The Neuroscience of Addiction and Recovery

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Cirque Lodge Family Program
October 2014

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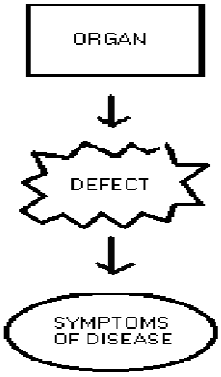
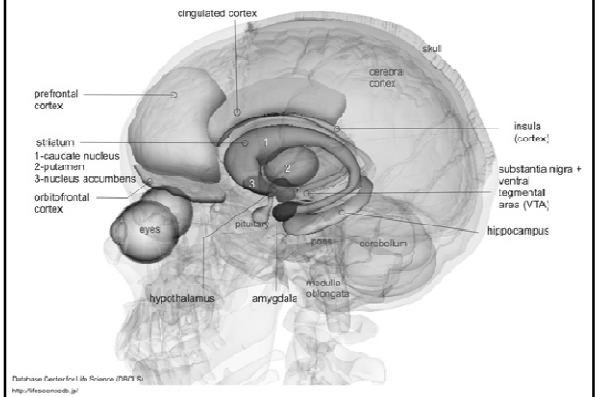
Is Addiction Really a "Disease?"

The "Disease Model"





ASAM Addiction Definition (Aug 2011)

A stress-induced (HPA axis),

genetically-mediated (polymorphisms, epigenetic mechs.)

primary, chronic and relapsing brain disease

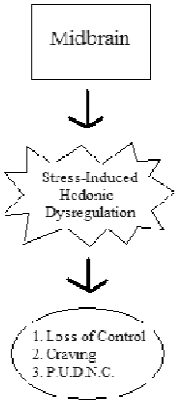
of reward (nucleus accumbens),

memory (hippocampus & amygdala),

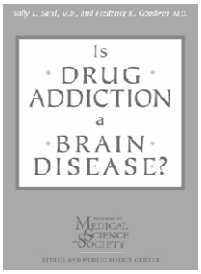
motivation and related circuitry (ACC, basal forebrain)

that alters motivational hierarchies such that addictive behaviors supplant healthy, self-care behaviors

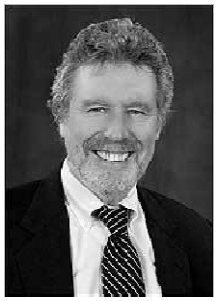
Addiction fits the "Disease Model!"

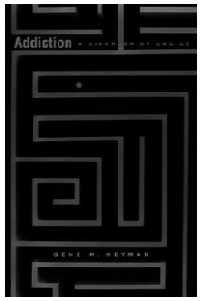


Sally Satel, MD

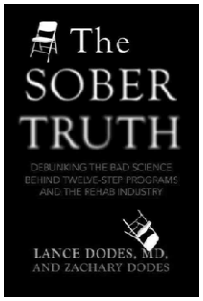


Gene Heyman, PhD





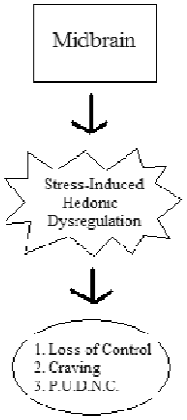
Lance Dodes, MD



A "Disease" of Volition

- Could such a thing exist? (ontologic argument)
- What would happen if such a thing existed? (teleologic argument)
- What is the nature of volition/free will/choice?
- Is there something special (non-material) about "choice?"
- If so, what is it?
- If not, how is "choice" realized in the

Something very important happened when we were finally able to call addiction a "disease". . .



If Addiction is a "Disease," then …

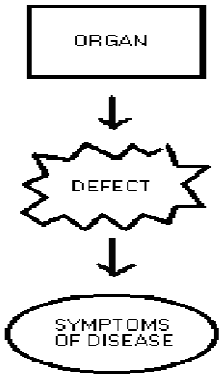
- *Addicts are patients!*
- *Addicts have the same rights as all patients*
- *All the ethical principles that apply to other patients now also apply to addicts*
- ***Addiction has parity***

Tom McClellan

Result: Mental Health Parity and Addiction Equity Act (2008)

Is Addiction an Acute Disease or a Chronic Disease?

