

# JOIN THE VOICES FOR RECOVERY

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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!**
- 

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# **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 <sup>a</sup>		DSM-IV Dependence <sup>b</sup>		DSM-5 Substance Use Disorders <sup>c</sup>	
Hazardous use	X	} ≥1 criterion	–	} ≥3 criteria	X	} ≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal <sup>d</sup>	–		X		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	

<sup>a</sup> 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.

<sup>b</sup> Three or more dependence criteria within a 12-month period.

<sup>c</sup> Two or more substance use disorder criteria within a 12-month period.

<sup>d</sup> 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

### AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	DIMENSION 1	<b>Acute Intoxication and/or Withdrawal Potential</b> Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	<b>Biomedical Conditions and Complications</b> Exploring an individual's health history and current physical condition
3	DIMENSION 3	<b>Emotional, Behavioral, or Cognitive Conditions and Complications</b> Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	<b>Readiness to Change</b> Exploring an individual's readiness and interest in changing
5	DIMENSION 5	<b>Relapse, Continued Use, or Continued Problem Potential</b> Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	<b>Recovery/Living Environment</b> Exploring an individual's recovery or living situation, and the surrounding people, places, and things

## 4 LEVELS OF CARE

Level I – Outpatient-weekly

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

Level III – Residential

Level IV - Inpatient Unit



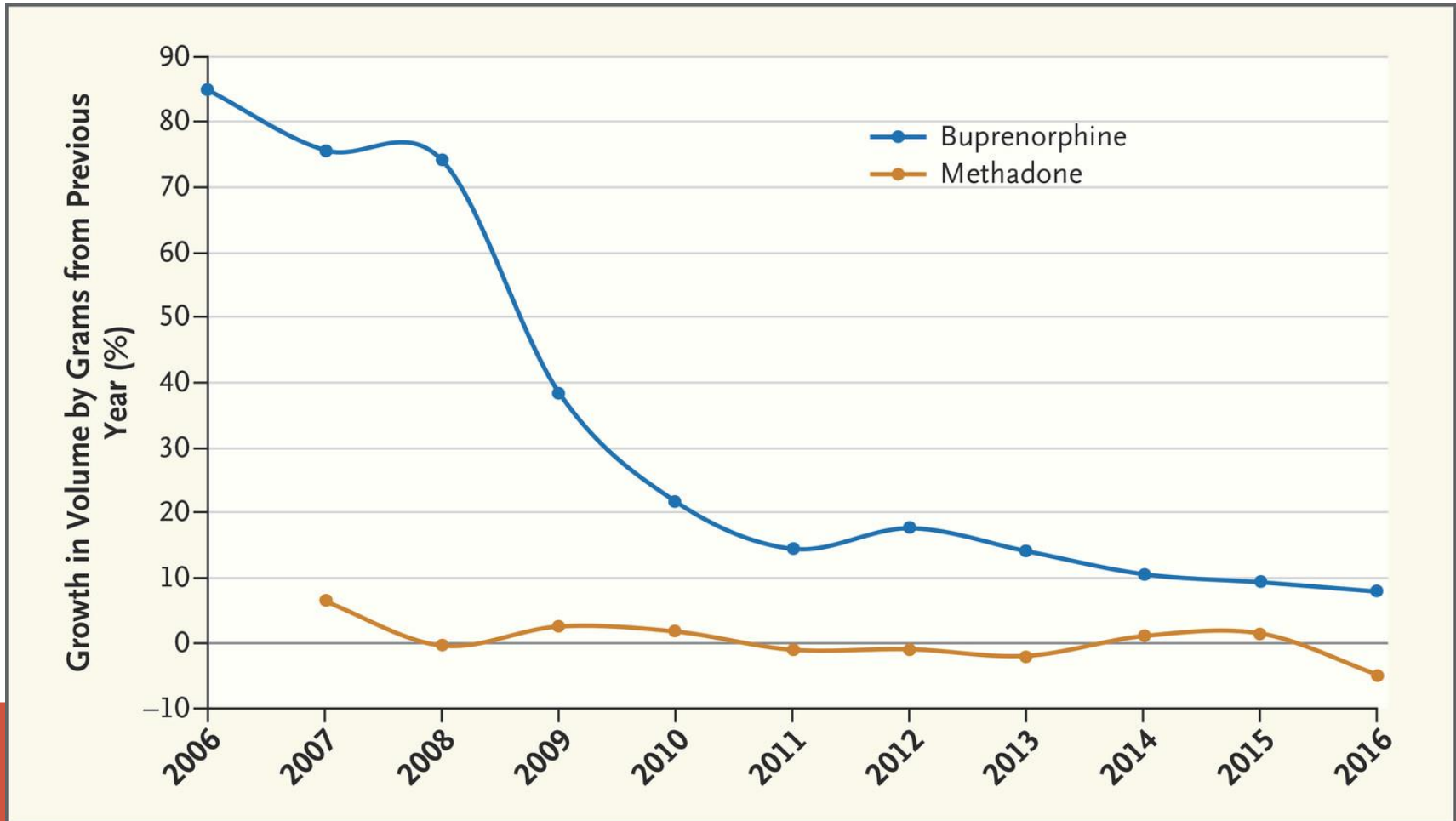
# **SUD RELAPSE PREVENTION MEDICATION OUTCOMES BETTER/ OTHER CHRONIC DISEASES**

- **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

# 3 LEARNING OBJECTIVES

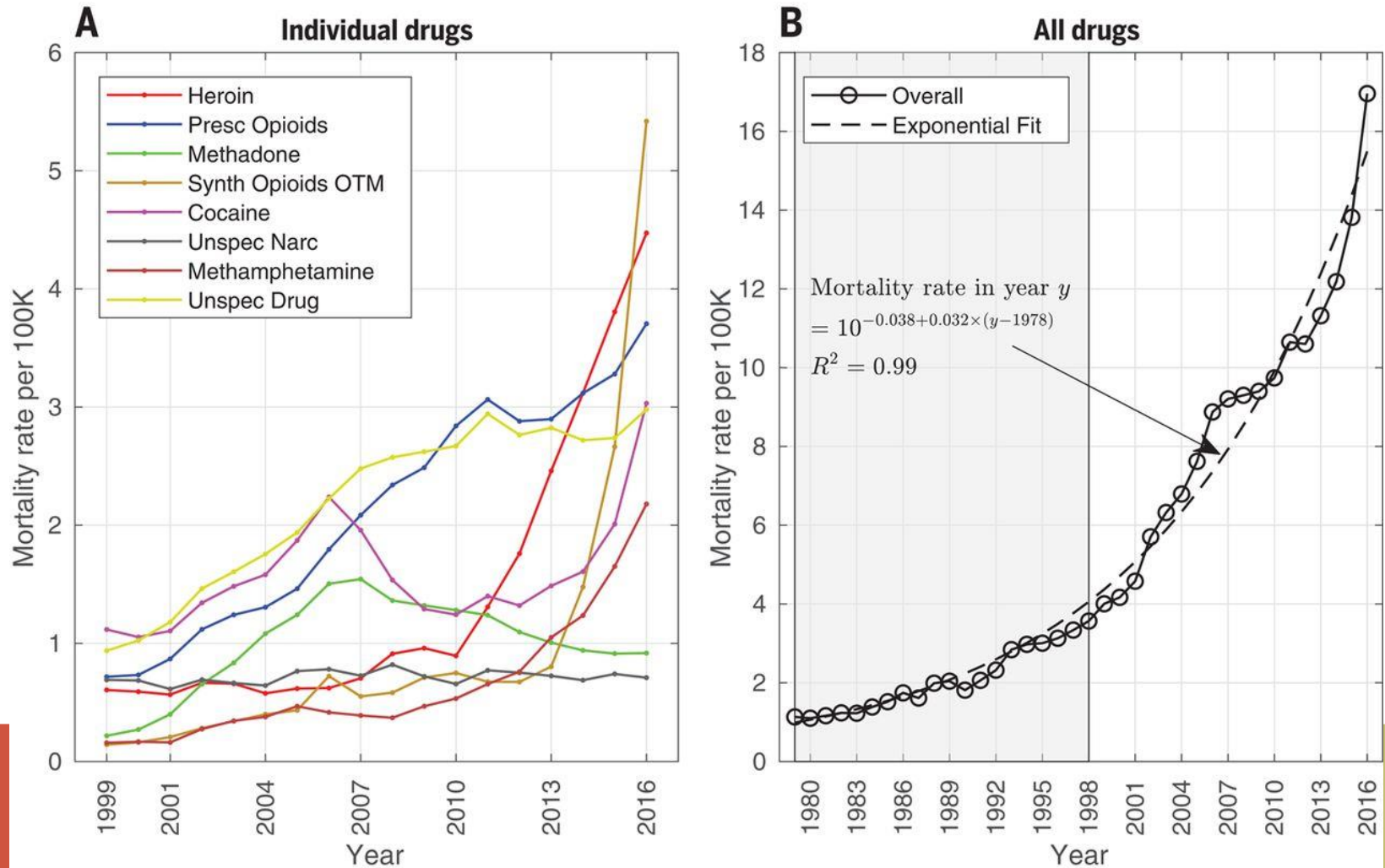
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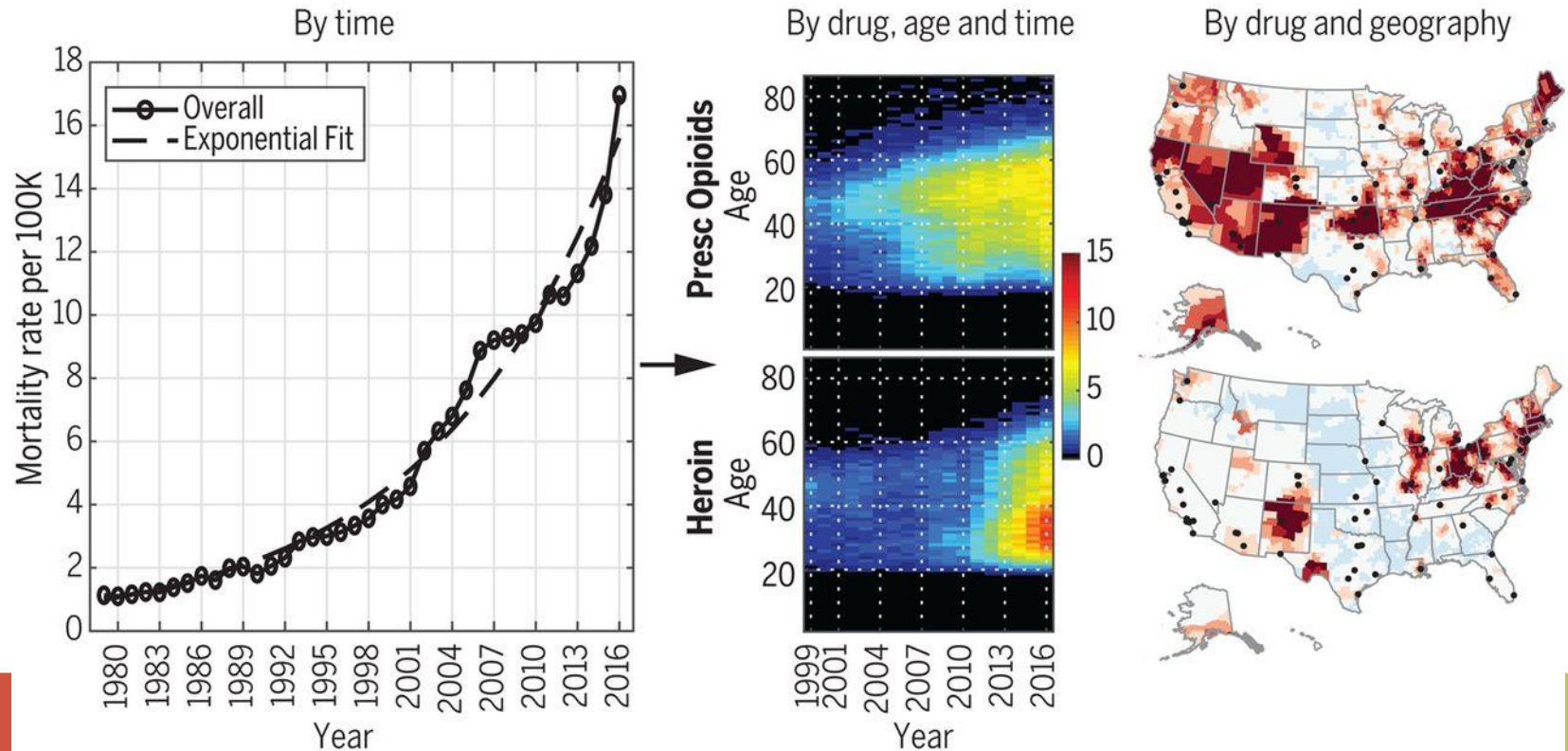
**Fig. 1 Mortality rates from unintentional drug overdoses.**



