JOIN THE VOICES FOR RECOVERY

invest in health, home, purpose, and community

National Recovery Month

Prevention Works · Treatment is Effective · People Recover

september 2018

TREAT ADDICTIONS 2018 SAVE LIVES

#TREAT – TREATMENT RX MEDICATIONS ENHANCE ADDICTION TRANSFORMATION

Stigma, Myths, Realities Limit Access to Care

MARGARET RUKSTALIS, MD

- **Director ACGME Addiction Medicine Fellowship @ Wake Forest School of Medicine**
- **No personal or family conflicts of interest or history of participation in industry trials**
- **Born, raised in Colorado (2012 legalized marijuana), 19+ members of my family graduates of University of Colorado Boulder**
- **Dartmouth Medical School 1987**
- **Clinician Investigator in phase 1-4 RCT Addictions, Obesity Treatment-Prevention Interventions**
- **Educator, PGY 31 with experience in over 25+ hospitals in CO, NH, VT, MA, CT, MA, IL, PA, NC**

3 LEARNING OBJECTIVES

Identify evidence based treatments for substance use disorders and difference between ideal and current <1 in 10 who receive treatment

Recognize how professional practice gaps (Stigma, MYTHS, Realities, Rural) limit access to ideal plus medications to assist treatments (MAT)

Describe best practices to prevent, assess and #TREAT addictions and SAVE LIVES!

3 LEARNING OBJECTIVES

Identify evidence based treatments for substance use disorders and difference between ideal (any) vs current <1 :10 who receive treatment

ADDICTION PREVENTION & TREATMENT SAVES LIVES

Based on FDA effectiveness standards, at present we have

1. **Four prevention interventions**
2. **NRT + Eight relapse prevention medications**
3. **Over a dozen effective behavioral therapies**

Prevent

Intervene Early

Manage Substance Use Disorders

DSM 5 SUBSTANCE USE DISORDER CRITERIA

DSM-5 CRITERIA FOR SUBSTANCE USE DISORDERS

FIGURE 1. DSM-IV and DSM-5 Criteria for Substance Use Disorders

	DSM-IV Abuse[a]		DSM-IV Dependence[b]		DSM-5 Substance Use Disorders[c]	
Hazardous use	X	≥1 criterion	–		X	≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal[d]	–		X	≥3 criteria	X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

[a] One or more abuse criteria within a 12-month period *and* no dependence diagnosis; applicable to all substances except nicotine, for which DSM-IV abuse criteria were not given.
[b] Three or more dependence criteria within a 12-month period.
[c] Two or more substance use disorder criteria within a 12-month period.
[d] Withdrawal not included for cannabis, inhalant, and hallucinogen disorders in DSM-IV. Cannabis withdrawal added in DSM-5.

(Am J Psychiatry 2013; 170:834–851)

ASAM CRITERIA: TREATMENT LEVELS

6 DIMENSIONS

4 LEVELS OF CARE

Level I – Outpatient-weekly

Level II – Intensive (3d/week) Outpatient/Partial Hospitalization

Level III – Residential

Level IV - Inpatient Unit

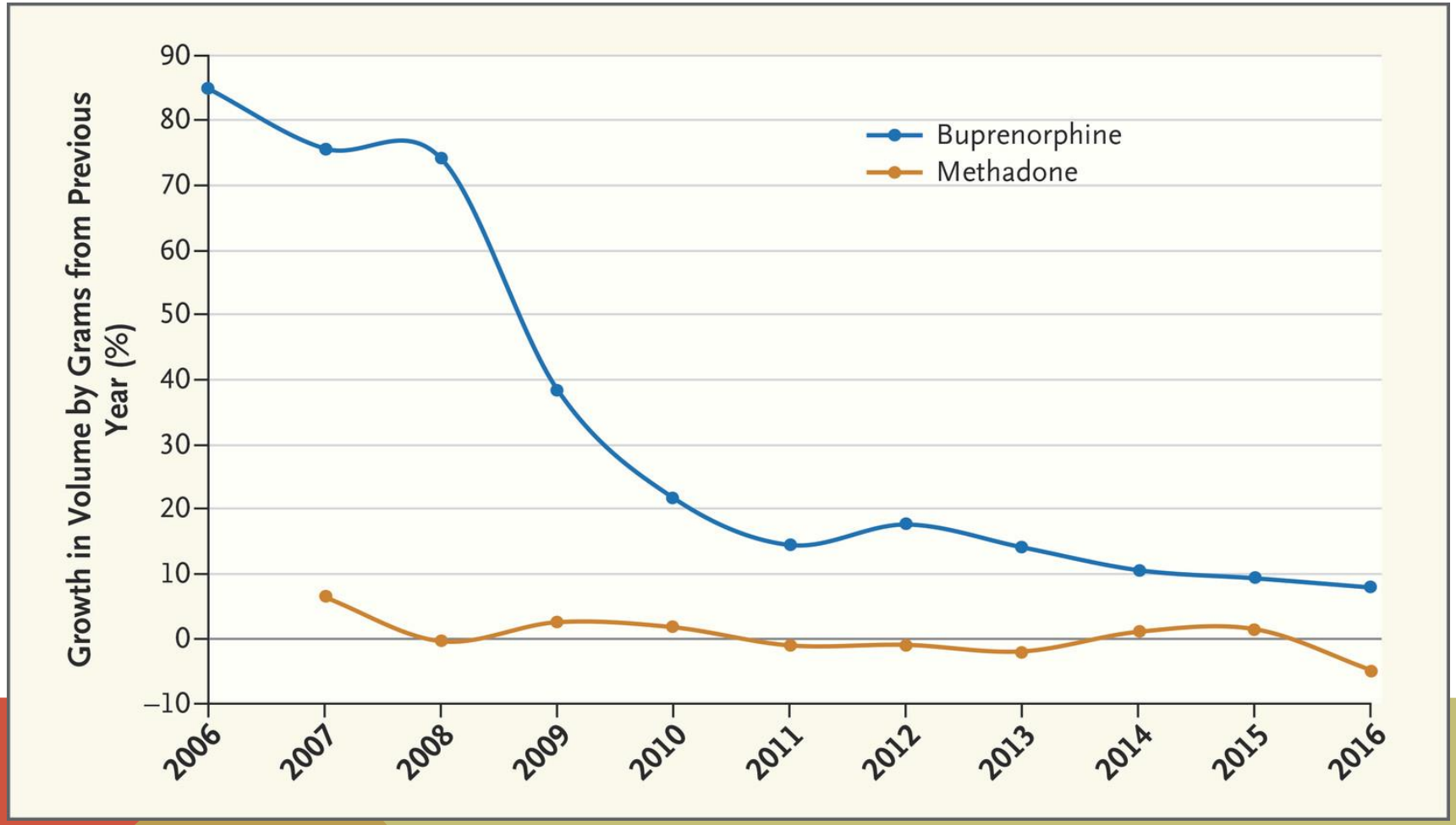
SUD RELAPSE PREVENTION MEDICATION OUTCOMES BETTER/= OTHER CHRONIC DISEASES

- **Abstinence from sugar doesn't cure diabetes**
- **30 days of insulin doesn't cure diabetes**
- **Low/no salt diets don't cure high blood pressure**
- **Blood pressure medications work only if taken**

