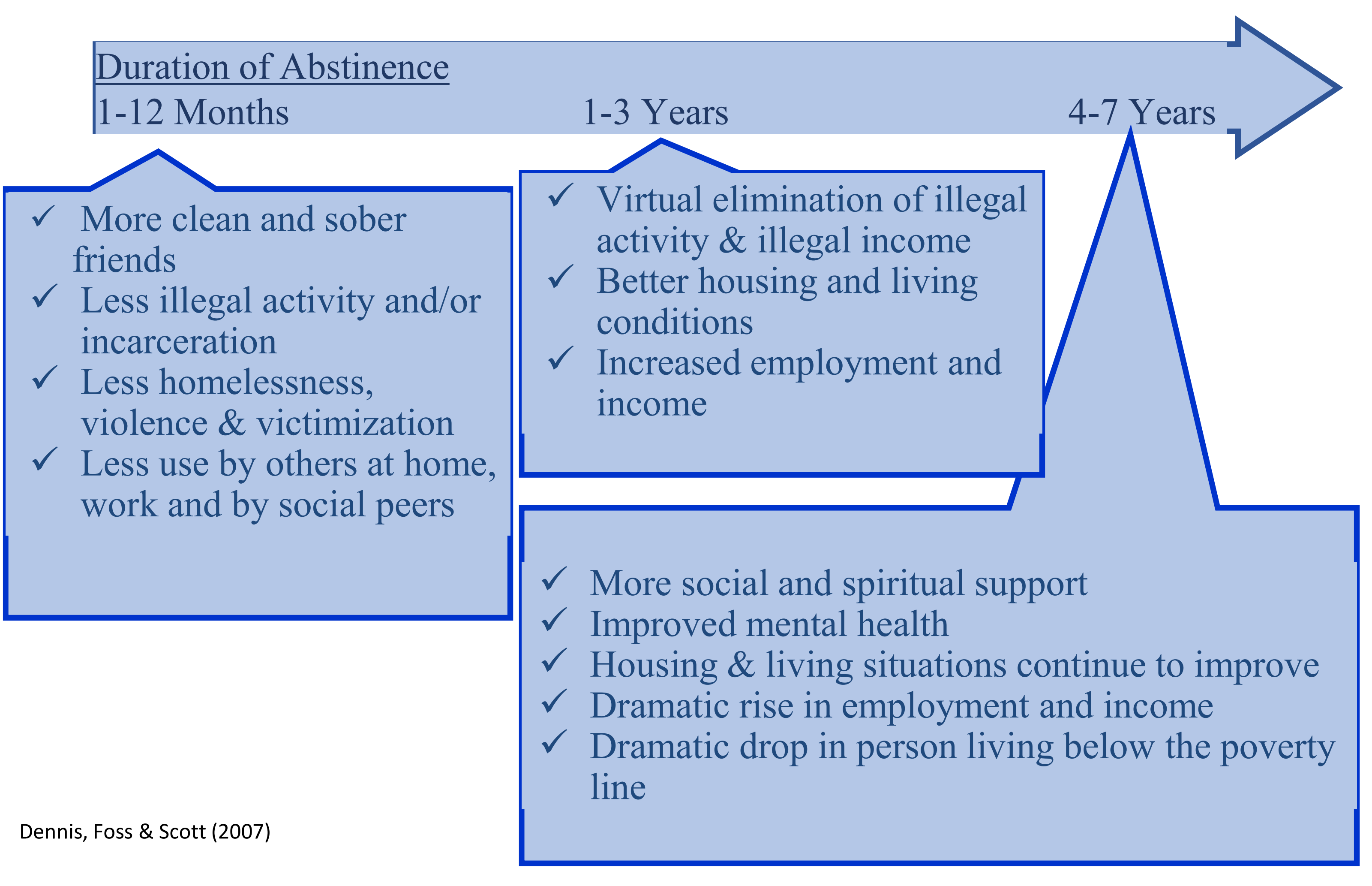
Person B – **LISTEN! 2 minutes**

Switch!



Dennis, Foss & Scott (2007)

What does recovery look like on average?



Dennis, Foss & Scott (2007)

Challenges for the Recovering Person

- Relapse Prevention
- Overcoming stigma & judgement
- Managing transitions (i.e. detox to residential – residential to RR – RR to stable housing)
- Education about co-occurring and medications
- Addressing stressors with recovering person (i.e. legal issues, child issues, DCF/CPC case
- Others?

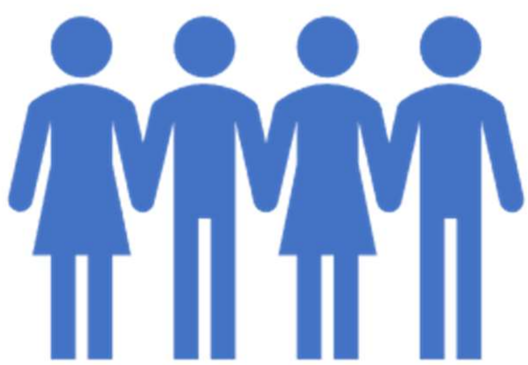
https://www.cwla.org/wp-content/uploads/2016/08/C8-%E2%80%93-Recovering-Families.pdf