Hawre Jalal et al. Science 2018;361:eaau1184

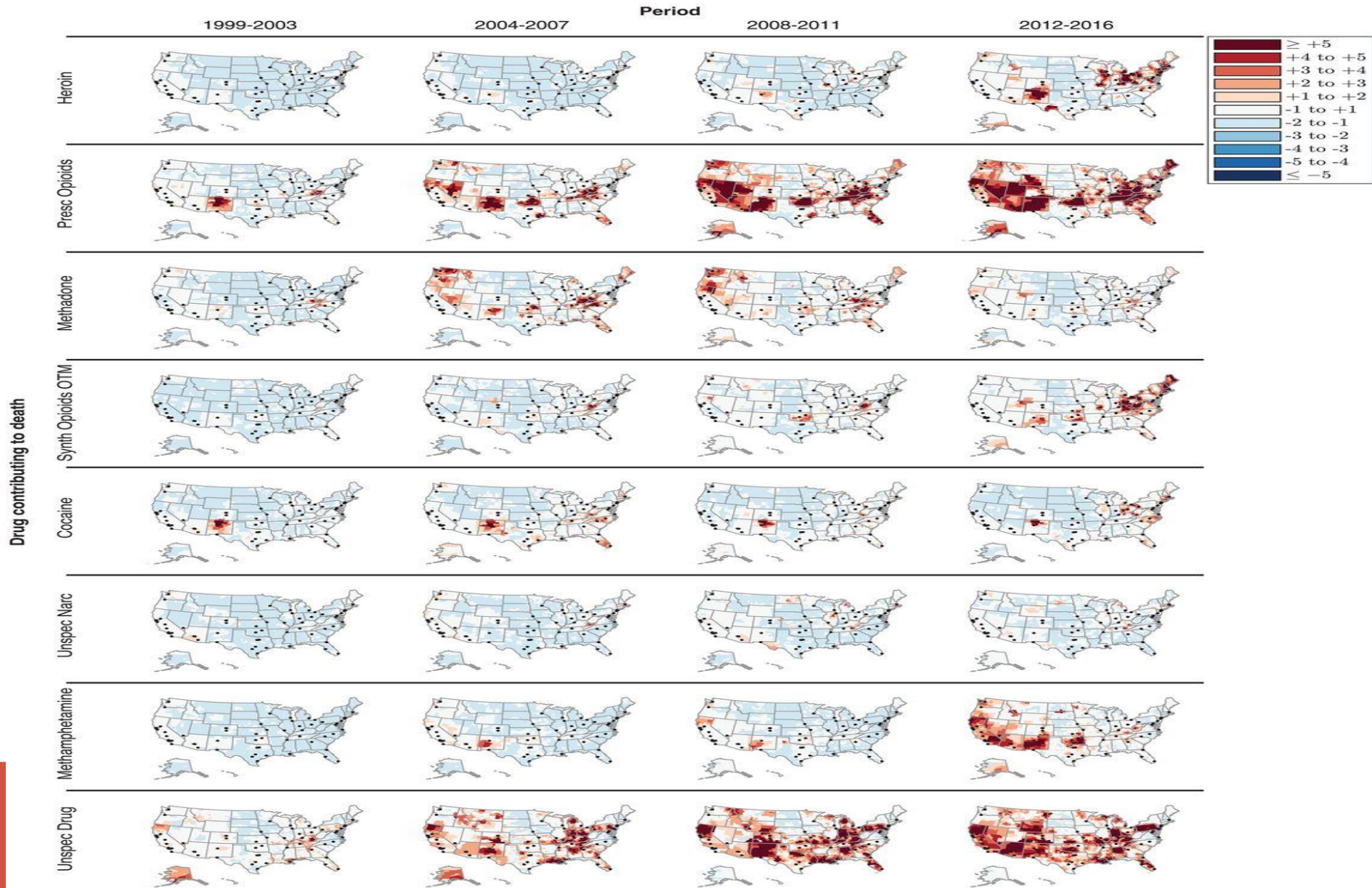
## Exponential growth in overdose deaths.