FDA medications approved for substance use disorders:

- **Can triple quit rates, reduce relapse to heavy drinking**
- **Reduce HIV, Hep C, lower crime**
- **<30% of addiction treatment programs offer medications**
- **<50% eligible patients receive medications**

Decline of Medications Dispensed for Opioid Use Disorder



SE WAKEMAN, ML BARNETT. N ENGL J MED 2018;379:1-4

The NEW ENGLAND JOURNAL of MEDICINE

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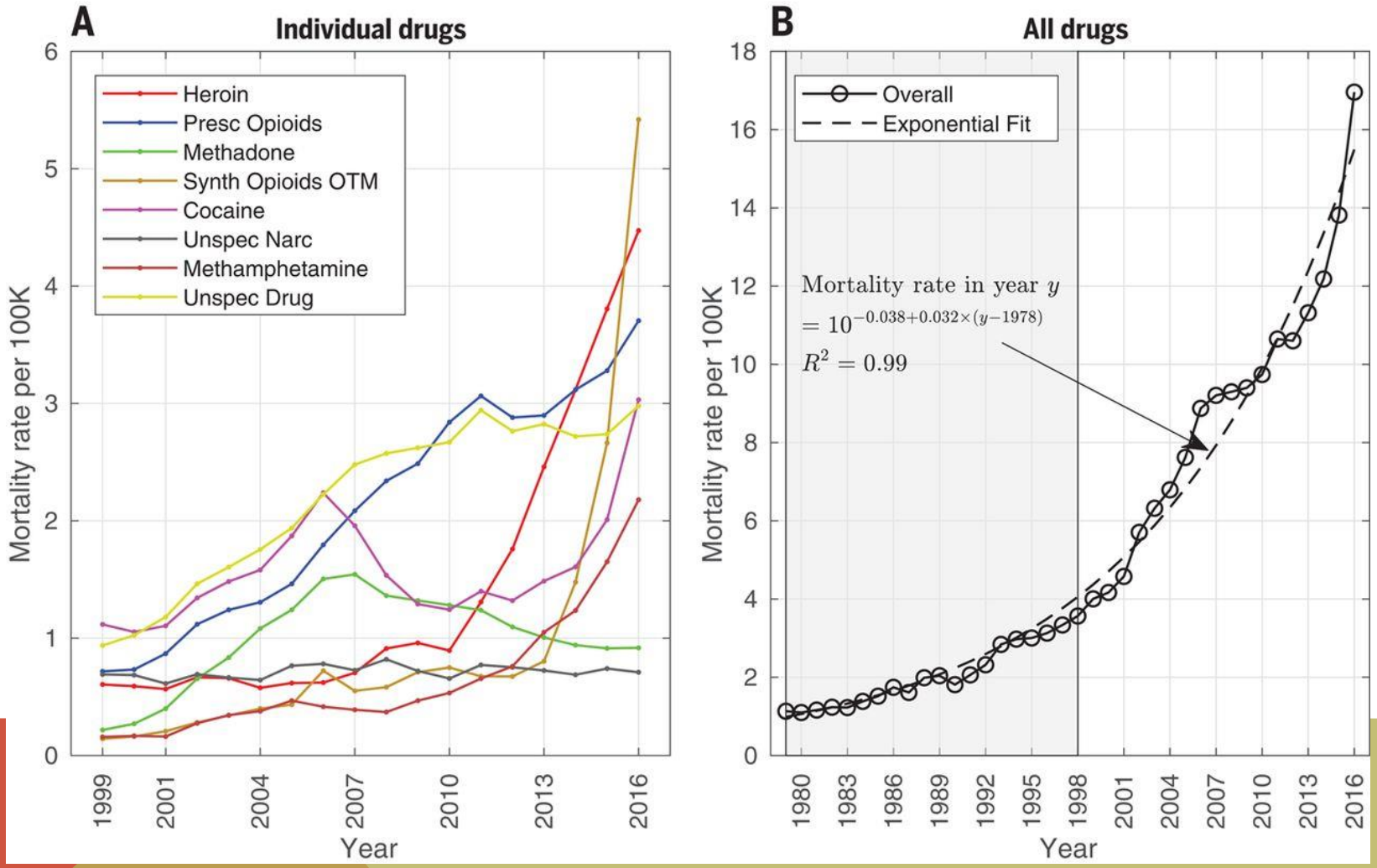
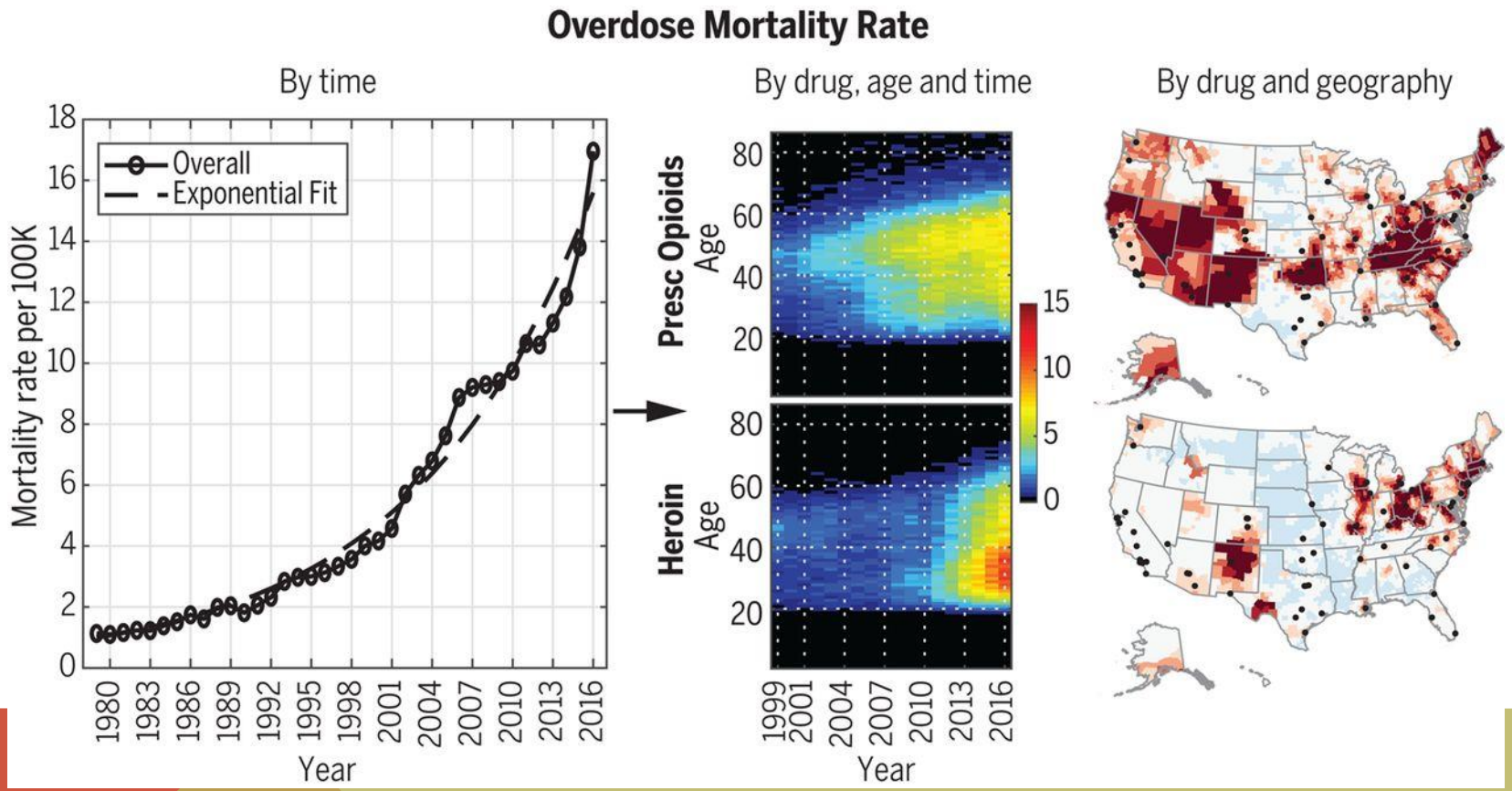
Recognize how professional practice gaps (Stigma, MYTHS, Rural) limit access to medications to assist treatments (MAT)

