
DRUGS
I'M
DRUNK

Emerging Trends in SUD Care

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DISCLOSURES

- No conflict of interest with this content
- Consultant: Braeburn Pharmaceuticals, Millennium Labs, Alere Laboratory, GW Pharmaceuticals
- Director: Two Dreams, Encounter Medical Group

OBJECTIVES

- Identify the connection between and among pain treatment policy, marijuana policy, technology of assessment, medicalization of the disease and treatment, and access under the Affordable Care and Parity Acts as the source of change in the industry
- Connect the epidemic of prescription drug abuse to potential expansion of Medication Assisted Treatment (MAT) without regard to TSF
- Understand and predict the consequences of earlier access to higher potency marijuana and create policy to manage newly-empowered patients using marijuana while in treatment for medical reasons
- Develop an action plan for staff- or self-development that targets the management of distractions from recovery focused care
- Describe the components of care essential to recovery enhancement in an ever evolving world of prevention, intervention, and treatment

SOURCES OF PROBLEMS

- New set of skills required to manage new circumstances
- Rapidly evolving science and practice of therapies
- Imprecise and confusing terminology- often politically charged
- Calls to medicalize drug use and its treatment as code for legalization

TENETS THAT I LIVE BY

- Drug possession is a crime
- Crimes committed to get money to get drugs are crimes
- Drug use is a preventable behavior, addiction is a disease
- In the U.S.A., we have the resources to treat everyone with this disease

TENETS, CONTINUED

- Civil societies protect their youth
- Course corrections follow data, not dogma
  - If you make a course correction you are obligated to study the anticipated and unanticipated consequences
- Good policy in one area of drug policy may not be good policy for another area; in fact it may be disastrous

TENETS, CONTINUED

- Non-users can be encouraged to continue in that status or to use, the line warns off would be users
- Non-dependent users have very few incentives to not use
- Dependent users tend to continue using, need strategically applied pressure to discontinue use

TENETS, CONTINUED

- U.S. cannot accept the provision of substandard care or give the tools of addiction to people with the disease
- Drug use is not healthy “recreation”- or at least should not be encouraged
- Policy makers cannot afford to take the narrow view

STARTING POINT

- The downside of drug use >>> than the upside
- Drugs of abuse have profound, immediate, and long-term effects on the chemical balance in the brain
- Those who have had a drug using experience, even if not current, are changed permanently by experience

POLITICS AND SCIENCE

- Politics is a process through which conflicts over values are settled
- Science is a process in which conflicts regarding facts (truth) are resolved
- The values that inspired the earliest controls which underpin today's policies related to basic human values of responsibility for mind and body

PUBLIC POLICY

- Course of action or inaction chosen by public authorities to address a problem
- Is expressed as a body of laws, regulations, decrees, and actions of government:
  - In name of public, made or initiated by government, implemented by public and private, intends to do or chooses not to do

CONFLICT IN VALUES

- Control: to sustain and promote basic human values
- Anti-control: liberty and freedom, underlying notion that unrestrained drug use in modern, complex society would not ultimately harm others

THE WAR ON THE“WAR ON DRUGS”

- Calls attention to the magnitude of the problem
- Endemic public health problem
  - Classical approaches sought
- Scientific basis
- Well-defined broad national goals
- Be aware of unintended consequences

ECONOMICS OF LEGALIZATION ARE INTERNALLY CONTRADICTORY

- Unless 100% given away, there will be black market
- Price elasticity fluctuates
  - Perceived luxury first time to inescapable necessity later

HEALTH CARE COSTS RISE

- Increased availability increases casual users
  - More casual use, more progression
  - More progression, more addiction
  - More addiction, more cost
- Less addictive drugs teach us that the higher the percentage addiction, the higher the cost
- Capture rates: Alcohol 15% lifetime; marijuana 9% lifetime (17% if young, 25-50% if daily); cocaine 4% who try, 20% after 2 years; heroin 23%; tobacco 32%

MOST CRIME WOULD RISE, NOT FALL

- Most crime is state level
- 80% in 1 of 3 types
  - Committed by those on drugs
  - Committed by those needing money to get drugs
  - Committed as distribution of drugs
- Most not imprisoned for possession, those who are made a plea bargain from distribution
- Legalization would not reduce these categories

TWO POLICY SILOS

- Demand reduction
- Supply reduction
- “Harm reduction” promotes safer ways to use drugs
  - Drug dependence care – defends against harm
  - Drug dependence treatment – defends against use

"HARM REDUCTION"

- Numerous societal analogies to reduce harm but not behavior by changing conditions under which behavior occurs
  - Guard rails, safety belts, lifeguards, helmets, expiration dates
  - Common, socially acceptable behavior, neither desirable nor realistic to prohibit activities

NICOTINE NOTES

- Social policies- label, restrict advertising
- Public health policies- taxation, patches
- 40 years after recognized harms still have 42 million cigarette addicts
- 2 million cocaine users, 500,000 crack users- avoids harm
- Nicotine’s easy availability, lax legal controls make it more desirable target