People in Early Recovery Have Basic Needs…

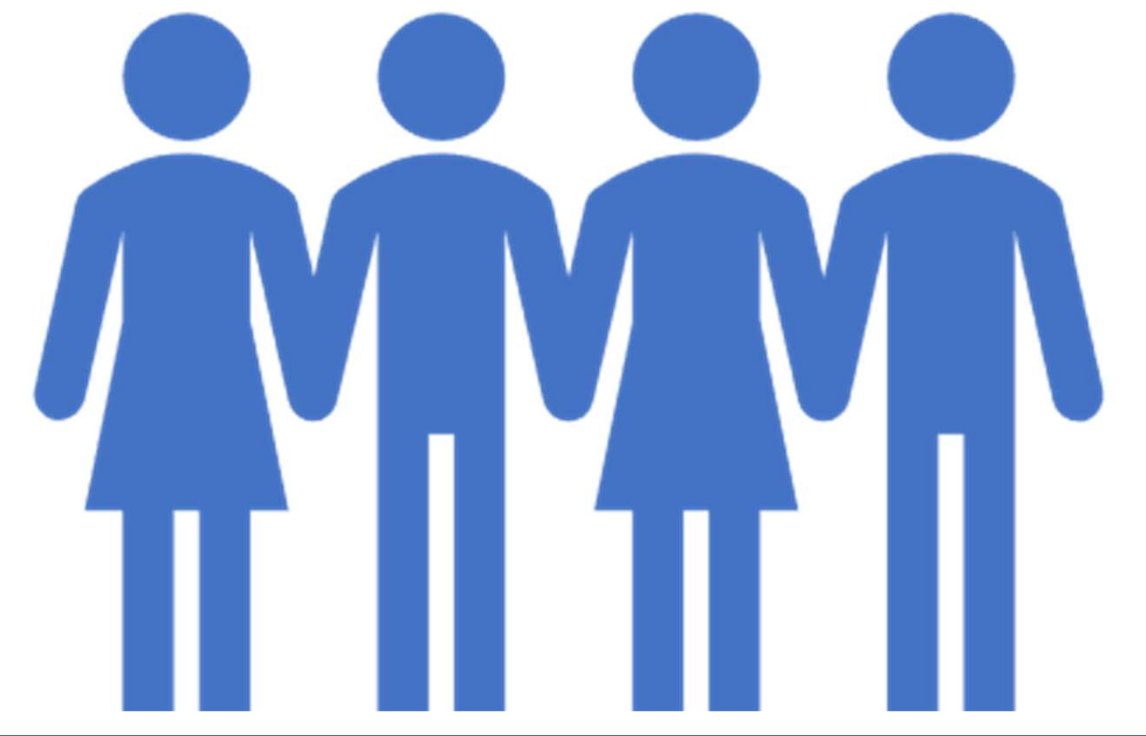
- Safe & affordable place to live
- Steady employment & job readiness
- Education & vocational skills
- Life & recovery skills
- Health & wellness
- Recovery based & safe social support networks
- Sense of Belonging

What is a Recovery Community Organization?

- ✓ RCO's are independent, non-profit organizations
- ✓ They are governed by representatives of local recovery communities (51% persons in recovery)
- ✓ They do not provide clinical services
- ✓ They offer a variety of peer based services and programs including:
  - ✓ Recovery-Focused Community Education
  - ✓ Recovery-Focused Policy Advocacy
  - ✓ Recovery-Focused Outreach Programs
  - ✓ Peer-Based Recovery Support Services



http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf



Recovery Community Organizations
Focus on four major categories

- ✓**Public Education**: Putting a face & a voice to recovery – remove stigma
- ✓**Advocacy**: Ending discrimination against people in or seeking recovery and their families/friends
- ✓**Services**: Peer based and other supports for recovery
- ✓**Inclusion**: Embracing all people & all pathways to recovery

We Believe…

- ✓ Recovery is REAL = Mental Health & Substance Use Disorder
- ✓ People are Inspired by Stories
- ✓ People want to be heard – NOT FIXED!
- ✓ No expert – LIVED EXPERIENCE!
- ✓ Sustainable change = being inclusive, invitational, working with strengths
- ✓ People support what they help create!
- ✓ Many Pathways!

Core Values of an RCO?

- RCO’s, their staff and programs always focused on recovery first
- RCO’s gear their services to all people. Their programs and services reflect cultural diversity and inclusion
- Decisions are made through the participatory process from the staff, stakeholders, partnerships, and individuals receiving services
- They run on the peer-helping-peer model
- Programs allow for leadership development in staff, volunteers and individuals receiving services
- All programs, services, communications and policies are strength-based
- All programs and services encourage individual autonomy and choice

Core Principles of an RCO?

- **Recovery** vision-Long-term recovery from substance use disorder happens
- **Authenticity** of voice-person's in long-term recovery drive the programs and services
- **Accountability** to the greater recovery community to help and support
- Continued **public education & awareness** to reduce stigma and help community members understand that recovery is possible
- Continued **policy advocacy**
- Offer peer-based and other recovery support services that support **multiple pathways** of recovery

Who Comprises a Recovery Community?

- People in or seeking long-term recovery from a substance use disorder
- Family/ Friends of persons in or seeking long-term recovery from a substance use disorder.
- Recovery-focused addiction and recovery professionals
- Organizations that reflect religious, spiritual and secular pathways of recovery
- Allies: Business owners, Law enforcement, Judges, Others…
- Others in the community who want to help

http://www.williamwhitepapers.com/pr/2004RoleofCommunityinRecovery.pdf

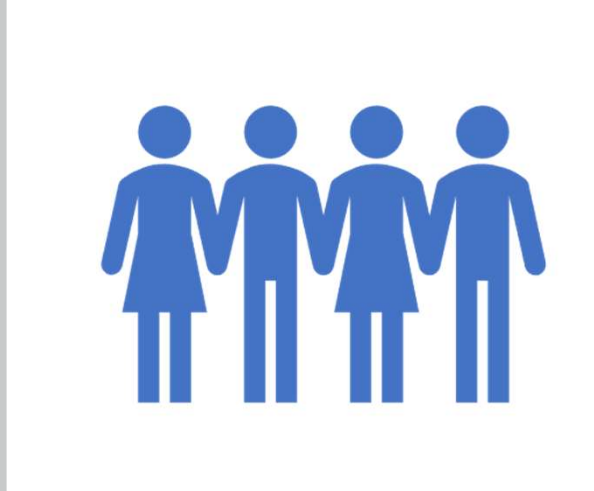
Benefits of an RCO?