Fig. 1 Mortality rates from unintentional drug overdoses.



Hawre Jalal et al. Science 2018;361:eaau1184

Exponential growth in overdose deaths.



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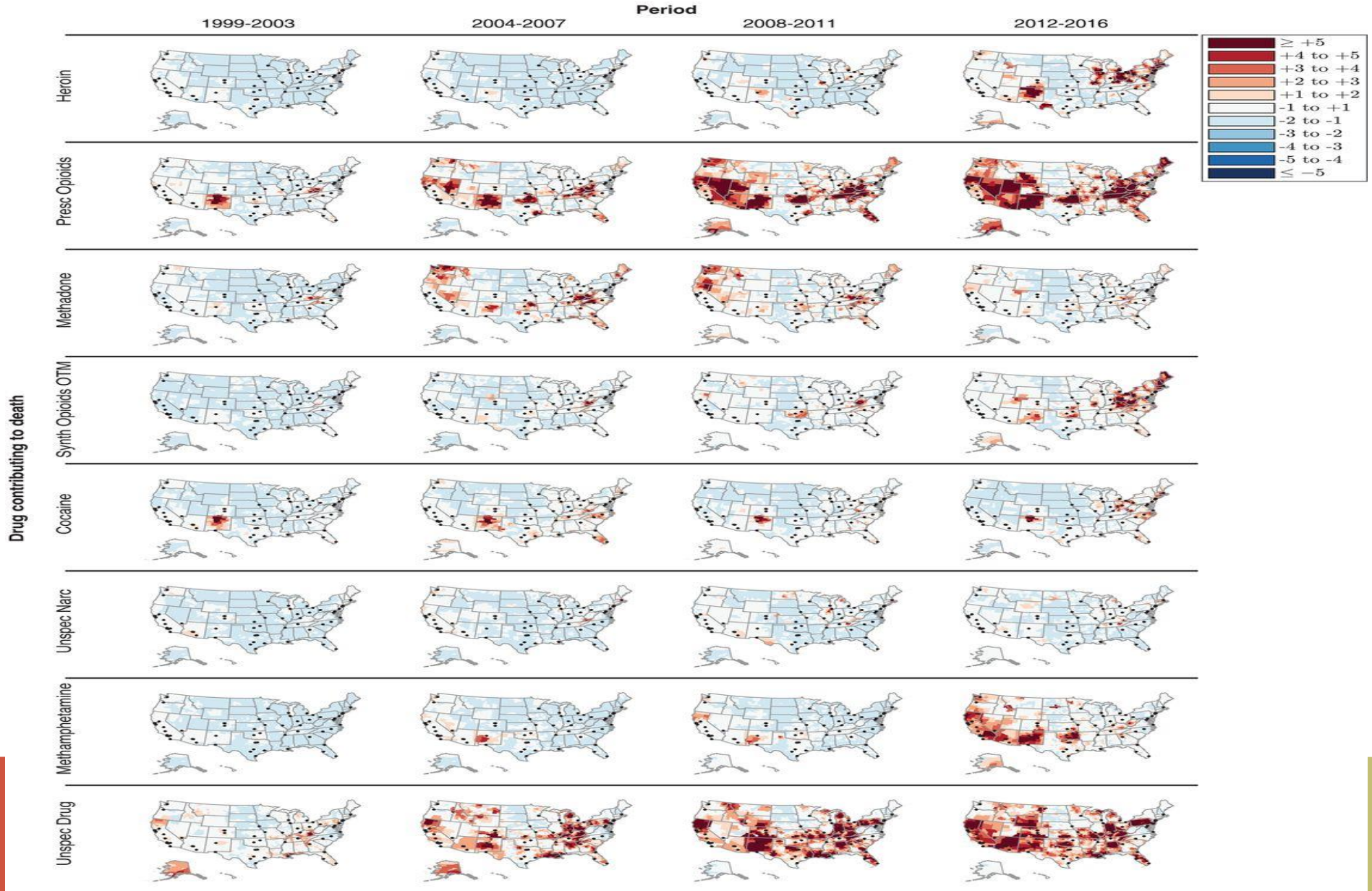
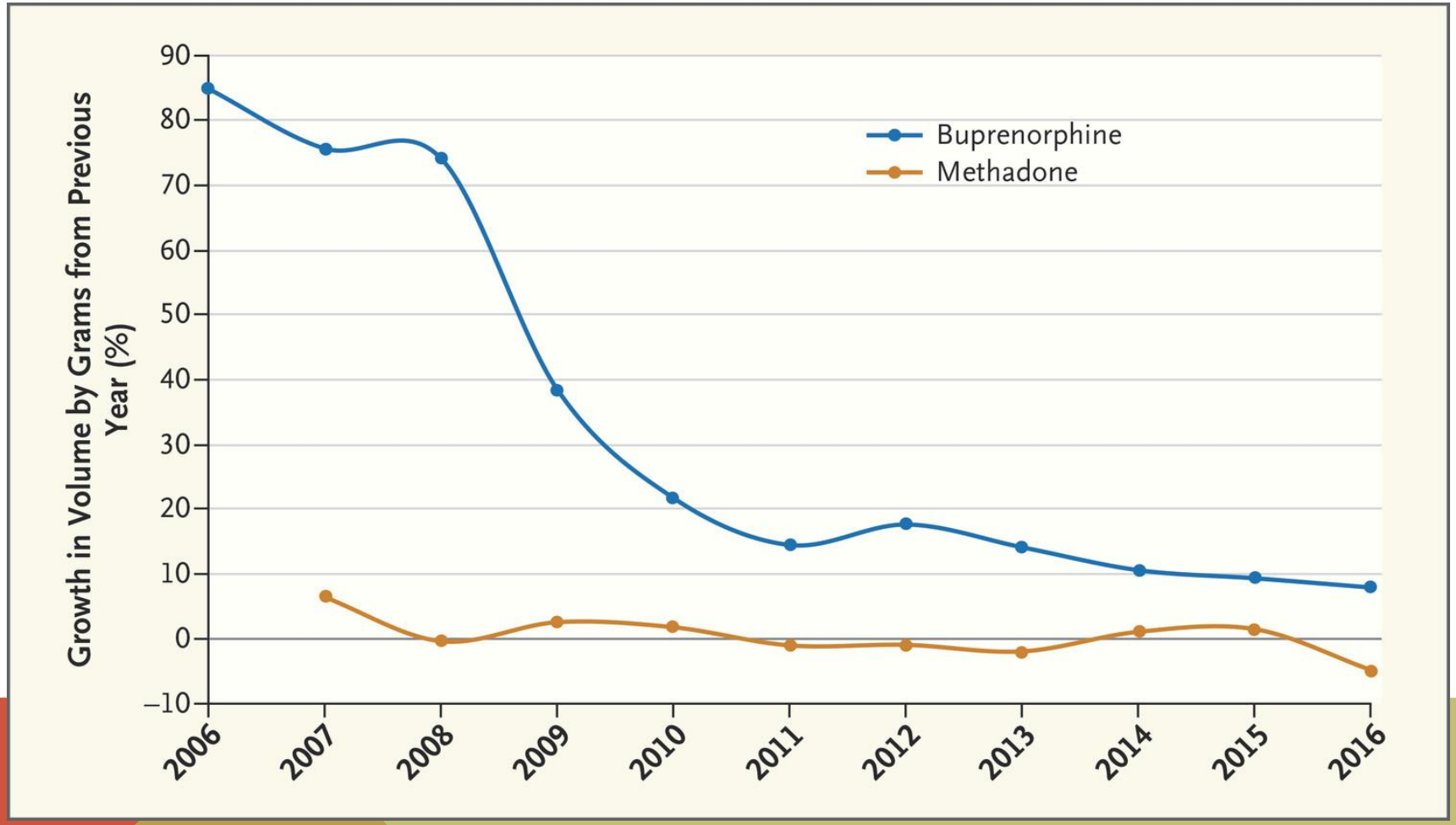


Hawre Jalal et al. Science 2018;361:eaau1184

Fig. 3 Geospatial hotspot analysis by drug and period.