HARM REDUCTIONS'S HARMS

- Non-using norm lessened as illegality, dangers, and social consequences made ambiguous (see "successful" users)
- Non-dependent users don't get message to stop (use safely)
- Dependent users get reinforcement to use and lessened incentive to stop (strengthens resolve to use)

QUASI-HARM REDUCTION LEANING

- Denial of residential levels of care for opioids
- Immediate initiation of MAT in young without abstinence based episode of care first
- Prescribers lack TSF experience

Like Minded Doctors

- We believe that Twelve-Step recovery modalities are compatible with other treatment strategies including medication management, and we are impressed with the evidence base drawn from extensive, well-designed studies demonstrating the significant benefits of Twelve-Step recovery modalities in facilitating long-term recovery. We believe that addiction specialist physicians need to facilitate a path for our patients toward the best possible state of wellness and recovery as they receive treatment for this chronic disease. We believe a well-rounded educational and clinical preparation for physicians choosing to practice addiction medicine and addiction psychiatry requires a comprehensive exposure to the psychosocial and spiritual modalities of treatment, including Twelve Step Facilitation (TSF) as an evidence based practice, as well as exposure to the neurobiological and psychopharmacological modalities. Finally, we believe that there is a need for greater understanding of the recovery process derived from research on the biological, psychological, social and spiritual aspects of the disease and individuals' recovery from it.

THREE TOOLS

- Influence
- Illumination
- Intention


THE PRESIDENT'S PLAN TO
Reform Drug Policy
1) PREVENT drug use before it ever begins through education
2) EXPAND access to treatment for Americans struggling with addiction
3) REFORM our criminal justice system to break the cycle of drug use, crime, and incarceration while protecting public safety
4) SUPPORT Americans in recovery by lifting the stigma associated with those suffering or in recovery from substance use disorders
Drug policy is a public health issue, not just a criminal justice issue.
SPREAD THE WORD
www.wh.gov/DrugPolicyReform
#DrugPolicyReform

POLICY

- Problem
- People
- Partnerships
- Policy
- Programs

PROGRAM EXAMPLES

- Schools- we care about you
- Prevention- we can make a difference
- Law enforcement- we will protect you
- Community Coalitions- we will work collaboratively to keep you safe
- D of J- we will work to reclaim you
- SAMHSA- we will treat you

U.S SPENDING

- Prevention- $1.4 billion
- Treatment- $9.3 billion
- Law Enforcement- $9.6 billion
- Interdiction- $3.7 billion
- International- $1.4 billion

THREE POLICY TARGETS

- Non-users
  - Never used
  - Not using
  - Never to use again
- Non-dependent users
- Dependent users

THREE STRATEGIES

- Stop **Initiation**
- Brief and Early **Intervention**
- **Improve** treatment

STOP INITIATION

- Cultural disapproval
- Reinforce non-using norms
- Deter use
- Address variables to initiation

VARIABLES TO EXPERIMENTATION

Availability- interdiction

Perceived risk- education, intentions

Prior use- prevent first use

Opportunity- reduce unsupervised time

Peer use- signal direction, normed behavior

Tendency to respect social norms- communicated in families

BRIEF AND EARLY INTERVENTIONS

- Zero tolerance
- Uncover use
- Stop the vector
- Prohibition, responsibility, and illegality
- Policy sets the rules, testing is the radar, discipline provides results

INTERVENTION TOOLS

- Proper use of Urine Drug Testing (UDT) in identifying and treating substance use disorders (SUD)
  - Patient safety
  - Public safety
  - Chronic disease management

TWO SCIENTIFIC METHODS

- Immunoassay
  - Presence or absence of class of substance or metabolite
  - Rapid result, verify self-report
  - Low specificity
- Chromatography
  - Identifies specific drugs
  - High specificity

TEST STRATIFICATION AND SELECTION

- Scientific method
  - Specificity, sensitivity, cost, speed, matrix, window of detection
- Location of test and complexity
- Locus of care (if not screening)
- Stage of care
  - diagnosis, active treatment, chronic disease management

IMPROVE TREATMENT

- Denial gap- create motivation (76%)
- Motivation gap- harness desire (5%)
- Treatment gap- Treat use (2%)
- Outcome gap- Support recovery (17%)

END STAGE IDENTIFICATION

- Progressive diseases worsen with time
- Late stage diagnosis associated with less-than-optimal outcomes
- Moderated use becomes the norm
- Failure to recognize role of therapeutic coercion; attraction not promotion
- Abstinence-based treatments cast as heartless, inhumane, unachievable

MEDICAL TREATMENT DISTINGUISHED

- Provide comfort
- Increase motivation
- Alter effects of drugs if they are ingested
- Reduces risk for consequences of behaviors
- With MAT- maintains underlying dependence on drug of choice

REIMBURSEMENT FOR TREATMENT

- Data confirm benefits, necessity of sustained care; “fail first” disasters
- Termination of coverage causes dropouts
- Dropout often results in relapse
- **Fuels belief** that treatment does not work, **supports notion** that people cannot recover, **bolsters argument** that treatment is futile- harm reduction necessary

MODIFIERS OF SUD

- Prescription drug abuse epidemic
- Affordable Care Act implementation
- Pharmaceutical development and drug coverage