- Unique capacity
- Offer support
- No power differential allows for rapid trust building
- Often services offered at no cost
- Provide a sense of belonging
- Provide a variety of pathways and freedom of choice in recovery
- Offer on-going and long-term help.

How do RCO's Fit in the Recovery Oriented Systems of Care?

- Precede formal treatment
- Accompany inpatient treatment
- Accompany outpatient treatment
- Follow treatment to assist in relapse prevention
- Apart from treatment
- Outreach and engagement
- Care Coordination

http://www.williamwhitepapers.com/pr/2009Peer-BasedRecoverySupportServices.pdf



RCO's May Provide…

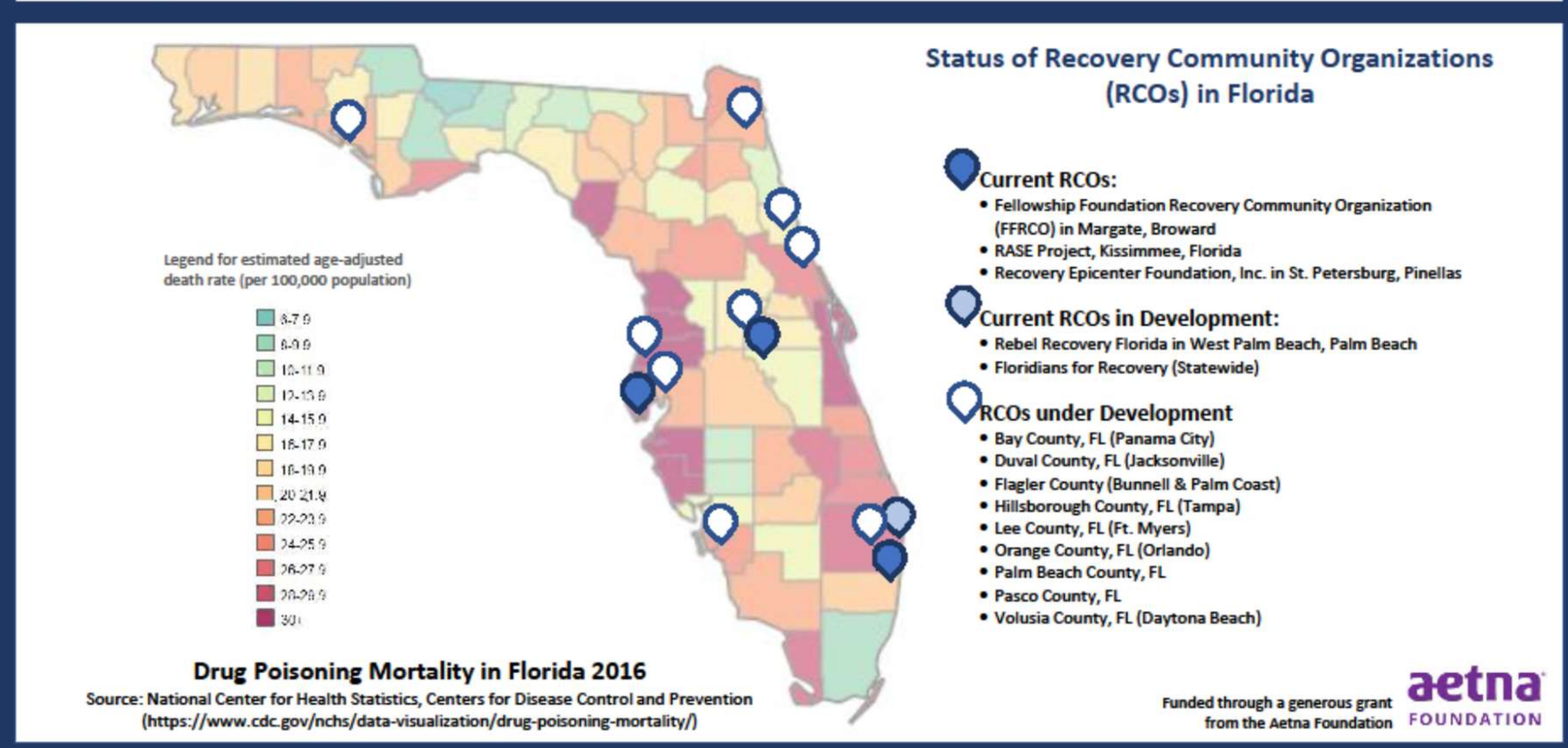
- ✓Employment Assistance
- ✓Transportation
- ✓Individual & Peer Recovery Support Services
- ✓Recreational Support
- ✓Spiritual Support
- ✓Family Support
- ✓Space for Independent Groups (i.e. 12 Step Groups)
- ✓Mutual Support Groups (i.e. All Recovery Meeting) that support multiple pathways
- ✓Peers in Emergency Department or Jail/Prison
- ✓Peer "Warm Line"

Florida's RCO's…

…are being developed purposefully through the RCO Development process so that each organization meaningfully responds to the needs of its community without duplicating services.