Science
AAAS
Published by AAAS

Decline of Medications Dispensed for Opioid Use Disorder



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YOU ARE INVITED # TREAT

- WHAT: #TREAT ADDICTIONS
- WHY: SAVE LIVES
- WHO: YOU…IF NOT YOU…WHO
- WHEN: NOW…IF NOT NOW…WHEN
- HOW: www.pcss.org

#JUSTICE COMMUNITY
Reduce Stigma, Myths
Improve Access to Care

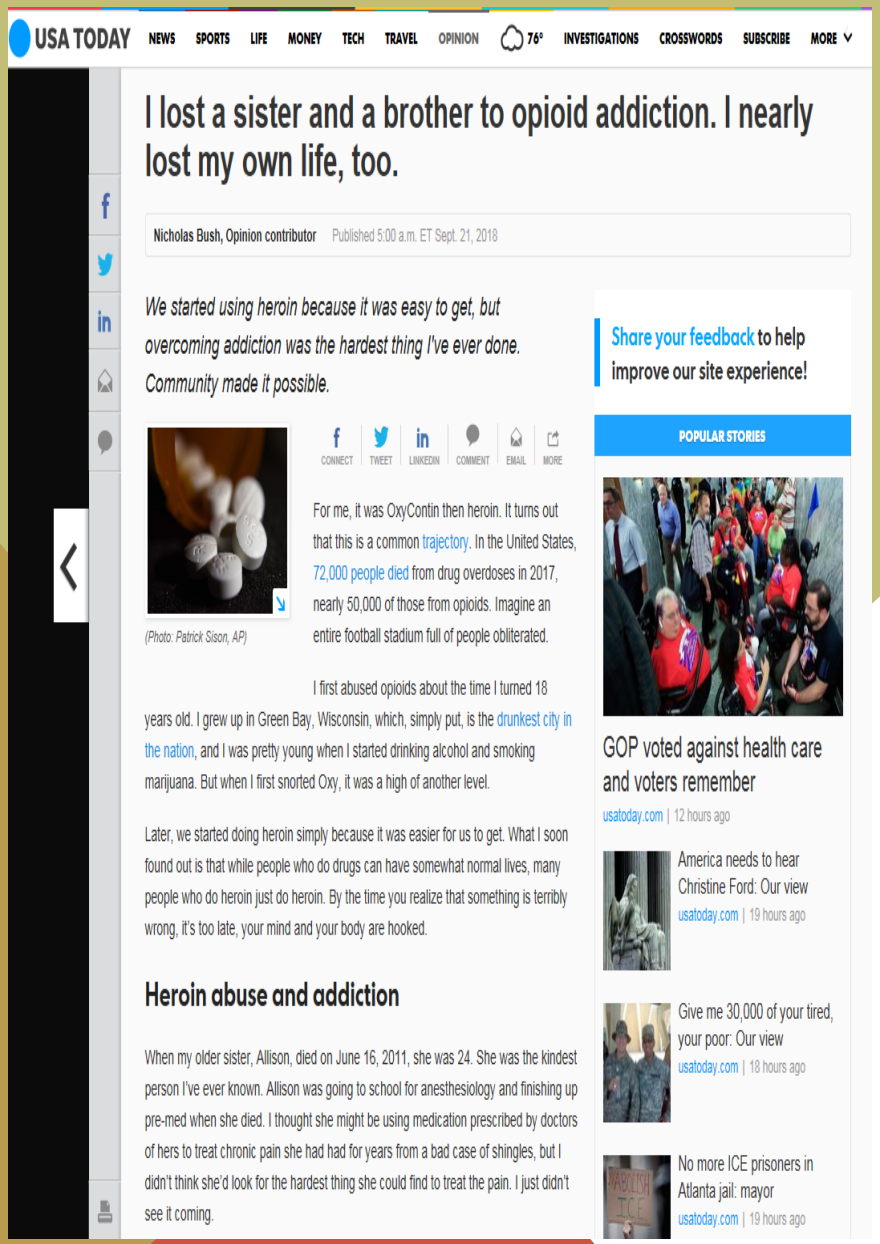
MISSION POSSIBLE: #TREAT ADDICTIONS SAVE LIVES
CHOOSE TO ACCEPT MISSION: #JUSTICE COMMUNITY

"When I visit my family, we hug and cry tears of joy because of what recovery has done for us. They are so proud. My heart is filled with hope today. The world is a beautiful place again. We do recover."

- Kristoph

#JUSTICE

JOY & Hope Come When You Understand
Substance Use Disorder
Treatment TEAMS Save Lives & Improve
Clinical Health
Experiences Build Recovery & Resilience



”Overcoming addiction was the hardest thing I’ve ever done.

Community made it possible.”

This Tuesday, Aug. 15, 2017 photo shows an arrangement of pills of the opioid oxycodone-acetaminophen in New York. Abuse of painkillers, heroin, fentanyl and other opioids across the country has resulted in tens of thousands of children being taken from their homes and placed in the foster care system. (AP Photo/Patrick Sison) ORG XMIT: NY541

(Photo: Patrick Sison, AP)

TREAT ADDICTIONS SAVE LIVES

#JUSTICE COMMUNITY
Reduce Stigma, Myths
Improve Access to Care

Myths and Realities of Opioid Use Disorder Treatment.		
Myth	**Reality**	**Possible Policy Response**
Buprenorphine treatment is more dangerous than other chronic disease management.	Buprenorphine treatment is simpler than many other routine treatments in primary care, such as titrating insulin or starting anticoagulation. But physicians receive little training in it.	Amend federal buprenorphine-treatment eligibility requirements to include training completed during medical school and require training during medical school or residency. Add competency questions to U.S. Medical Licensing Examination and other licensing exams.
Use of buprenorphine is simply a "replacement" addiction.	Addiction is defined as compulsively using a drug despite harm. Taking a prescribed medication to manage a chronic illness does not meet that definition.	Public health campaign to reduce stigma associated with addiction treatment, similar to past campaigns (e.g., HIV) that provided education and challenged common myths.
Detoxification for opioid use disorder is effective.	There are no data showing that detoxification programs are effective at treating opioid use disorder. In fact, these interventions may increase the likelihood of overdose death by eliminating tolerance.	Advocacy from professional physician organizations to educate federal and state agencies and policymakers about evidence-based treatment and the lack of evidence for short-term "detoxification" treatment.