SCHEDULING

- The CSA of 1970 classifies drugs by potential risk of abuse, harmfulness, and medical usefulness.
  - I- High potential for abuse, no accepted medical use in U.S., lack of accepted safety under medical supervision
  - II- High potential for abuse, current accepted use with severe restrictions, may lead to dependence*
  - III- Potential for abuse, currently accepted use, low or moderate physical dependence and high psychological dependence
  - IV-Low potential for abuse, accepted use, limited dependence
  - V- Low potential for abuse, accepted use, narrow scope for physical and psychological dependence

PRESCRIPTION DRUG ABUSE DEFINED

- Misuse: use of a medication (for a medical purpose) other than as directed or as indicated, whether intentional or unintentional" (Katz et al 2007)
- Abuse: the intentional self-administration of a medication for a nonmedical purpose such as alerting one's state of consciousness, e.g., getting high (Katz et al 2007)

WHAT IS DIFFERENCE BETWEEN THERAPEUTIC USE AND ABUSE?

- Dose and frequency of dosing
  - Lower, fixed regimens vs. escalating use
- Route of administration
  - Oral vs. snorting vs. smoking vs. injecting
- Expectation of drug effect
  - Expectation of clinical benefit vs. euphoria, “high”
- Context of administration
  - Home or hospital vs. school, disco, bar, party, etc.

PRESCRIPTION DRUG ABUSE DEFINED

- Admissions to treatment centers for prescription pain relievers increased 300 percent from 1995 to 2005 (ONDCP 2008)
  - Admissions to hospitals for overdoes of prescription pain relievers increased a similar amount in the same time period (ONDCP 2008)
- There is evidence that abusers of OxyContin® graduate to heroin (Educating Voices)

LIMITING PRESCRIPTION DRUG ABUSE

- Decreasing access to opioid analgesics
  - Anti-diversion efforts reduce supply
  - DEA raids, pharmacy responses
  - Aggressive insurer policies and practices
- Increasing access for detoxification and maintenance
- Mandatory prescribing standards for opioids, others to follow?

PAIN MANAGEMNT HAS EVOLVED TO REDUCE SUFFERING

- 1/3 people > 12 y/o used prescription drugs as first drug; new finding!
- 1997-2007 per person use of opiates increased from 74 mg to 369 mg, 402% increase
- 2000-2009 prescriptions filled by pharmacies from 174 million to 257 million (48% increase)

PAIN MANAGEMENT FOLLOWED BY MORE DIVERTED OPIOIDS

- Policy responses- education, track and monitor, proper protocols, enforcement
- BUT
- Single drug “witch hunts” at the expense of strategic, system wide policy that could reduce morbidity and mortality (ex. Zohydro)

Pain Management Protocols

- Stratification protocols- risk is inherent to exposure in pain clinic
  - Low risk: 1-2 times/year and targeted
  - Moderate risk: 2-4 times/year and targeted
  - High risk: 4 times/year and targeted
- In SUD setting- risk is inherent to patient
- In overlap- risk is inherent to both

Pain and Addiction Overlap- Managing Results

- Unexpected result to random UDT
- Step 1: Assessment and Diagnostic testing to characterize status
- Step 2: Early Stabilization to detect issues and deter progression
- Monitor and manage- return to pain pool or continue in active treatment for SUD

SUD Protocols

- Assessment/ Diagnosis
- Phases of Active Treatment:
  - < 30 days
  - < 90 days
  - < 2 years
- Phases of Recovery
  - 2-5 years
  - 5-10 years
  - > 10 years, mature recovery

MANAGEMENT TARGETS

- Being clean
- Relationships
- Highs and Lows
- Work and Growth

MATURE RECOVERY

- Abstinent
- Well-learned habits
- Ample social networks
- Solid, intimate relationships
- Healthy recreation
- Employment and career development
- Philosophy of life
- Key activities or interests
- Acceptance of the past