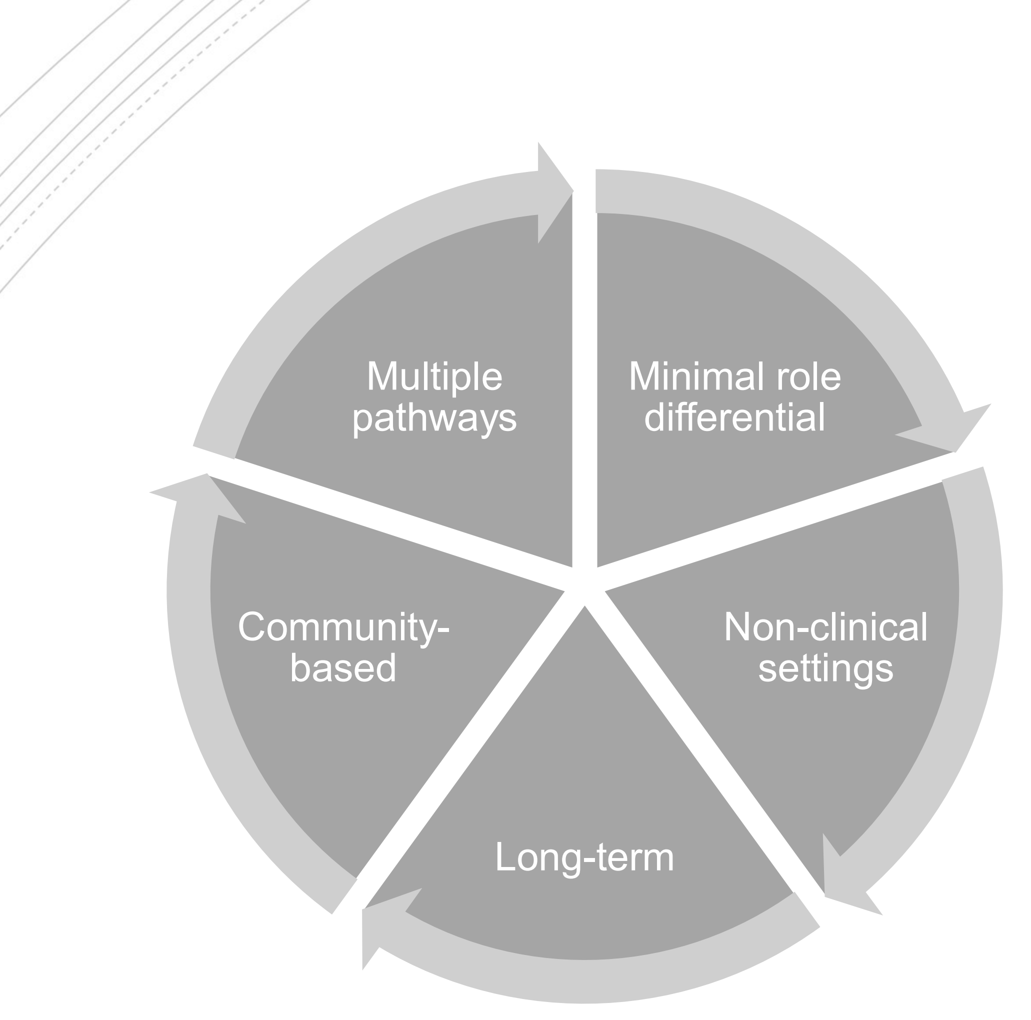
Existing or Developing RCO's in Florida

All In for Florida: A Recovery Project



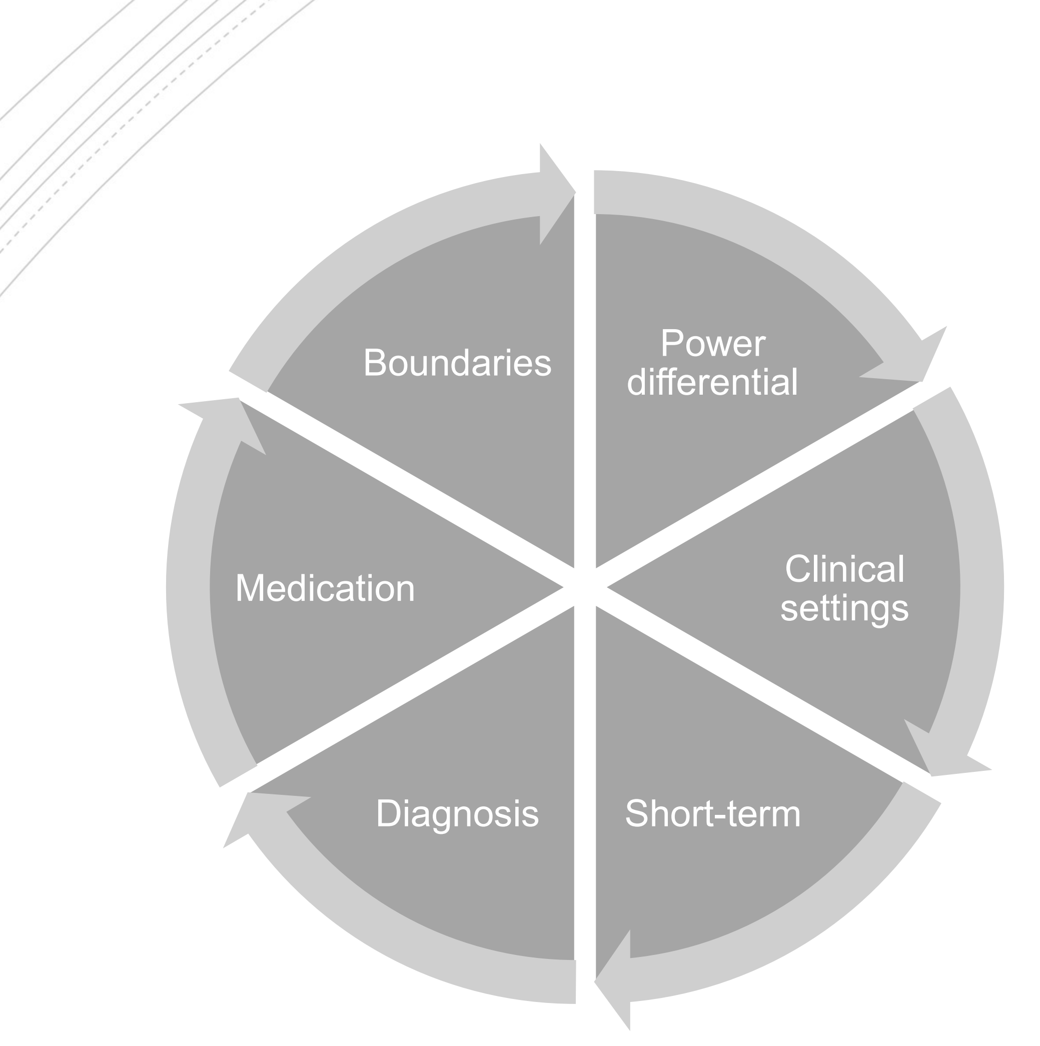
https://www.fadaa.org/page/Rec_communities