Prescribing buprenorphine is time consuming and burdensome.	Treating patients with buprenorphine can be uniquely rewarding. In-office inductions and intensive behavioral therapy are not required for effective treatment.	Develop and disseminate protocols for primary care settings that emphasize out-of-office induction and treatment.
Reducing opioid prescribing alone will reduce overdose deaths.	Despite decreasing opioid prescribing, overdose mortality has increased. Patients with opioid use disorder may shift to the illicit drug market, where the risk of overdose is higher.	Develop a national system of virtual consultation for physicians to reach addiction and pain specialists who can support treatment of patients with suspected opioid use disorder.

SE WAKEMAN, ML BARNETT. N ENGL J MED 2018;379:1-4.

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STIGMA & MYTHS PREVAIL

STIGMA

NOUN

stigmas (plural noun)

1. **Disgrace associated with a particular circumstance, quality, or person**
2. **Vsible sign or characteristic of a disease**

1. 60% US Counties have no psychiatrists
2. 16% of 52,000 active psychiatrists have DEAX waiver to prescribe buprenorphine

DON'T LET MYTHS PREVAIL: Widely Held False Beliefs & Ideas WILL YOU REMEMBER?

1. Medications for substance use disorder are **NOT** more dangerous than other medical interventions

2. Patients do **NOT** become addicted (defined as compulsive use despite harm) to buprenorphine

3. Abstinence based treatment-**detoxification** for opioid use disorder is **NOT** more effective than medications
   1. Lowers tolerance
   2. Increases risk for overdose deaths

SUD MEDICATIONS ARE NOT MORE DANGEROUS

LITHIUM

Low therapeutic index

Renal Toxicity

Tremors

Diabetes Insipidus

ANTIPSYCHOTICS

Tardive Dyskinesia

Agranulocytosis

Metabolic Syndrome

REALITIES: PATIENTS IMPROVE ON MEDICATIONS

PHARMCOLOGIC DEPENDENCE ≠LOSS OF CONTROL

- **Medications**
  - Improve treatment engagement
  - Quit rates
  - Abstinence
  - Work
  - Care for self, family, kids
  - Treatment retention
- **Use as prescribed ≠ Compulsive use despite harm**

Medications for OUD Treatment

Agent	Dose	Dosing
Buprenorphine sublingual film, tablets (generic)	PO: 2 mg, 8 mg film and tablets	**Initial:** 2–4 mg (Increase by 2–4 mg) **Daily:** ≥8 mg **Max:** 24 mg/day
Methadone tablets/liquid (generic)	PO: 5 mg, 10 mg, tablets; 10 mg/mL liquid	**Initial:** 10-30 mg (Reassess in 3–4 hours; add ≤10 mg PRN) **Daily:** 60-120 mg[a]
Naltrexone XR injection *(Vivitrol®)*	IV/IM: 380 mg in 4 cc	Every 4 weeks
Naltrexone tablets (generic)	PO: 50 mg	**Daily:** 50 mg (May give 2–3 daily doses at once on M–W–F.)