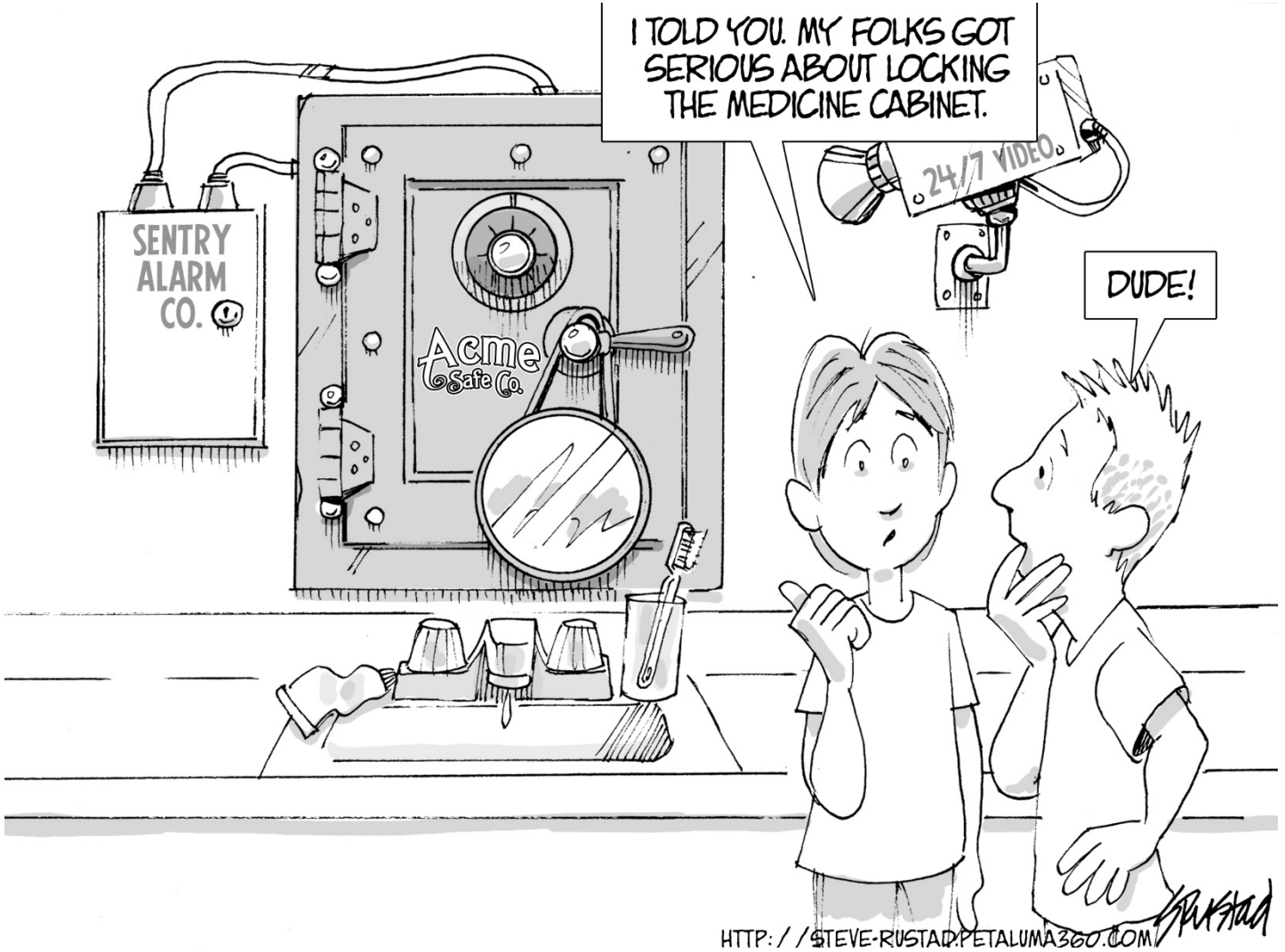
ISSUES OF INCREASING ACCESS TO CARE: AFFORDABLE CARE ACT IMPLEMENTATION

- Newly insured people are consuming care (premium increases of 25%)
- Cost and quality adjust shifts in access
- Deductibles and high cost sharing for meds
- Quality of care concerns
- Out-of-network without out-of pocket credit
- Increased out of pocket costs lead to reduced adherence to medications

PHARMACEUTICAL DEVELOPMENT

- R&D focused on specialty drugs, new indications for existing products
- National debate over cost of new therapies (Hepatitis C- cost sharing, cost per cure, longer life v. reduced suffering)
- Role of pharmacogenetics and precision medicine
- No coverage for off-label use, counterfeits

Safe Storage



THE MARIJUANA PROBLEM

- Most widely used illicit drug in America
- Of 5.6 million suffering, 62% are using marijuana
- Young people represent 23% of the suffering population

