Opiates: Not Just for Breakfast Anymore

Financial Disclosure Statement
I have no conflicting financial interests.

Overview of Presentation
- Scope of the problem
- Common prescription opioid drugs of abuse in adults and adolescents
- Diagnosis
- Treatment
- Medication-assisted treatment
Nonmedical use of psychotherapeutics increased by 157% between 1998 and 2008.
In the same 10-year period, first-time abuse of opioids increased by 41%.
By 2010, prescription opioids were the second most common drug of abuse in patients 12 and older in the U.S. (2 million), trumped only slightly by new users of marijuana (2.4 million).
By 2010, 5.1 million Americans reported nonmedical use of opioids in the past month.

Medical use of opioids have also increased dramatically with oxycodone prescriptions increasing by 866% from 1997-2007.
Hydrocodone has become the most frequently prescribed drug in America, with the U.S. consuming 80% of the world’s supply yet being only 4.6% of the total world population.
Since 2002, the number of patients addicted to opioids has risen from 936,000 to 1.9 million, with 586,000 using heroin.
Opioid overdose deaths rose to 18,893 in 2014, with heroin overdose deaths at 10,574.
Opioid abusers have health care costs averaging $15,884 annually, as compared to those not abusing opioids, $1,830.

The source of nonmedically used prescription opioids is predominantly family and/or friends (71.2%).

Adolescent opioid abuse has become epidemic.

Neonatal abstinence syndrome related to maternal use/abuse of opioids has skyrocketed.

Women are more likely to have chronic pain, be prescribed pain relievers, be given higher doses for longer periods than men, and be more likely to become dependent.

48,000 women died of prescription opioid overdoses between 1999 and 2010.

Opioid overdose deaths in women increased more than 400% from 1999, compared to 237% in men.

Heroin overdose death among women tripled from 2010 to 2013.

When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis
- Check that non-opioid therapies tried and optimized
- Discuss benefits and risks (e.g., addiction, overdose) with patient
- Evaluate risk of harm or misuse.
- Discuss risk factors with patient.
- Check prescription drug monitoring program (PDMP)
- Check urine drug screen
Set criteria for stopping or continuing opioids.
Assess baseline pain and function (eg, PEG scale).
Schedule initial reassessment within 1–4 weeks.
Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit, check that return visit is scheduled ≤ 3 months from last visit.

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
Assess pain and function (eg, PEG); compare results to baseline.
Evaluate risk of harm or misuse:
Observe patient for signs of over-sedation or overdose risk.
= If yes: Taper dose.
Check PDMP.
Check for opioid use disorder if indicated (eg, difficulty controlling use).
– If yes: Refer for treatment.
Check that non-opioid therapies optimized.
Determine whether to continue, adjust, taper or stop opioids.
Calculate opioid dosage morphine milligram equivalent (MME).

If ≥ 50 MME /day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone
Avoid ≥ 90 MME /day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
Schedule reassessment at regular intervals (≤ 3 months).
Drug Deaths Exceed Traffic Deaths

By KATIE MOISSE (@katiemoisse)
Sept. 20, 2011
Drugs now kill more people than motor vehicle accidents in the U.S. – a monumental shift that reflects gains in road safety amid a troubling rise in prescription drug abuse.

Motor vehicle traffic, poisoning, and drug poisoning death rates of all intents, U.S., 1980-2009

Poisoning Deaths Involving Opioid Analgesics and Other Drugs
In 2014, 467,000 adolescents were current nonmedical users of opioids with 168,000 having an addiction. In 2014, an estimated 28,000 adolescents had used heroin in the past year, and an estimated 16,000 were current users.

An estimated 18,000 adolescents had a heroin use disorder in 2014.

The rate of prescribing opioids to adolescents and young adults nearly doubled from 1994 to 2007. Marijuana remains the most commonly used illicit drug.
Epidemiology

- Previous use of alcohol, cigarettes, and marijuana and subsequent abuse of prescription opioids in young adults.
  - PMID: 23332479 [PubMed-indexed for MEDLINE]

- Previous alcohol, cigarette, and marijuana use were each associated with current abuse of prescription opioids in 18-25-year-old men, but only marijuana use was associated with subsequent abuse of prescription opioids in young women. Prevention efforts targeting early substance abuse may help to curb the abuse of prescription opioids.