[a]The dose should be individualized and may be higher or lower than this usual dosage.

ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

WHAT HAPPENS WHEN PSYCHIATRY & MEDICINE ARE NOT IN SYNC

IN SYNC WIDE AGREEMENT

- Naloxone for opioid overdose reversal prevents death
- Medical alcohol detoxification prevents DTs, death
- Thiamine prevents Wernicke-Korsakoff

WHAT'S NOT USED

<u>9 FDA Approved Medications</u>

3 - Relapse prevention medications for Alcohol Use Disorder

3- Relapse prevention medications for Opioid Use Disorder

3- Relapse prevention medications for Tobacco Use Disorders

Naloxone-Prescribing Practices: A Missed Opportunity

Shane Stone, Erin Barnes, Christopher McLouth, Candice J. McNeil

To the Editor—We read with interest your recent issue describing the statewide care efforts for opioid-addicted patients, particularly Khatiwoda et al.'s article assessing naloxone kit use [1]. Given the Surgeon General's emphasis on naloxone in combatting the opioid epidemic [2], we assessed the opioid and naloxone-prescribing practices at Wake Forest Baptist Health System, an 885-bed tertiary referral center in northwest North Carolina. We assessed 2 groups for whom naloxone should be considered: those with an opioid abuse disorder and those prescribed opioid doses ≥ 50 morphine milligram equivalents (MME)/day. Doses ≥ 50 MME/day have been associated with increased overdose risk [3].

To determine patients at risk for opioid addiction, we extracted patients aged 18 and older with ICD codes of opioid use disorder, intoxication, withdrawal, and/or unspecified opioid-related disorder from January 1, 2012, through January 1, 2017. We then extracted all opioid prescriptions written during this same period, converted them to MME, and flagged prescriptions of ≥ 50 MME/day as "at risk [4]." Intravenous, bulk-form, and prescriptions with incalculable total opioid value were excluded. Finally, we pulled all naloxone prescriptions during this period.

During the study period 2,214,438 opiate prescriptions were written for 159,746 individuals. 220,998 (0.1%) prescriptions for 8,992 (0.06%) individuals qualified for naloxone due to receiving an "at risk" prescription. The most common opiates prescribed (by proportion of total prescriptions) were oxycodone (52.02%), hydrocodone (38.02%), and morphine (3.69%). Oxycodone (143,707), morphine (29,304), and hydromorphone (20,173) had the highest total number of naloxone-eligible prescriptions while methadone (51.59%), oxymorphone (39.40%), and morphine (32.65%) had the highest proportion of naloxone-qualifying prescriptions. Recipients averaged 47.2 years of age (standard deviation = 20.8) and were 76% Caucasian and 17% African American; 3,936 patients had an opioid abuse ICD code during the study period. Combining these 3,936 patients with the 8,992 patients who received an "at-risk" prescription yielded an estimated 12,928 patients who qualified for naloxone, but only 4 (0.0003%) individuals received a prescription.

The limitations of our study include the potential for missed prescriptions and for overlap between the opioid prescription and opioid disorder group; however, multiple formulations of naloxone were assessed to minimize potential missing data. Additionally, it is possible that prescriptions were not captured if they were acquired utilizing the state's standing order for naloxone which allows patients to receive naloxone directly at a pharmacy without an individual prescription [5]. While the CDC's opioid and naloxone-prescribing guidelines and recommendations emerged in the last 2 years of our study period, the gap between the patients at risk and those with a naloxone prescription is striking. We are missing an important opportunity to impact this public health crisis through prescribing naloxone for opioid overdose prevention. Investigations to better understand the barriers and attitudes regarding naloxone prescribing are needed. NCMJ

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Potential conflicts of interest. The authors have no relevant conflicts of interest.

References

1. Khatiwoda P, Proeschold-Bell RJ, Meade CS, Park LP, Proeschold-bell S. Facilitators and barriers to naloxone kit use among opioid-dependent patients enrolled in medication assisted therapy clinics in North Carolina. N C Med J. 2018;79(3):149-155.

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N C Med J. 2018;79(5):343-344.
0029-2559/2018/79518

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Identify evidence based treatments for substance use disorders and difference between ideal (any) and current treatments

Recognize how professional practice gaps (Stigma, MYTHS, Rural) limit access to medications to assist treatments (MAT)

Describe best practices to prevent, assess and #TREAT addictions and SAVE LIVES!

#POWER OF MEDICATIONS TO ASSIST TREATMENTS (MAT)

#Prevent Relapse, Decrease Cravings & Withdrawal, Prevent Overdose and Death with medications, people, places and things to support relapse prevention, recovery & resilience