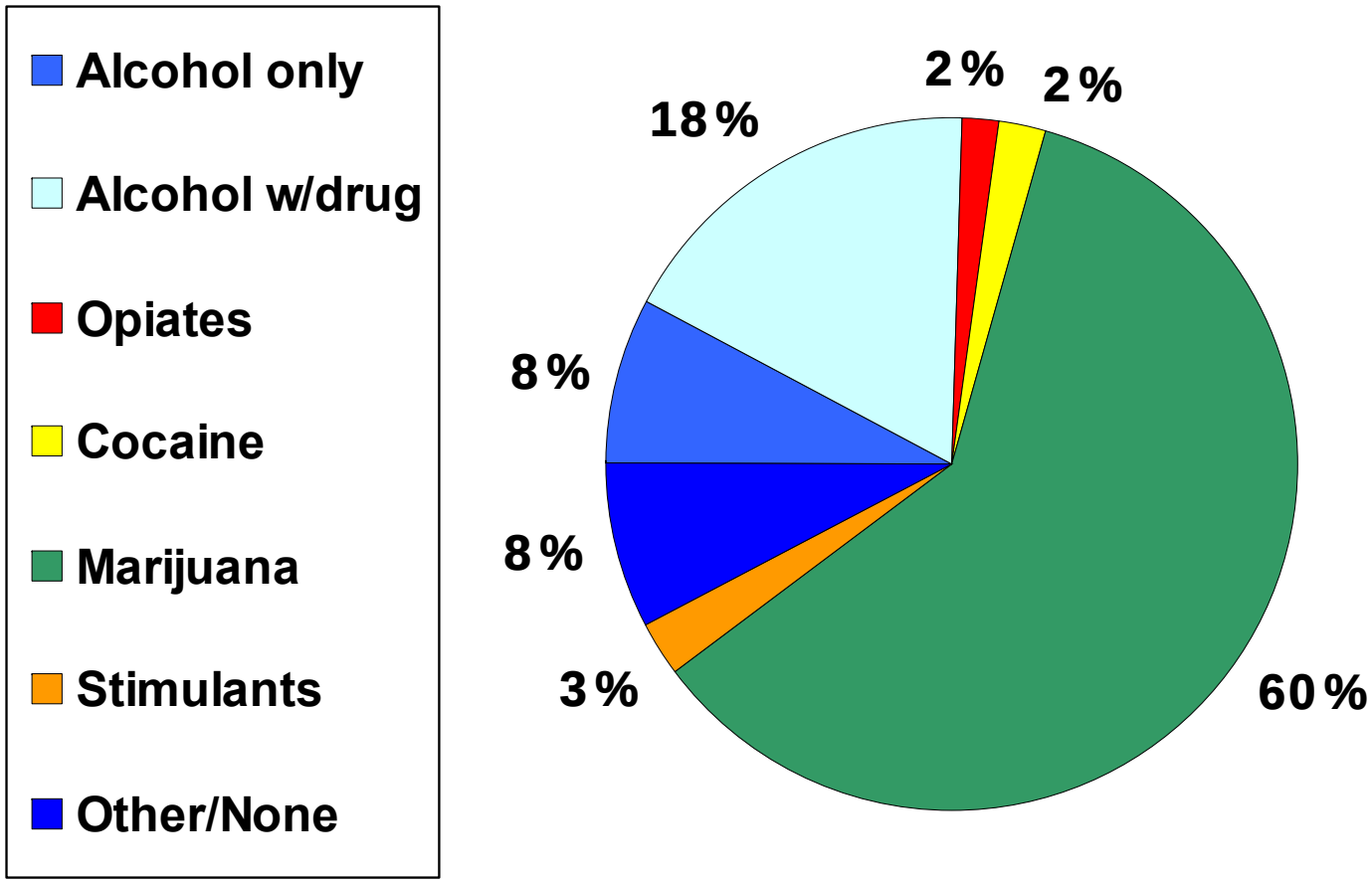
THE MARIJUANA PROBLEM

- Average age of initiation decreasing
- Marijuana's potency is increasing
- With increasing potency and earlier use, marijuana poses significant threat

THE MARIJUANA PROBLEM

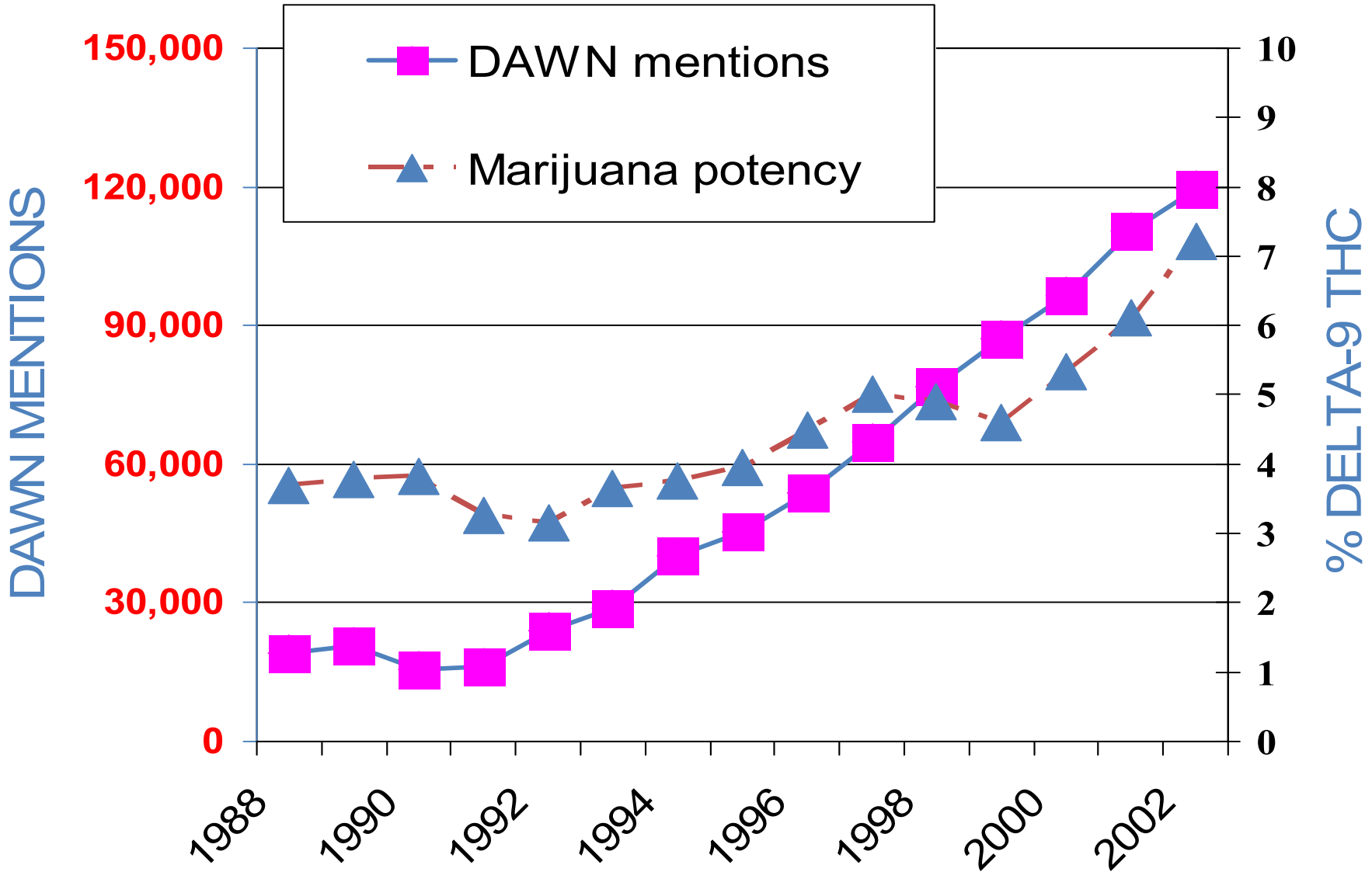
- Of all teens in drug treatment, 62% had primary marijuana diagnosis
- More young people in treatment than for alcohol
- Almost equal numbers from criminal justice and other sources