Epidemiology

  - Proenkephalin mediates the enduring effects of adolescent cannabis exposure associated with adult opioid vulnerability.
  - These data establish a direct association between THC-induced NAc Penk upregulation and heroin SA and indicate that epigenetic dysregulation of Penk underlies the long-term effects of THC.
  - Tomasiewicz HC, Jacoby MM, Wilkinson MB, Wilson SP, Nestler EJ, Hurd YL.
  - Fishburg Department of Neuroscience, Mount Sinai School of Medicine, New York, New York, USA.

Epidemiology

- Young adults aged 18–25 had the highest overall rates of abuse.
- Adolescents aged 12–17 showed a steady decline in past-month drug use (10.6%).
- Native American adolescents had the highest rates of abuse (26%), compared with multiracial (12%), white (11%), Latina (10%), African-American (9%), and Asian (6%).
Decline was largely attributable to substantial drop (from 9.1% to 8.1%) in use of marijuana in past month by boys. Abuse of methamphetamine, cocaine, and cigarettes also declined. Adolescents with parents who strongly disapproved of drug use were much less likely to abuse substances.

Overall use of tobacco decreased; however pregnant teens smoked at the same rate as those who weren’t.
Alcohol remains the most frequent drug of abuse, with marijuana a close second. The adolescent brain is permanently impaired by substance abuse. Prevention is essential. Intervention must be done as soon as substance abuse is suspected.

Categories of Opiates and Opioids
Chemicals directly obtained from the poppy plant
Include: opium, morphine, codeine, and thebaine

All synthetic and semi-synthetic derivatives of opiates
Include: heroin, hydrocodone, oxycodone, hydromorphone, oxymorphone, fentanyl, meperidine, tramadol, buprenorphine, methadone, kratom, and carfentanil.

Generic name is diacetyl morphine
Original manufactured by Bayer Pharmaceuticals
Metabolized to 6-monoacetylmorphine, which is then metabolized to morphine
Opioids - Hydrocodone
- Lortab, Lorcet, Vicodin
- Metabolized to hydromorphone (Dilaudid)

Opioids - Oxycodone
- Percodan, Percocet, Tylox, Oxycontin, Roxycodeone
- Metabolized to oxymorphone (Opana)

Opioids - Fentanyl
- Used intravenously in O.R.s as preoperative anesthetic
- Available in sucker form (Actiq) and long-acting transdermal patch for chronic pain (Duragesic)
Opioids - Meperidine
- Demerol
- Metabolized to normeperidine, which can accumulate and cause seizures
- Not widely used in many facilities anymore

Opioids - Tramadol
- Ultram, Ultracet
- Primarily a kappa agonist, causing dysphoria, but at higher doses, has mu agonist effect
- High doses cause seizures.

Opioids - Buprenorphine
- Buprenex, Subutex, Suboxone
- Long-acting opioid which can be given parenterally or sublingually
- Combined with naloxone (Suboxone) to discourage IV use
Another great invention of Bayer Pharmaceuticals!
Extremely long-acting, potentially lethal
Used in opioid maintenance programs and pain management clinics

Opioids - Methadone

Kratom

Opioid-like plant primarily indigenous to Thailand and other parts of Southeast Asia
Attaches to mu and kappa opioid receptors
Withdrawal resembles that of other opioids
Available over-the-counter in convenience stores, although illegal in some states
Powder and capsules available on-line

Carfentanil

A 10-mg dose is powerful enough to sedate, even kill, a 15,000-pound elephant.
If diluted sufficiently, a dose of the same size – just a fraction of the weight of a paperclip – could send 500 humans to the morgue.
10,000 times more potent than morphine
Heroin cut with carfentanil offers a harder-hitting, longer-lasting high.
Odorless and colorless
A dose the size of a grain of salt could be fatal, and it can even be lethal when absorbed through the skin.
The Reward Pathway and Addiction
Addiction