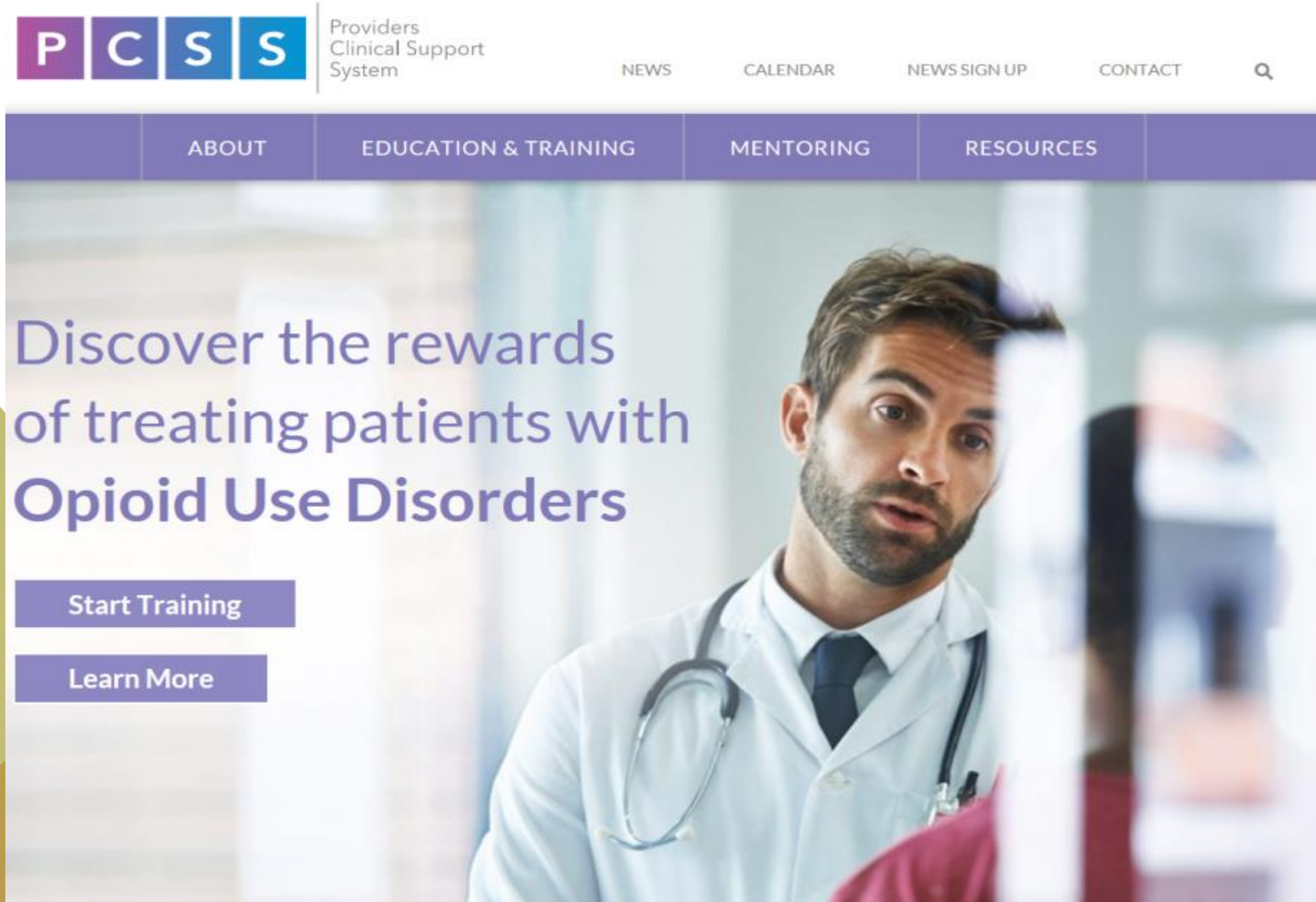
#Overdose reversal saves lives temporarily but ≠ relapse prevention & recovery treatment

#Withdrawal symptoms = NEED for relapse prevention and recovery treatment

#Empathy, Educate, Engage team support for medications to assist recovery treatment

#Recovery improves with relapse prevention medications, groups, community, people, places and things that support resilience

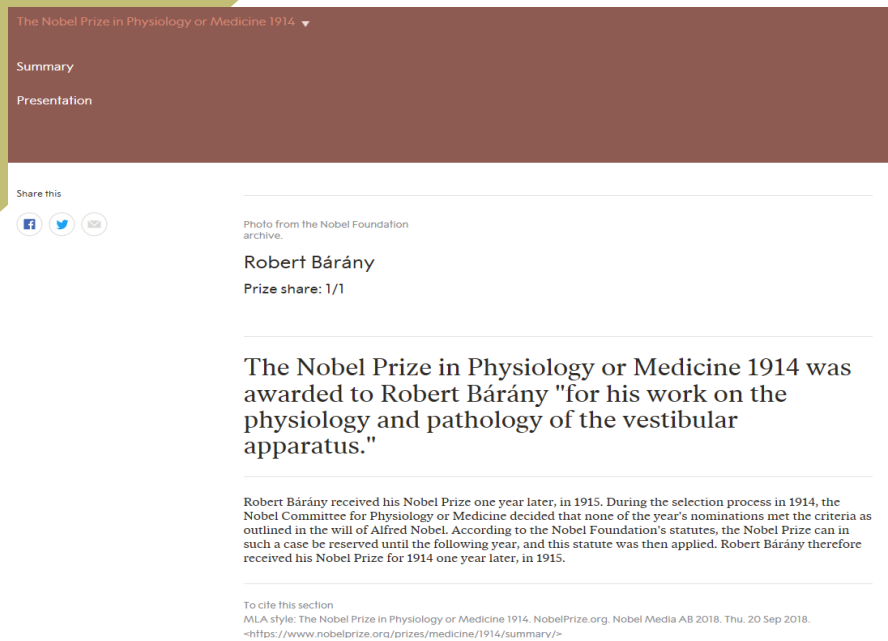
HTTPS://PCSSNOW.ORG/



COMING SOON: NEW TREATMENTS

Stay Tuned

Keep Reading



STR-TA Consortium

State Targeted Response Technical Assistance

SUMMARY

- **Despite effective treatments, Stigma, MYTHS, Realities limit access to effective medications to assist treatments (MAT) for addictions**

- **TREAT Addictions. PREVENT Relapse. SAVE LIVES**

- **Addiction related problems grow exponentially**
  - Opioid Crisis
  - Alcohol & Marijuana Use Up in Women
  - Alcohol Binge Drinking Up & Related Deaths