Peer Support



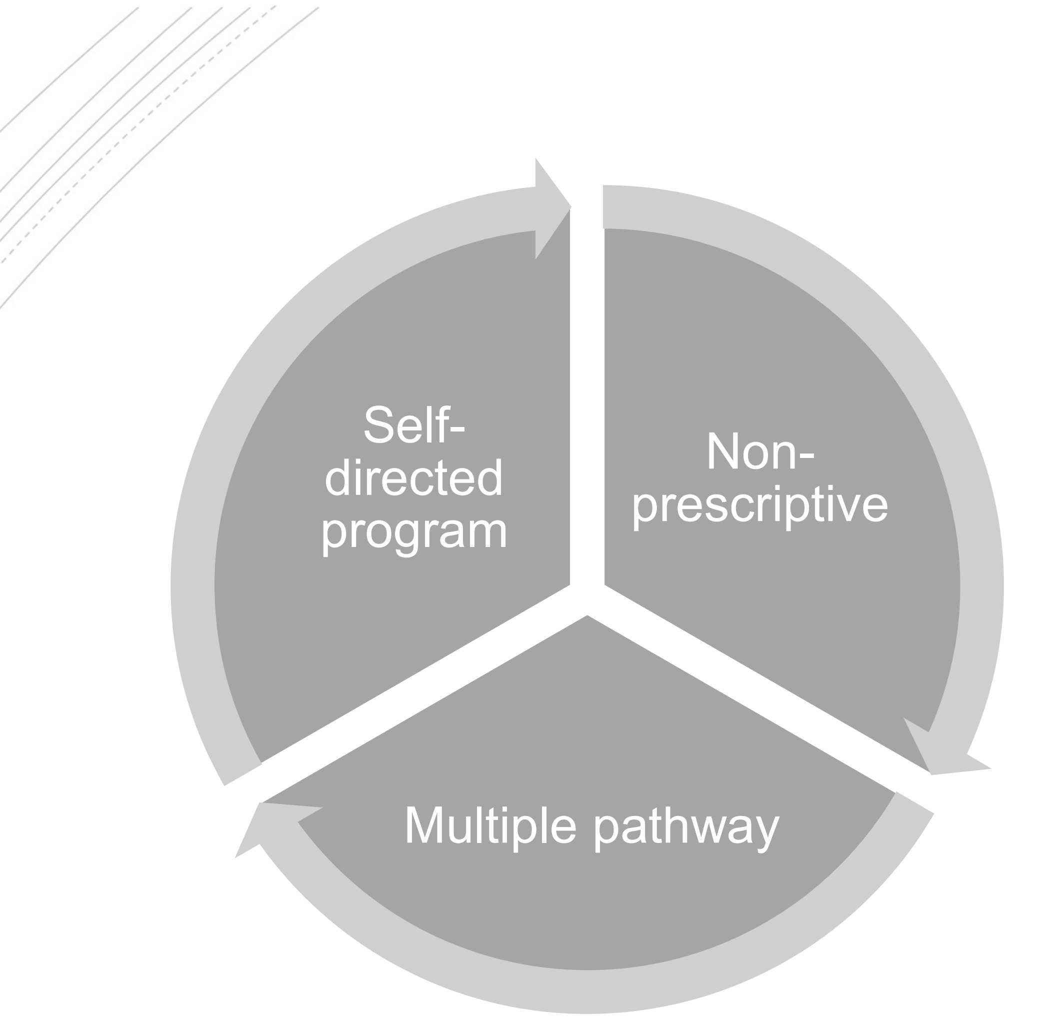
Peer Support Services

Understanding the Differences



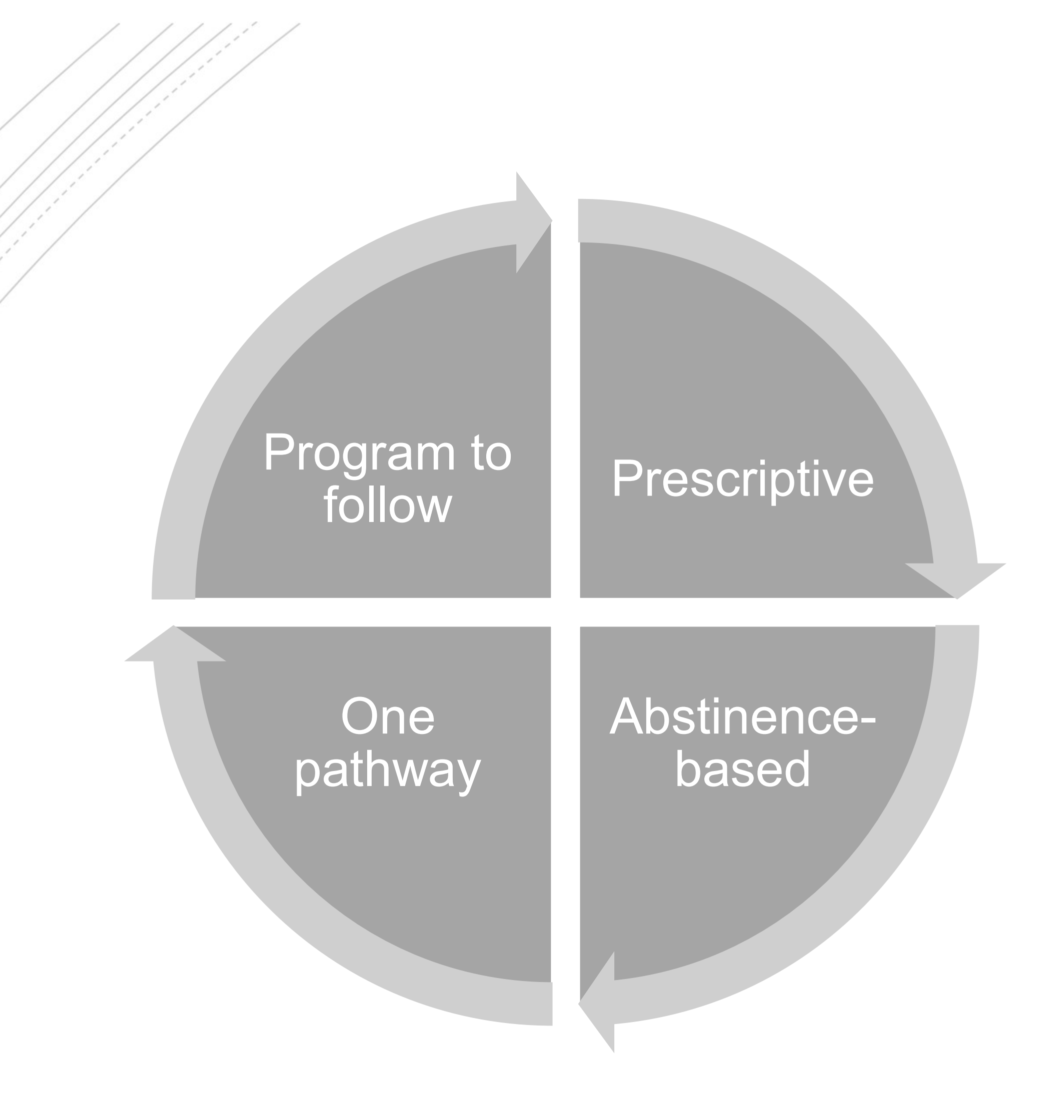
Clinical Support Services

Understanding the Differences



Peer Support Services