### Overdose Mortality Rate



Hawre Jalal et al. Science 2018;361:eaau1184

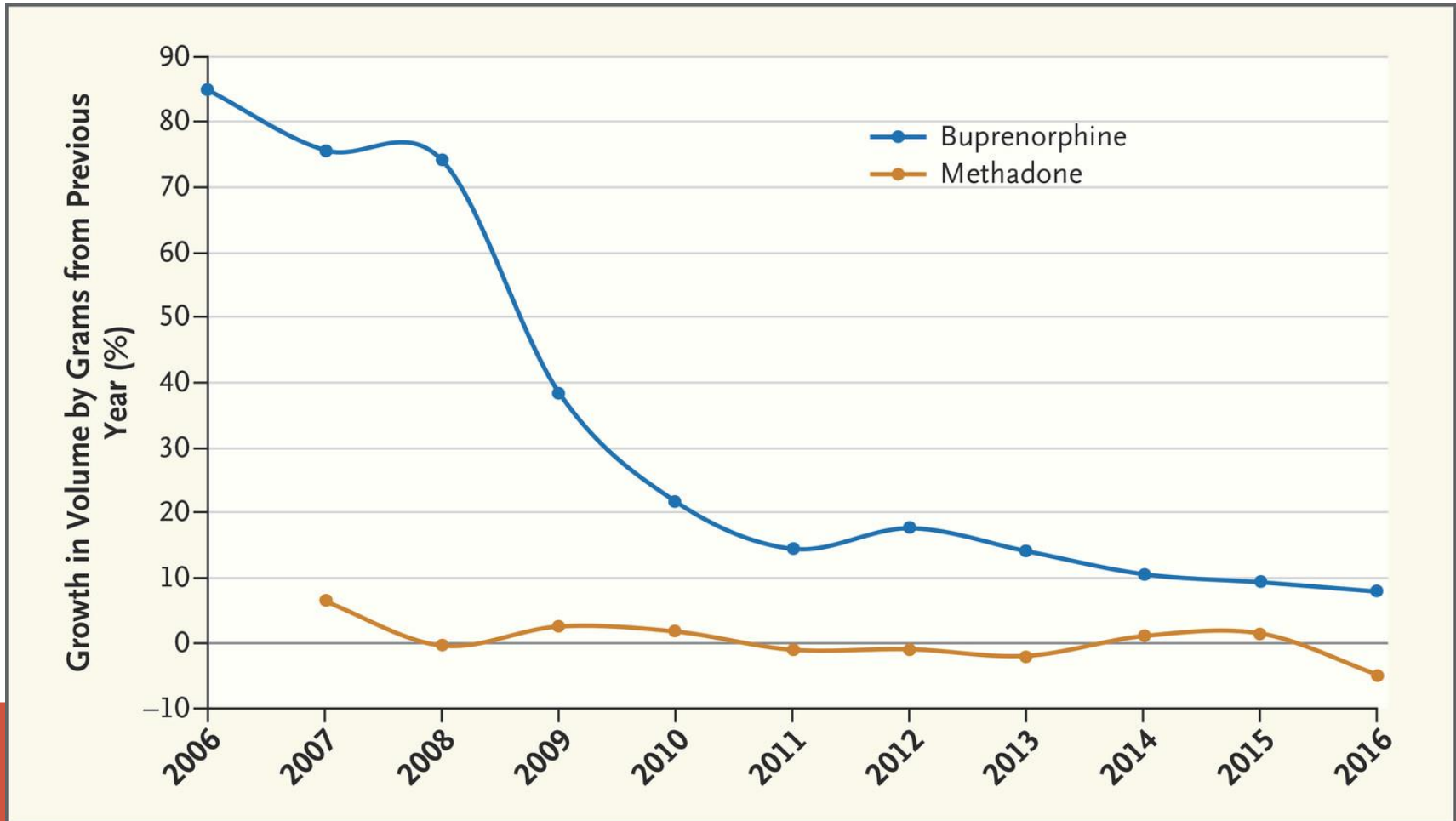




Hawre Jalal et al. Science 2018;361:eaau1184

**Fig. 3 Geospatial hotspot analysis by drug and period.**

# Decline of Medications Dispensed for Opioid Use Disorder



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



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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.pcass.org](http://www.pcass.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**

# I lost a sister and a brother to opioid addiction. I nearly lost my own life, too.

Nicholas Bush, Opinion contributor Published 5:00 a.m. ET Sept. 21, 2018

*We started using heroin because it was easy to get, but overcoming addiction was the hardest thing I've ever done. Community made it possible.*



(Photo: Patrick Sison, AP)

CONNECT TWEET LINKEDIN COMMENT EMAIL MORE

For me, it was OxyContin then heroin. It turns out that this is a common [trajectory](#). In the United States, [72,000 people died](#) from drug overdoses in 2017, nearly 50,000 of those from opioids. Imagine an entire football stadium full of people obliterated.

I first abused opioids about the time I turned 18 years old. I grew up in Green Bay, Wisconsin, which, simply put, is the [drunkest city in the nation](#), and I was pretty young when I started drinking alcohol and smoking marijuana. But when I first snorted Oxy, it was a high of another level.

Later, we started doing heroin simply because it was easier for us to get. What I soon found out is that while people who do drugs can have somewhat normal lives, many people who do heroin just do heroin. By the time you realize that something is terribly wrong, it's too late, your mind and your body are hooked.

## Heroin abuse and addiction

When my older sister, Allison, died on June 16, 2011, she was 24. She was the kindest person I've ever known. Allison was going to school for anesthesiology and finishing up pre-med when she died. I thought she might be using medication prescribed by doctors of hers to treat chronic pain she had had for years from a bad case of shingles, but I didn't think she'd look for the hardest thing she could find to treat the pain. I just didn't see it coming.

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”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.