The "Disease Model"



ACUTE Disease vs CHRONIC Disease

- REDUCTIVE: simple causation (traumatic, infectious, toxicologic)
- EMERGENT: rapid onset, severe symptoms, short duration
- EPISODIC CARE: Usually cured with a single, intense, time-limited hospitalization involving definitive treatment with …
- MATERIALISTIC: primarily surgical or pharmacological interventions
- TECHONOCRATIC: Expert delivered, expensive, encourages "sick role" dependency, poorly targeted, fragmented care
- Ex. Heart Attack, Pneumonia, Encephalitis, traumatic injury

Chronic Diseases

- Asthma
- Diabetes mellitus
- Chronic Obstructive Pulmonary Disease (COPD)
- Post-chemotherapy/Cancer
- Hepatitis B/C
- HIV/AIDS
- Major Depression
- Chronic Pain
- Lupus Erythematosis
- Cystic Fibrosis
- Alzheimer's Disease
- Kidney Disease
- Heart Disease/Post-MI
- Hypertension
- Rheumatoid Arthritis
- Epilepsy
- Irritable Bowel Disease
- ADHD
- Addiction/Recovery
- Migrainosis
- Anticoagulation Therapy (post-DVT, Atrial Fibrillation)

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- CONTEXTUAL: multiple causation (genetic vulnerability, early adverse experiences, poverty, societal disenfranchisement
- VARIABLE COURSE: sudden or gradual onset, relapsing, life-course variations
- LONGITUDINAL CARE: non-urgent, across the life-span, electronic health records, preventive focus
- PATIENT-CENTERED: care takes personal values, cultural context and spiritual considerations into account
- COMMUNITY-BASED: mix of professional and lay-treatment, team approach, continuous

advantages of a Chronic Care Model (Wagner)

- Non-urgent
- More efficient and cost-effective
- Preventive
- Based on continuous, healing relationships
- Provides services across the continuum of care for life
- Centralized, local (no aircraft needed)
- Family-centered
- Informational (EMRs > NHII > research)

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- Informational (EMRs > NHII > research)
- Self-management support
- Pro-active case management

What "Disease Management" looks like for … **Diabetes**

- Daily Fasting Blood Glucose testing (and recording)
- Intensive ("Flexible") Insulin therapy with MDI/pump
- Periodic Hemoglobin A1C testing to check long-term glycemic control
- Annual Ophthalmologic Exam
- Periodic Podiatric Exam/Foot Care
- Diet, Weight Control, Exercise
- Monitoring serum cholesterol and lipid profile
- Diabetes patient support groups

What "Disease Management" looks like for … **Addiction**

- Community-based Sober Living/Residential Support
- Monitoring (non-random drug testing)
- Group Therapy/Cognitive-Behavioral Therapy
- Peer-Based Recovery Support Groups (AA, etc)
- Addictionologist/Addiction Psychiatrist
- Web-based Assessment Tools
- Call centers/Phone counseling
- Occupational/Vocational Assistance

Disease Management

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

Goal: improving quality of life and reducing healthcare costs for individuals with chronic diseases by preventing or minimizing the effects of the disease through integrative care

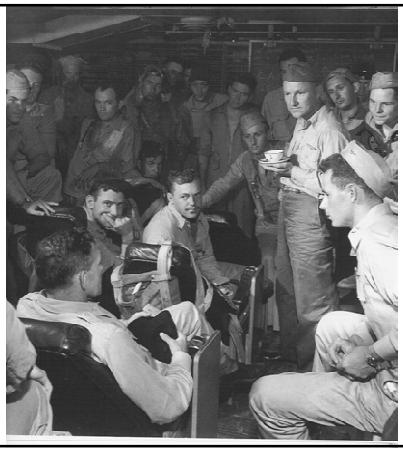
Recovery Management

Recovery management is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.

Goal: improving quality of life and reducing healthcare costs for individuals with addiction by preventing or minimizing the effects of the disease through integrative care

What does Recovery Management look like in action?