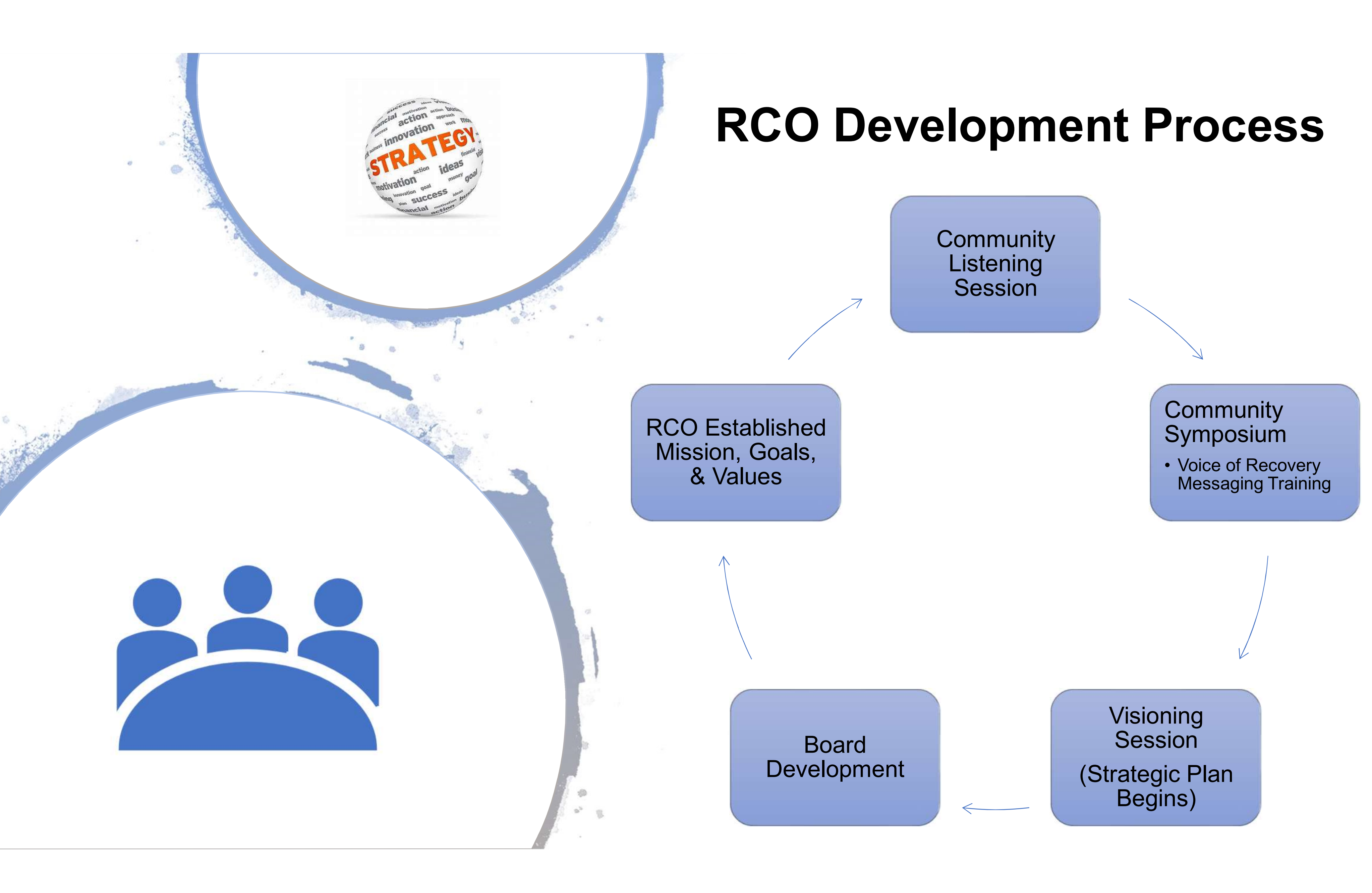
Understanding the Differences



12th Step Programs

Understanding the Differences

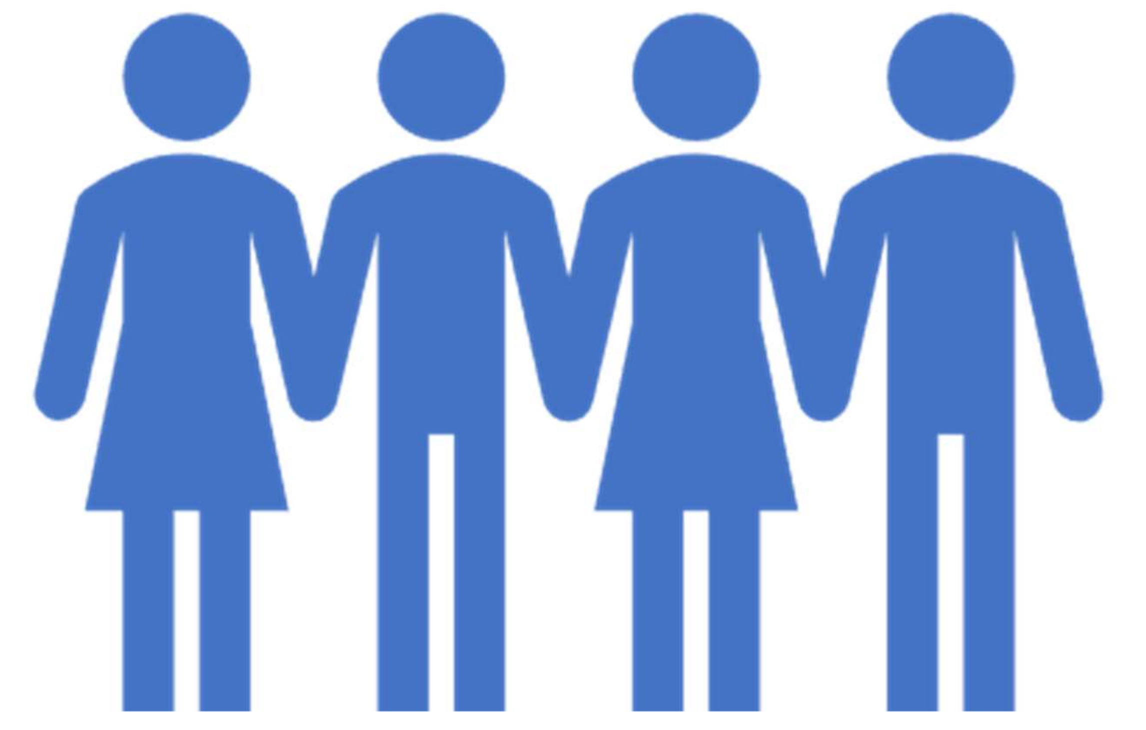
The Building Blocks
RCO Development Process
STRATEGY
innovation
action
motivation
ideas
success
goal
financial
approach
money



RCO Development Process
Community Listening Session
Community Symposium
• Voice of Recovery Messaging Training
Visioning Session
(Strategic Plan Begins)
Board Development
RCO Established Mission, Goals, & Values
STRATEGY