# STIGMA & MYTHS PREVAIL

## STIGMA


### NOUN

stigmas (plural noun)

1. Disgrace associated with a particular circumstance, quality, or person
2. Visible 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  $\neq$  LOSS OF CONTROL

- **Medications**
  - Improve treatment engagement
  - Quit rates
  - Abstinence
  - Work
  - Care for self, family, kids
  - Treatment retention
- **Use as prescribed  $\neq$  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: $\geq 8$ 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 $\leq 10$ mg PRN) Daily: 60-120 mg <sup>a</sup>
Naltrexone XR injection ( <i>Vivitrol</i> ®)	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.)

<sup>a</sup>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

### 9 FDA Approved Medications

**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  $\geq 50$  morphine milligram equivalents (MME)/day. Doses  $\geq 50$  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  $\geq 50$  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%), oxycodone (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

Shane Stone, BS medical student, Wake Forest School of Medicine, Wake Forest University, Winston-Salem, North Carolina.

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Christopher J. McLouth, MS department of biostatistics, Wake Forest Health Sciences, Wake Forest University, Winston-Salem, North Carolina.

Candice J. McNeil, MD, MPH assistant professor, Wake Forest Health Sciences, Department of Medicine, Section on Infectious Diseases, Wake Forest University, Winston-Salem, North Carolina.

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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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Address correspondence to Shane Stone, Department of Infectious Disease, Wake Forest School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157 (snstone@wakehealth.edu).

*N C Med J*. 2018;79(5):343-344. ©2018 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2018/79518

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# #POWER OF MEDICATIONS TO ASSIST TREATMENTS (MAT)

- #**P**revent Relapse, Decrease Cravings & Withdrawal, Prevent Overdose and Death with medications, people, places and things to support relapse prevention, recovery & resilience
  - #**O**verdose reversal saves lives temporarily but ≠ relapse prevention & recovery treatment
  - #**W**ithdrawal symptoms = NEED for relapse prevention and recovery treatment
  - #**E**mpathy, Educate, Engage team support for medications to assist recovery treatment
  - #**R**ecovery improves with relapse prevention medications, groups, community, people, places and things that support resilience
- 

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COMING SOON: NEW TREATMENTS

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**STR-TA**  
Consortium  
State Targeted Response  
Technical Assistance

The Nobel Prize in Physiology or Medicine 1914 ▾

Summary

Presentation

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Photo from the Nobel Foundation archive.

**Robert Bárány**

Prize share: 1/1


The Nobel Prize in Physiology or Medicine 1914 was awarded to Robert Bárány "for his work on the physiology and pathology of the vestibular apparatus."

Robert Bárány received his Nobel Prize one year later, in 1915. During the selection process in 1914, the Nobel Committee for Physiology or Medicine decided that none of the year's nominations met the criteria as outlined in the will of Alfred Nobel. According to the Nobel Foundation's statutes, the Nobel Prize can in such a case be reserved until the following year, and this statute was then applied. Robert Bárány therefore received his Nobel Prize for 1914 one year later, in 1915.

To cite this section

MLA style: The Nobel Prize in Physiology or Medicine 1914. NobelPrize.org. Nobel Media AB 2018. Thu, 20 Sep 2018. <<https://www.nobelprize.org/prizes/medicine/1914/summary/>>