VMFAT-101 Sharpshooters MCAS El Toro, CA



Treatment Outcome Variance in Pilots Treated for Alcoholism:

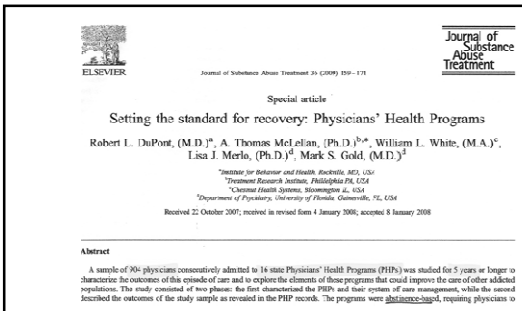
"The United States Navy enjoys a 95-97% return to flying status rate in its pilots treated for alcoholism."

- Joseph A. Pursch, M.D.

"Since the inception of its impaired pilot program in conjunction with the FAA and ALPA EAPs, UAL has an 87% return to flight status rate in pilots treated for alcohol problems."

- Stanley Mohler, M.D.

HIMS Program



ELSEVIER

Journal of Substance Abuse Treatment 36 (2009) 159–171

Journal of Substance Abuse Treatment

Special article

Setting the standard for recovery: Physicians' Health Programs

Robert L. DuPont, (M.D.)[a], A. Thomas McLellan, (Ph.D.)[b,*], William L. White, (M.A.)[c], Lisa J. Merlo, (Ph.D.)[d], Mark S. Gold, (M.D.)[d]

[a]Institute for Behavior and Health, Rockville, MD, USA
[b]Treatment Research Institute, Philadelphia PA, USA
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Received 22 October 2007; received in revised form 4 January 2008; accepted 8 January 2008

Abstract

A sample of 904 physicians consecutively admitted to 16 state Physicians' Health Programs (PHPs) was studied for 5 years or longer to characterize the outcomes of this episode of care and to explore the elements of these programs that could improve the care of other addicted populations. The study consisted of two phases: the first characterized the PHPs and their system of care management, while the second described the outcomes of the study sample as revealed in the PHP records. The programs were abstinence-based, requiring physicians to

Dupont RL, McLellan AT, White WL, Merlo LJ, Gold MS. Setting the standard for recovery: physicians' health programs. Journal of Substance Abuse Treatment 2009 Mar; 36(2): 159-71.

Characteristics of Physician Health Programs

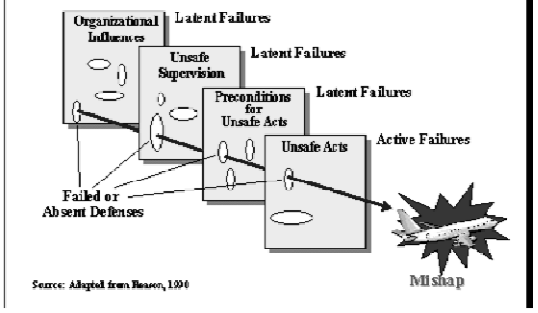
- Self-Reporting ("safe harbor") or Workplace Referral
- Comprehensive Evaluation
- Signed Contract specifying in detail the elements of care and monitoring as well as consequences for non-compliance Contingency Mgmt
- Inpatient Tx for 60–90 days (69%)
- Intensive Outpatient Tx (31%)
- Agonist pharmacotherapy rare (but 1/3 received antidep/antianx Rx)
- Facilitated groups (Caduceus meetings) Monitoring/Prof Norms
- Return to work Professional Norms
- Drug testing (random call-in, approx. four times/month) Monitoring
- Required participation in abstinence-based peer support groups (AA, NA, other) Social Norms
- Monitoring for five years, reporting to board of progress **Monitoring**
- Family, colleague, employer involvement Professional Norms
- Rapid response to relapse, usually clinical reevaluation & intensification of care (but not administrative discharge) **Contingency Mgmt**

(Dupont RL, McLellan AT, Skipper GE. How are physicians treated? A national survey of physician health programs. J Sub Abuse Tx (2009) 37:1-7.

Things we do for pilots & doctors:

- Medical Detoxification
- Inpatient or Residential Treatment
- Aftercare: Immediately after Tx for 3-5 Years
- A.A. Attendance
- Regular testing ("monitoring")
- Return to duty
- Personal physician

The Reason Model and Accident Causal Chain



US Drug War: 1971 - 2011

What did it cost us?