TREATMENT ADMISSION (AGES 12-17)
PRIMARY DIAGNOSIS



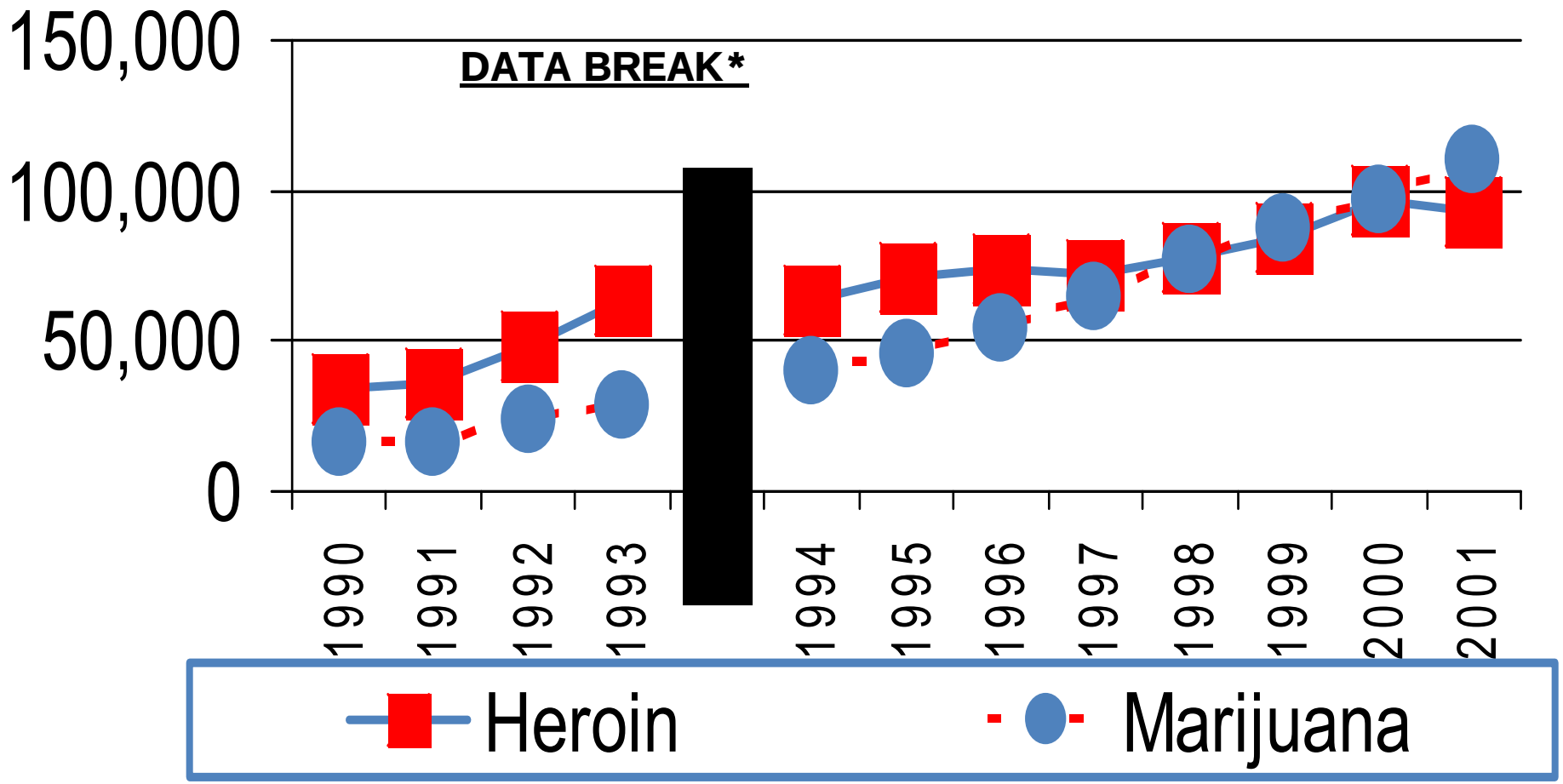
DEBUNKING THE MYTHS

- Marijuana is harmless
- Marijuana is not addictive
- Youth experimentation is inevitable
- The criminalization of marijuana use is more harmful that the drug itself