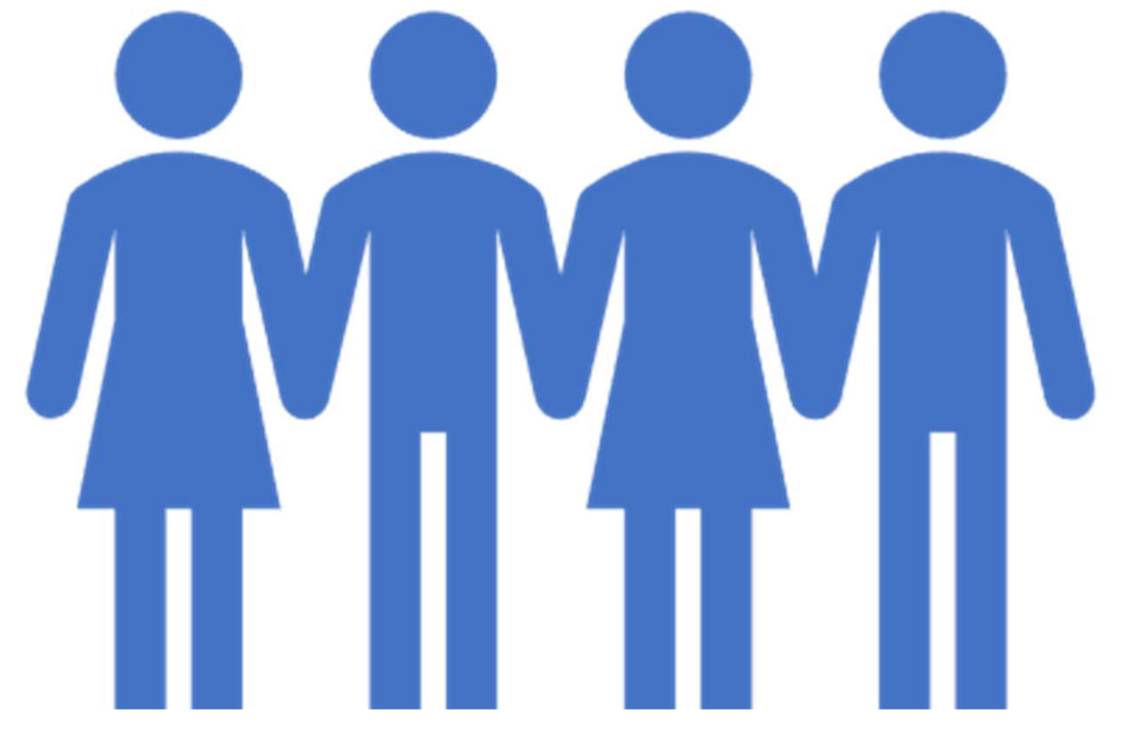
RCO Technical Assistance Team

- ✓ **Floridians for Recovery** – State RCO Advisory Board
- ✓ Organize **focused conversation** about recovery and training
- ✓ Plan for and host a local **recovery symposium**
- ✓ Foster local **collaborative relationships** for continued development of communities that are recovery-focused
- ✓ Many Pathways!



What is a Listening Session?

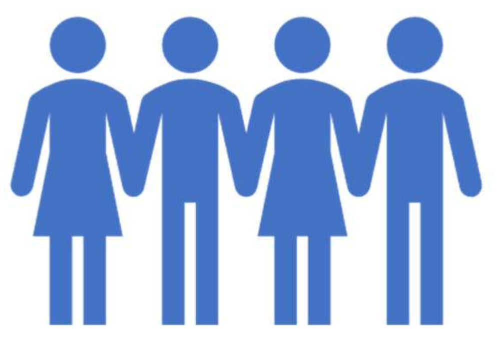
- ✓Inclusive and invitational of community members. Introduce RCO concept, and encourage Recovery Symposium.
  - ➢Prevention
  - ➢Treatment
  - ➢Judicial
  - ➢Criminal Justice
  - ➢Faith-based Orgs.
  - ➢Housing
  - ➢Families
  - ➢Voice of Recovery!



Recovery Symposium Planning Meeting?

- ✓ At completion of Listening Session, community agrees to plan a Recovery Symposium.
- ✓ Planning takes time as to be inclusive and bring about community partnerships and individual gifts

What is a Recovery Symposium?

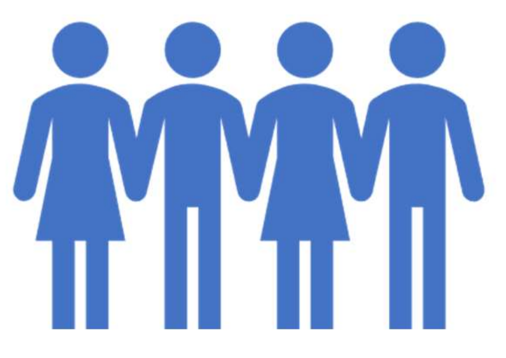


- ✓A collection of opinions expressed or articles contributed by several on a given **subject**.
- ✓Introduces ***multiple pathways of recovery***, panel of RCO's through the State and Nation, and has keynote speaker that embodies "voice of recovery."
- ✓Professional panel of community members sharing need of community
- ✓Café Conversation that gather information about community needs

Recovery Symposium

Multiple Pathways

Purpose of Recovery Symposium?



- ✓Address stigma
- ✓Collaboration & integration of treatment for mental health and SUD
- ✓Develop allies & partners to continue to create a system of care.
- ✓Family support & education
- ✓Supports to persons in the CJ system
- ✓Peer support
- ✓Recovery support for youth
- ✓Transitional housing & permanent housing

What is Visioning?

- ✓After Recovery Symposium, Recovery Champions reconvene to develop a sustainable RCO in County.
- ✓RCO Bootcamps and other training begins

Visioning for Community

✓ Committees are formed:
- ➢ Mission, Vision, & RCO Name
- ➢ Board Development/By-Laws/Non-Profit Status
- ➢ Strategic Plan
- ➢ Funding (sustainability plan)
- ➢ Outreach

What's Next?

RCO Development

Thank You!

Florida Alcohol and Drug Abuse Association
and
Floridians for Recovery

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Director – Recovery Project
glarue@fadaa.org

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Wrap Up

4:15 PM - 4:30 PM

Thank you

2019 Highlands
Opioid Symposium
May 23, 2019
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