A state in which an organism engages in a compulsive behavior

- behavior is reinforcing (rewarding or pleasurable)
- loss of control in limiting intake

The Action of Heroin (Morphine)
Tolerance
A state in which an organism no longer responds to a drug
- a higher dose is required to achieve the same effect

Dependence
A state in which an organism functions normally only in the presence of a drug
- manifested as a physical disturbance when the drug is removed (withdrawal)
Substance Use Disorders (DSM-V Criteria)

1. Substance often taken in larger amounts or over a longer period of time than intended (impaired control)
2. A persistent desire or unsuccessful efforts to cut down or control use (impaired control)
3. A great deal of time spent in activities necessary to obtain the substance, use it, or recover from its effects (impaired control)
4. Craving, or strong desire or urge to use (impaired control) (New criteria)

Substance Use Disorders: Diagnostic Criteria

5. Recurrent use resulting in failure to fulfill major role obligations at work, school, or home (social impairment)
6. Continued use despite having persistent or recurrent social/interpersonal problems caused or exacerbated by use (social impairment)
7. Important social, occupational, or recreational activities given up or reduced because of use (social impairment)
Substance Use Disorders: Diagnostic Criteria

8. Recurrent use in situations which are physically hazardous (risky use)

9. Use is continued despite knowledge of having a persistent or recurrent physical/psychological problem likely to have been caused or exacerbated by use (risky use)

Substance Use Disorders: Diagnostic Criteria

10. Tolerance: the need for markedly increased amounts of substance to achieve intoxication or desired effect, or a markedly diminished effect with continued use of same amount (pharmacological)

11. Withdrawal: a characteristic syndrome, or use to relieve or avoid withdrawal (pharmacological)

Recording Procedures for Substance Related Disorders

* New recording procedures to occur by 10/14
* Use the code for the class of substances, but record the specific substance
* Severity determined by # of symptom criteria
  * Mild (2-3); Moderate (4-5); Severe (6 or more)
* Severity can change over the course of time by reductions or increases
* Record for each individual substance disorder
Substance Dependence (ASAM Criteria)
- Control
- Compulsion
- Consequences

ADOLESCENT-SPECIFIC DIAGNOSTIC CRITERIA

Risk Factors for Adolescent Substance Abuse
- Family History of alcoholism or drug abuse
- Poor academic performance
- Low self-esteem
- Depression
- History of behavioral problems
- Tobacco use
- Sexual behaviors that contribute to unintended pregnancy and STDs
- Unhealthy dietary behaviors
- Physical inactivity
Symptoms of Adolescent Substance Abuse
- Change in behavior
- Dropping grades
- Truancy
- Change in peer group, especially associating with an older peer group
- Isolation
- Depression

Increased Risk for Alcohol Use
- Poor/inadequate parent/child communication; family history of substance abuse, positive attitudes toward alcohol, prenatal alcohol exposure
- Psychiatric diagnoses: anxiety, depression, conduct disorders, history of physical/emotional/sexual abuse
- Academic problems and school failure
- Possibly, early puberty

Assessing Risk and Screening
- HEADSSS: Series of increasingly personal questions to identify strengths and risk areas
- CRAFFT: Substance Abuse Screening Test
- NIAAA: Alcohol Screening and Brief Intervention for Youth: A Practitioner’s Guide: Two Question Screen
H.E.A.D.S.S.S.

- Home
- Education
- Activities and Employment
- Drugs (and alcohol)
- Suicidality
- Sexuality
- Safety and Eating

Where do you live? How long have you lived there? Who lives at home with you? Do you have any pets? Do you feel safe at home? Do you feel safe in your neighborhood? Are there any guns or weapons at home? How are they stored? Do you have access to them?

Home

Where do you go to school? Have you changed schools recently? What grade are you in? What do you like or not like about school? What is your favorite or least favorite class? Do you feel safe at school? What are your grades like? What were your grades like last year? Do you have an IEP (individual education plan) in place? What do you want to do after finishing school?
Activities/Employment

- What do you do for fun? What do you and your friends do together? Do you have a best friend?
- Are you in any clubs or teams? Do you have a job? What is your workplace environment like?
- Do you drive?