Sources: Drug Abuse Warning Network, SAMHSA, August 2003
Univ of Miss Marijuana Potency Report #82, Aug 2003

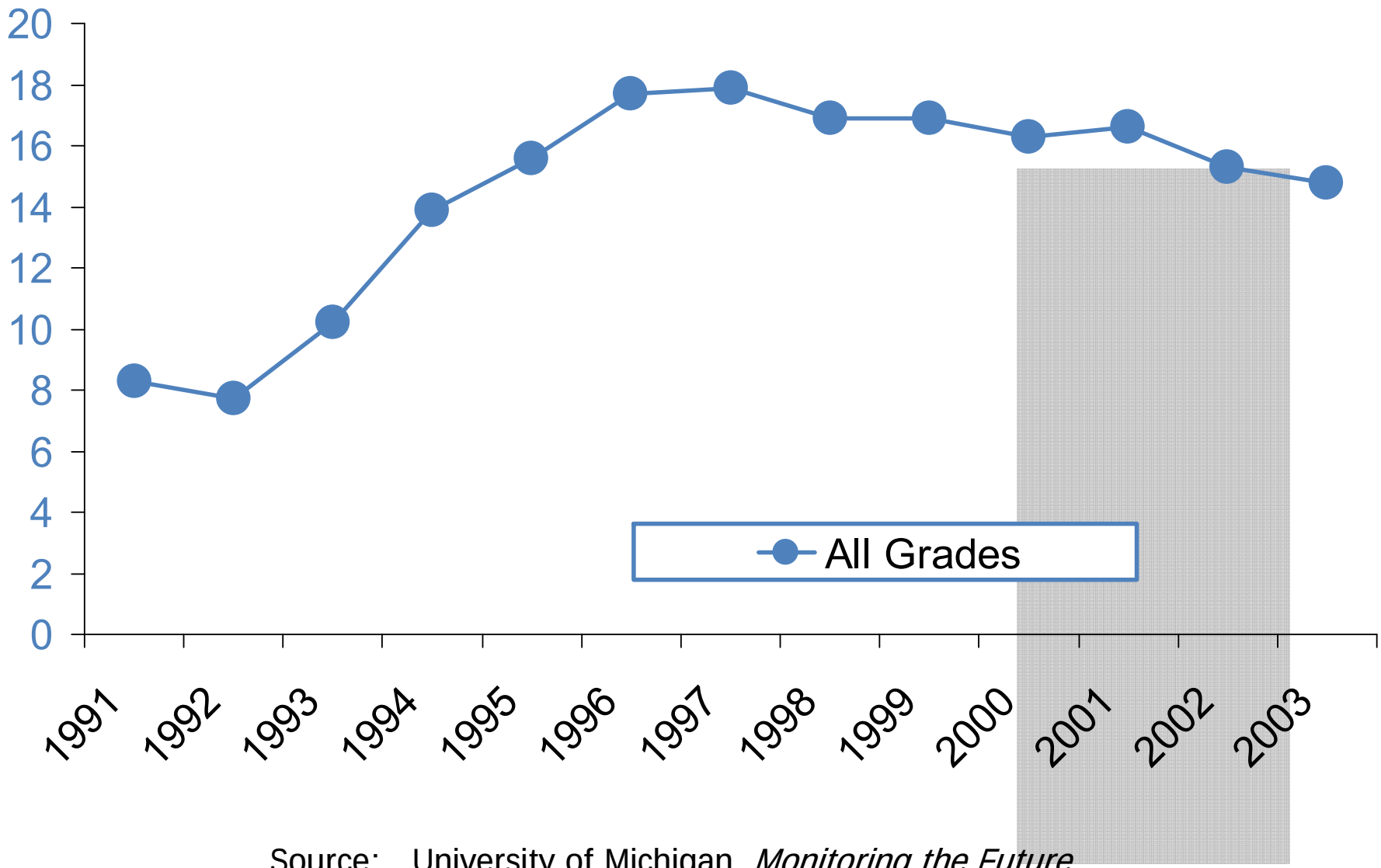
*NOTE: Data prior to 1994 may not be comparable to 1994 through 2001



Source: SAMHSA, Drug Abuse Warning Network

PREVENTION MESSAGES

- Drugs can hurt you
- Drugs cause addiction and death
- Drugs are not healthy
- Breaking the law is not responsible behavior



Source: University of Michigan, *Monitoring the Future Study*, 2003

TRENDS

- Recognition of addiction as a disease
  - Improved prevention
  - More treatment seeking
- Anti-smoking trend causes decreased use of drugs
- Abuse deterrent pharmaceutical products decrease intentional prescription abuse