# 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

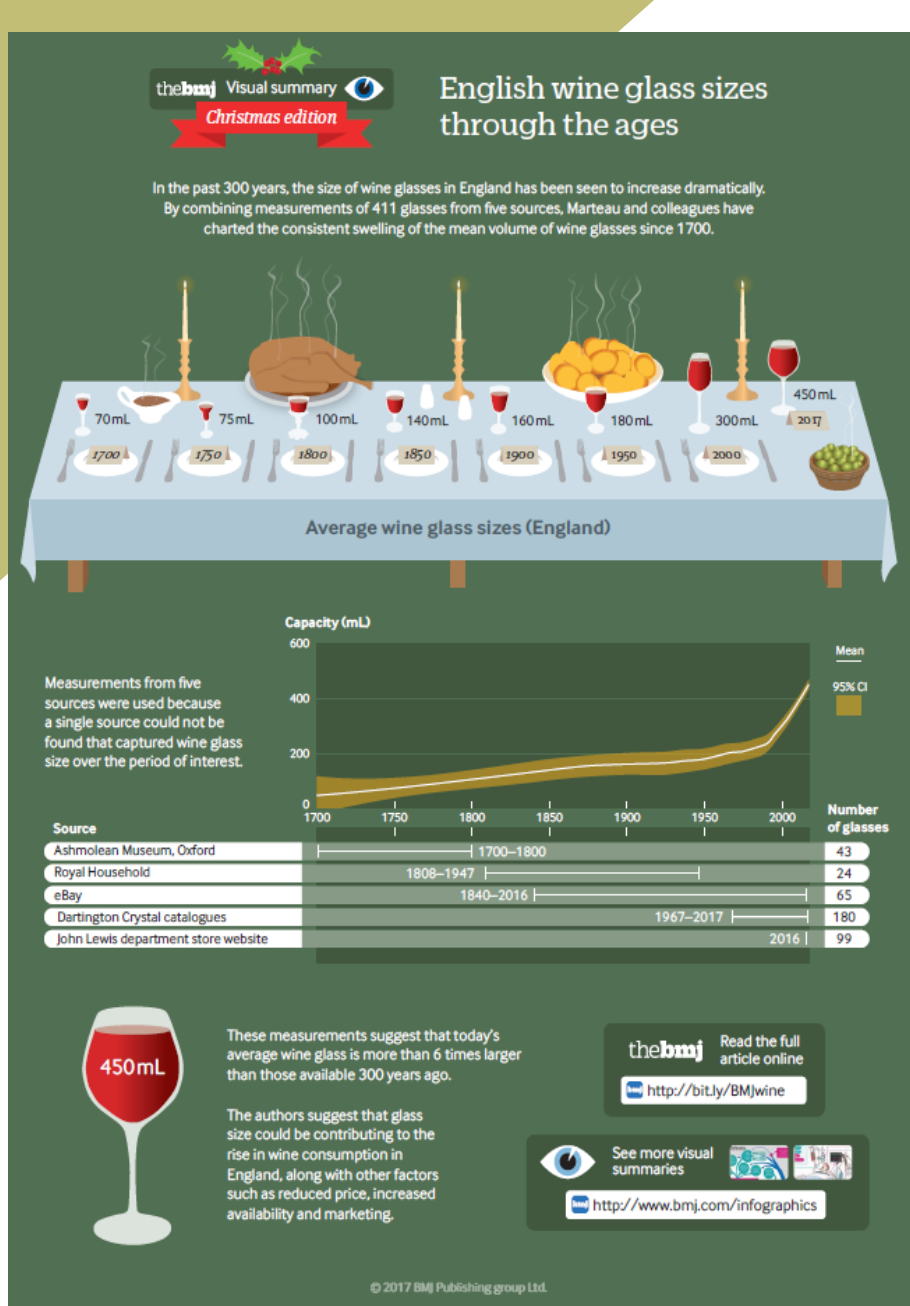
# Do moms need too much wine? Women's drinking habits spark concern

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



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CREATE TEAM & BUILD RECOVERY COMMUNITY**



# **SPECIAL POWERS & MISSION FOR PHYSICIANS ADVOCATE**

## **#RESPECT = MEDICATIONS ASSIST TREATMENT (MAT)**

**#R**ecovery skills improve with relapse prevention medications

**#E**mpathy, family, friends, sponsors, peers and community teams enhance treatment

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

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

**#E**ducate self & others how established medical treatments improve recovery, resilience

**#C**linical health emphasis reduces stigma, myths, medical complications and overdose deaths

**#T**reat Addictions Save Lives



# MISSION ?POSSIBLE: 2017

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

**843**

MAT Providers in North Carolina

**55,000**

Approximate Treatment Capacity

**369,000**

Approximate Addicted or Abusing

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