Drugs

- Do any of your friends smoke or drink? Do you know anyone who smokes or drinks? Have you ever smoked or drank?
- Have you ever used other drugs (pills without a prescription, cocaine, methamphetamine, ecstasy, heroin)?
- Have you ever used needles? How often do you drink or use drugs? Have you ever had a blackout? Have you ever done anything you later regretted when drinking?

Suicidality

- Have you ever been so sad you thought about hurting yourself? Have you ever tried? Do you feel sad now?
- Have you ever run away from home? Have you ever cut yourself intentionally?
Sexuality

Have you ever dated anyone? Boy, girls, or both?

How old is he or she? Do you like your boyfriend or girlfriend? Do you feel safe with him or her? Does your boyfriend or girlfriend ever get jealous? Has he or she ever hit you or pushed you?

“Yes” to dating

- Have you ever kissed anyone? Have your ever had sex? Oral sex? Anal sex? How many sexual partners have you had? How old were you when you first had sex?
- Has anyone ever touched you in a way you didn’t want to be touched or forced you to do something you did not want to do sexually?

“Yes” to sexual encounters

- When did you last have sexual intercourse? Did you use a condom with your last sexual encounter? Have you ever had a sexually transmitted infection? Have you ever been tested for HIV? Have you ever been pregnant? Have you ever traded money or drugs for sex?
Eating Habits

- Do you exercise? Do you feel comfortable with your body and weight? Do you feel comfortable with your eating habits? Do you ever think about ways to lose weight? Do you ever eat in secret? Do you have a goal weight? What has been your highest weight? Your lowest weight? Have you ever thrown up to lose weight? Do you use diet pills or laxatives?

CRAFFT

- If time is short, consider implementing the CRAFFT for every teen.

- Two or more “yes” answers indicate a positive screen.
- Validated among adolescents, inner city and suburban sites, Boston Children's Hospital
- Car, Relax, Alone, Forget, Friends, Trouble
Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?

Do you use alcohol or drugs to relax, feel better about yourself, or fit in?

Do you ever use alcohol or drugs while you are by yourself, alone?
Do you ever forget things you did while using alcohol or drugs?

Do your family or friends ever tell you that you should cut down on your alcohol or drug use?

Have you ever gotten into trouble while you were using alcohol or drugs?

Alcohol screening and brief intervention for Youth: a practitioner’s guide

National Institute of Alcohol Abuse and Alcoholism
Ask two age-specific screening questions. Guide patient who does not drink or assess risk for patients who do drink. Advise and assist. Follow up and continue support.

**Four Steps**

**Step One: Two Questions**

Ask first for 9-14 yo:
- Friends: Any drinking?
  - Do you have any friends who drink beer, wine, or any drink containing alcohol in the past year?

Ask first for 14-18 yo:
- How many days in the past year, or how many days have you had more than a few sips of beer, wine, or any drink containing alcohol?

**Step Two: Guide Patient**

- If friends do not drink or friends drink but patient does not:
  - Reinforce health choices and elicit and affirm reasons to stay alcohol-free.
  - Educate: Alcohol harms brain; early drinking can lead to serious problems as an adult.
  - Explore how to say no; do not ride with a driver who has been using alcohol or drugs.
Step Two: Assess Risk

- Highest risk (past year drinking days)
  Age 11: 1 day
  Ages 12-15: 6 days (about every other month)
  Age 16: 12 days
  Age 17: 24 days (twice a month)
  Age 18: 52 days (weekly)

- Moderate Risk (past year)
  Age 12-15: 1 day
  Ages 16-17: 6 days
  Age 18: 12 days

At Risk? Ask more questions...