TRENDS

- Treatment capacity expands as more people seek treatment, more coverage, thins services
- As treatment becomes more commonly accepted, used, and available market forces will spur new treatment approaches
- Treatment shifts occur
- Drug and DUI courts expansion lead to more publically funded treatment

TRENDS

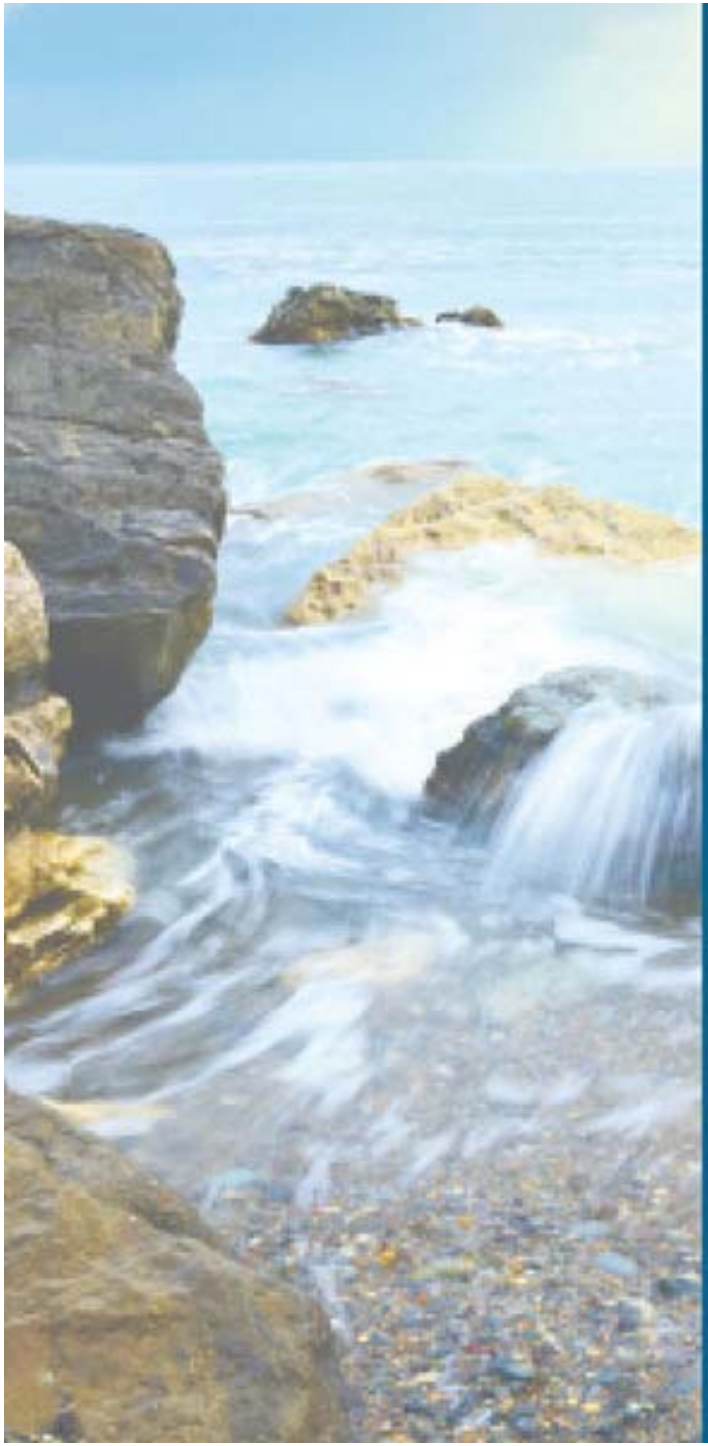
- Demand for social activities for abstinent and recovering population increases
- Natural/organic food and cosmetic trends increase use of marijuana, mushrooms, and other drugs occurring in nature

TRENDS

- Prevalence of obesity increases the misuse of substances
- Addictions to essential technologies present treatment and recovery challenges
- Legal challenges to denial bring about change in managed behavioral health care
  - Disease management is one strategy to contain costs

ELEMENTS OF RECOVERY ENHANCEMENT

- Abstinence
- Professional guidance
- Peer support
- Nutrition
- Exercise
- Medication
- Ritual



Who you are is not defined by your mistakes
but by your potential.
It is time to take stock and take care
in a place where your best interests are not only looked
after but discovered.

Simplify your life
so you can cope with complexity.
Accept your past
so you can create your future.

Experience serenity
in the absence of suffering.
Face weakness with strength
and fear with courage.

Where your best self takes form
and your best efforts take shape.

Professionals guide you to find the value in your values.
Peers support you with understanding and trust.
Rituals that confine you are replaced by ones that
expand you
and healthy risk taking is encouraged.

This is Two Dreams
Making the Deliberate Choice to Love, to Work, to Play

RESOURCES

- ASAM website for PPC (http://www.asam.org/publications/patient-placement-criteria/ppc-2r)
- Two Dreams (http://www.twodreams.com)
- Dr. AGB (https://twitter.com/dragb)
- Dr. AGB Goes to Back Rehab (http://drbarthwell.wordpress.com/)

THANK YOU

Questions?