- **WILL YOU help it be easier to SUD treatment?**

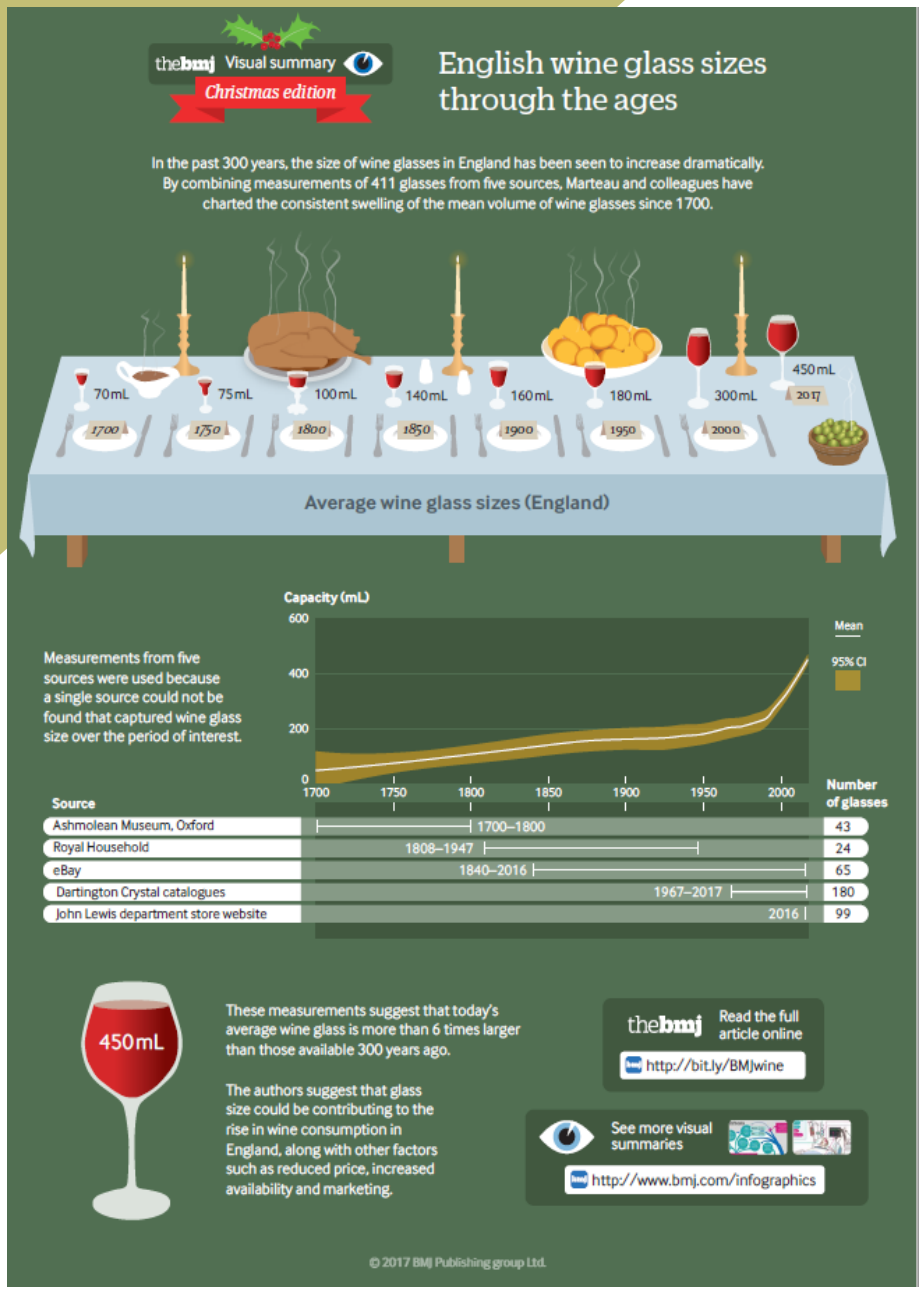
MIND & BODY

Do moms need too much wine? Women's drinking habits spark concern

September is National Recovery Month. Women are at greater risk for some of the negative effects of alcohol, but their drinking is catching up to men.

by A. Pawlowski / Sep.12.2018 / 8:56 AM EDT / Source: TODAY

Getty Images



JOIN #JUSTICE COMMUNITY #TREAT ADDICTIONS CREATE TEAM & BUILD RECOVERY COMMUNITY

SPECIAL POWERS & MISSION FOR PHYSICIANS ADVOCATE #RESPECT = MEDICATIONS ASSIST TREATMENT (MAT)

#Recovery skills improve with relapse prevention medications

#Empathy, family, friends, sponsors, peers and community teams enhance treatment

#Self-Help + Groups + 1:1 Interventions + medications –do everything to help build recovery skills

#Prevent (don't just watch) withdrawal, PREVENT-OFFER all SUDs relapse prevention medications

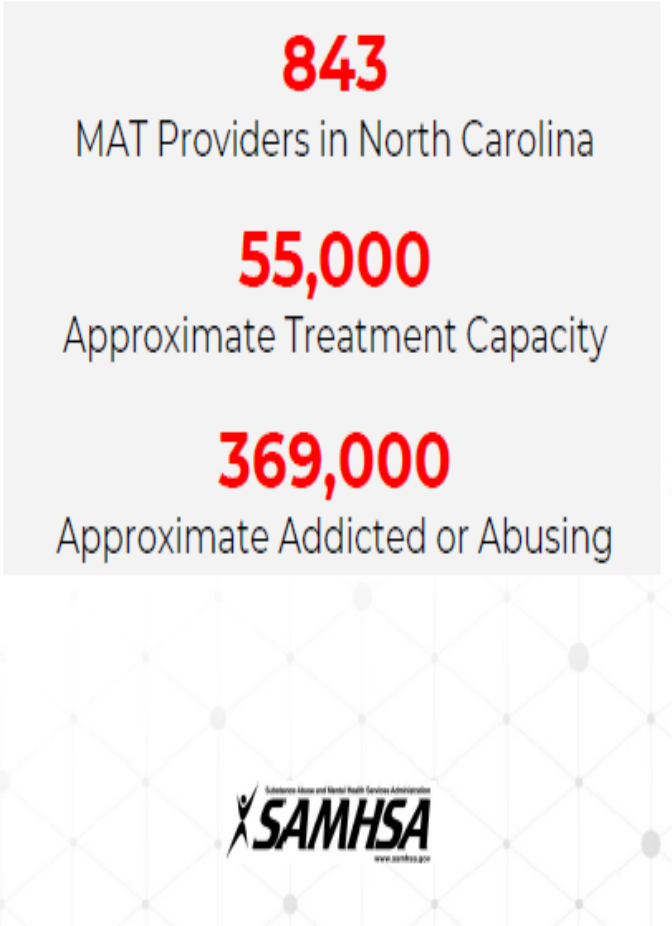
#Educate self & others how established medical treatments improve recovery, resilience

#Clinical health emphasis reduces stigma, myths, medical complications and overdose deaths

#Treat Addictions Save Lives

MISSION ?POSSIBLE: 2017

- **20.7 million people with SUD (1 in 13)**
- **Improve our 843 in NC!**



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