- How much do you usually have? What is the most you have ever had?
- Ask about problems or risks taken: school problems, fighting, sexual experimentation, blackouts, property damage
- Ask about other substance use including non-medical use of prescription drugs.
Other Factors

- Co-occurring Disorders
  Depression, anxiety, ADD/ADHD, conduct problems
- Alcohol-related problems: Accidents, injuries, STDs, pregnancy, chronic pain, change in sleep or appetite
- Behavioral changes
- Family problems

Step Three Advise and Assist

- Lower Risk: Brief advice, reinforce choices, explore and troubleshoot
- Moderate Risk: Check for alcohol-related problems, ask if parents know, arrange for follow-up
- High Risk: Motivational interviewing, ask if parents know, consider referral, arrange follow-up

Step Four Follow Up

- Many teens will not keep an appointment unless there is a “hook”.
- Ask about current alcohol use, any associated problems.
- If patient set goals, ask if they were successful. Avoid drinking friends, try abstinence, cut back, bring problems to you.
- Reassess level of risk.
Get an assessment from an interventionist trained in detection of adolescent substance abuse.

Treatment Modalities

Medical Detoxification
Clinical Opiate Withdrawal Scale

- Subjective scoring tool for assessing severity of opioid withdrawal
- Assesses major symptoms of opiate withdrawal and severity and assigns a number
- Total score indicates severity of withdrawal.

<table>
<thead>
<tr>
<th>Times</th>
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Clinical Opiate Withdrawal Scale (COWS)
Flow-sheet for measuring symptoms over a period of time during buprenorphine induction. For each item, write in the number that best describes the patient's signs or symptom.

Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate should not add to the score.

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
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<tbody>
<tr>
<td>Resting Pulse Rate</td>
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<tr>
<td>Measured after patient is sitting or lying for one minute</td>
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<tr>
<td>0 pulse rate 80 or below</td>
<td></td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td></td>
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<tr>
<td>2 pulse rate 101-120</td>
<td></td>
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<tr>
<td>4 pulse rate greater than 120</td>
<td></td>
</tr>
<tr>
<td>Sweating</td>
<td></td>
</tr>
<tr>
<td>over past ½ hour not accounted for by room temperature or patient activity</td>
<td></td>
</tr>
<tr>
<td>0 no report of chills or flushing</td>
<td></td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
<td></td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td></td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td></td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td></td>
</tr>
<tr>
<td>Restlessness</td>
<td></td>
</tr>
<tr>
<td>Observation during assessment</td>
<td></td>
</tr>
<tr>
<td>0 able to sit still</td>
<td></td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
<td></td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
<td></td>
</tr>
<tr>
<td>5 Unable to sit still for more than a few seconds</td>
<td></td>
</tr>
<tr>
<td>Pupil size</td>
<td></td>
</tr>
<tr>
<td>0 pupils pinned or normal size for room light</td>
<td></td>
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<tr>
<td>1 pupils possibly larger than normal for room light</td>
<td></td>
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<tr>
<td>2 pupils moderately dilated</td>
<td></td>
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<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
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<tr>
<td>Bone or Joint aches</td>
<td></td>
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<tr>
<td>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</td>
<td></td>
</tr>
<tr>
<td>0 not present</td>
<td></td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
<td></td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
<td></td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
<td></td>
</tr>
<tr>
<td>Runny nose or tearing</td>
<td></td>
</tr>
<tr>
<td>Not accounted for by cold symptoms or allergies</td>
<td></td>
</tr>
<tr>
<td>0 not present</td>
<td></td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td></td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td></td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td></td>
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<tr>
<td>GI Upset</td>
<td></td>
</tr>
<tr>
<td>over last ½ hour</td>
<td></td>
</tr>
<tr>
<td>0 no GI symptoms</td>
<td></td>
</tr>
<tr>
<td>1 stomach cramps</td>
<td></td>
</tr>
<tr>
<td>2 nausea or loose stool</td>
<td></td>
</tr>
<tr>
<td>3 vomiting or diarrhea</td>
<td></td>
</tr>
<tr>
<td>5 Multiple episodes of diarrhea or vomiting</td>
<td></td>
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<tr>
<td>Tremor</td>
<td></td>
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<tr>
<td>Observation of outstretched hands</td>
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<tr>
<td>0 No tremor</td>
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<tr>
<td>1 tremor can be felt, but not observed</td>
<td></td>
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<tr>
<td>2 slight tremor observable</td>
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<tr>
<td>4 gross tremor or muscle twitching</td>
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<tr>
<td>Yawning</td>
<td></td>
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<tr>
<td>Observation during assessment</td>
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<tr>
<td>0 no yawning</td>
<td></td>
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<tr>
<td>1 yawning once or twice during assessment</td>
<td></td>
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<tr>
<td>2 yawning three or more times during assessment</td>
<td></td>
</tr>
<tr>
<td>4 yawning several times/minute</td>
<td></td>
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<tr>
<td>Anxiety or Irritability</td>
<td></td>
</tr>
<tr>
<td>0 none</td>
<td></td>
</tr>
<tr>
<td>1 patient reports increasing irritability or anxiousness</td>
<td></td>
</tr>
<tr>
<td>2 patient obviously irritable anxious</td>
<td></td>
</tr>
<tr>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
<td></td>
</tr>
<tr>
<td>Gooseflesh skin</td>
<td></td>
</tr>
<tr>
<td>0 skin is smooth</td>
<td></td>
</tr>
<tr>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
<td></td>
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<tr>
<td>5 prominent piloerection</td>
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</tbody>
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Total scores with observer's initials

Score:
- 5‐12 = mild;
- 13‐24 = moderate;
- 25‐36 = moderately severe;
- more than 36 = severe withdrawal.
Withdrawal usually not life-threatening, but patients “think” they are dying!

Buprenorphine and methadone are only “legal” opioids that may be used.

Start Buprenorphine at 2 mg/twice a day for 2 days, then 2 mg qd x 2 days, then stop. Don’t start until pt in full withdrawal!

OR

Phenobarbital 60 mg qid x 1 day, then 30 mg qid x 1 day, then 30 mg tid x 1 day, then 30 mg bid x 1 day, then 10 mg qd x 1 day, then stop.

Clonidine 0.2 mg qid x 5 days, then prn; Robaxin 750 mg 2 po qid x 5 days, then prn; Ibuprofen 600 bid x 5 days, then prn; plus prn meds for nausea, diarrhea, abdominal cramps, and sleep.

Methadone, buprenorphine, and propoxyphene have very long half-lives. Wait until Clinical Opiate Withdrawal Scale indicates need for detoxification before starting replacement opioids!
TREATMENT MODALITIES

Medical detoxification first, if applicable
Group therapy
Individual therapy
Experiential therapy
Twelve Step facilitation
Length of stay, regardless of level of care, correlates directly with rate of sobriety.
Monitoring and accountability enhance that rate.

CHEMICAL DEPENDENCY TREATMENT

10/6/2016
Evidence for 12-Step Facilitation

Dennis M. Donovan, Ph.D.
Alcohol & Drug Abuse Institute
and
Department of Psychiatry & Behavioral Sciences
University of Washington

NIDA Blending Conference, “Blending Addiction Science & Treatment: The Impact of Evidence-Based Practices on Individuals, Families, and Communities.”
Cincinnati, OH, June, 2008

Pacific Northwest
12-Step Salmon Recovery Program

What Is the Relationship Between 12-Step Attendance/Involvement and Outcomes?
Results from Previous Research on 12-Step Involvement

- AA and NA participation is associated with greater likelihood of abstinence, improved social functioning, and greater self-efficacy
- 12-Step self-help groups significantly reduce health care utilization and costs
- Combined 12-Step and formal treatment leads to better outcomes than found for either alone
- Engaging in other 12-Step group activities seems more helpful than attending meetings

Results from Previous Research on 12-Step Involvement

- Consistent and early attendance/involvement leads to better substance use outcomes
- Even small amounts of participation may be helpful in increasing abstinence, whereas higher doses may be needed to reduce relapse intensity
- Reductions in substance use associated with 12-Step involvement are not attributable to potential third variable influences such as motivation, psychopathology, or severity

Jones would walk through a blizzard to score his dope. The question remains: what will he do to get to a meeting?
Factors Contributing to Greater 12-Step Involvement

- Patients are less likely to become involved in 12-step activities if left to do so on their own than if more active encouragement and referral are provided in treatment.
- Treatment programs that are 12-Step based produce higher rates of Self-Help participation than programs that are not 12-Step based.
- Patients from 12-Step based treatment seem to gain more (have better outcomes) from self-help participation than patients from non-12-Step based treatment.
- Programs that are 12-Step oriented and have a higher percentage of staff in recovery are more likely to refer to 12-Step Self-Help groups.
- Professional facilitation strategies increase engagement in mutual help groups.

“In Stop fighting and surrender. Jones. As your sponsor, all I ask is that you attend 90 meetings in 90 days.”

Innovations in Treatment

The Latest in “Pharmaceutical Assistance”
Buprenorphine (Subutex, Suboxone)

- Partial opiate agonist indicated for opiate maintenance therapy and/or opiate detoxification.
- Can be given IM or SL. Do not give until patient is in full withdrawal!!!
- SL form available combined with naloxone, so can’t, theoretically, be abused IV (but is).
- Requires special DEA certificate.

Naltrexone (Revia, Vivitrol)

- Full opioid antagonist
- Oral route initially; now available in monthly (q28 days) intramuscular injections
- Blocks the effect of illicitly administered opioids.
- Has demonstrated efficacy in relapse to alcohol, especially when administered I.M.

Naloxone

- Opioid antagonist administered either intravenously or intranasally to reverse opioid overdose
- ASAM Public Policy Statement supports widespread availability, including lay persons (family and friends).
- Available in “autoinject” formulation
Methadone maintenance was never a medical solution to the disease of opioid dependence. It was created to remove heroin addicts from the streets to reduce crime and reduce the spread of communicable diseases. Crime rates and infectious diseases have not been reduced with methadone maintenance. Primary benefit is in compliant patient, overdose is unlikely from opioids.

Buprenorphine, a partial opioid agonist, is deemed safe to prescribe in an outpatient setting due to reduced likelihood of overdose, especially when combined with naloxone. Suboxone maintenance is based on the same philosophy as methadone. May be prescribed by an licensed MD or DO with a valid license who has taken an 8-hour course on its administration. Suboxone and Subutex are divertable and frequently are. Main benefit is reduced mortality in compliant patients.

Abstinence and Twelve Step Recovery result in improved biopsychosocial functioning. Debate is whether one on maintenance can benefit from Twelve Step participation. Bottom Line: How do we keep these patients alive?
We Like Minded Docs are a group of compassionate physicians who support efforts to improve the quality of care for persons with addiction. We seek to put more “heart and soul” back into all aspects of the practice of addiction medicine. As we strive to achieve that shared goal, we will continue to work with ASAM and other organizations toward a comprehensive, integrative approach to addiction treatment.

We acknowledge the complex neurobiological nature of addiction and endorse ASAM’s definition: “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuits. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursing reward and/or relief by substance use and other behaviors.”
We are diverse in our members’ methods of practice, with some utilizing medication‐managed treatments including opioid maintenance, and others not. We support the individual addiction doctor’s freedom to practice his or her own style of treatment and choice of treatment modalities utilized, as long as each patient’s plan of treatment is individualized and considers all aspects of that person’s illness, including resources available. However, we are all passionate in our belief that psychosocial and spiritual interventions are important for every patient, and that medication management alone is not adequate. Prescribing medication, without evaluating all dimensions of the patient’s disorder and prescribing appropriate psychosocial and spiritual interventions, falls short of best practices for an addiction specialist.

We believe that evidence from extensive, well‐designed studies demonstrates the great benefits of Twelve‐Step recovery modalities including Twelve Step Facilitation in promoting long‐term recovery. Further, Twelve‐Step modalities are compatible with other treatment strategies including medication management. We believe that Addiction specialists 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 or addiction psychiatry requires a comprehensive exposure to the psychosocial and spiritual modalities of treatment as well as the neurobiological and psychopharmacological modalities. Finally, we believe that there is also 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.

Questions?
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