- Mass incarceration
- Worsening of racial inequality
- Increased health disparity
- Criminalization of mental illness
- Large numbers of Americans coping with the long-term sequelae of incarceration
- Moral hazard of historic proportions

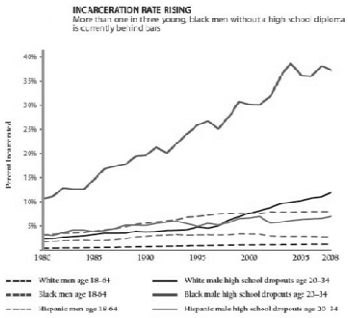
"Criminal responsibility is embedded in a context of social & economic disadvantage"

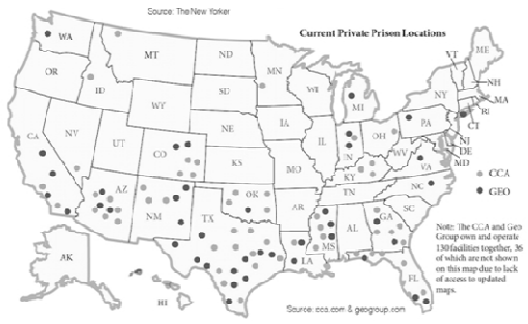
- Black men under 40 years of age
- Poorly educated
- Lack of work preparation
- Mental illness
- Substance use disorder

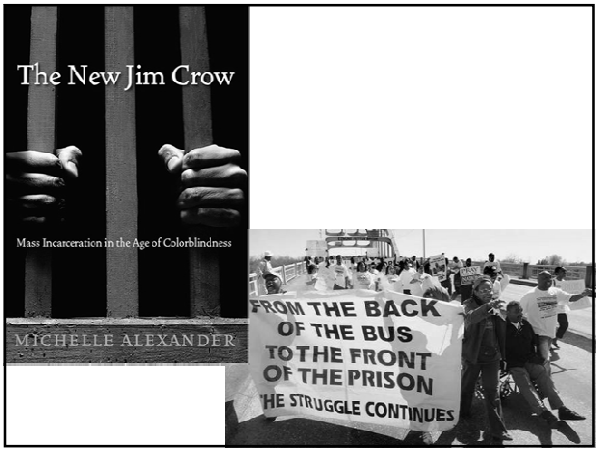
Two thirds of black male high-school dropouts have a prison record

National Research Council. The growth of incarceration in the United States: exploring causes and consequences. National Academies Press, 2012.

Racial Disparities in Incarceration







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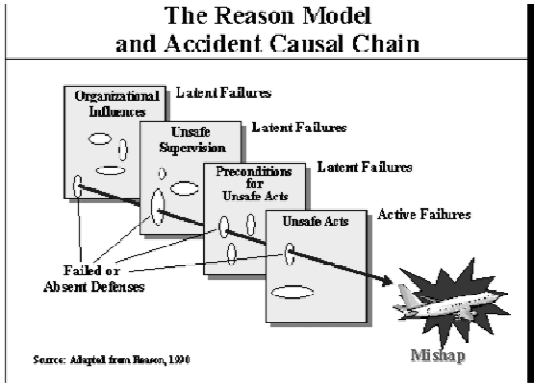
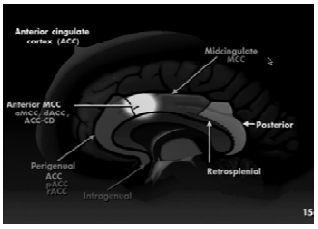
Tom McClellan
Result: Mental Health Parity and Addiction Equity Act (2008)



Tips for the First Year of Recovery

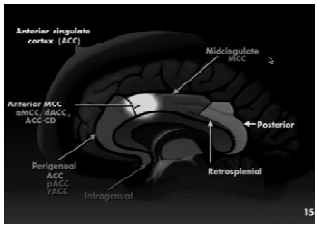
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Anterior Cingulate Cortex (ACC)



- Works with OFC: decision-making based on reward values
- But also generates new actions based on past rewards/punishments
- Appreciation and valuation of social cues
- MRI: active in tasks

damage to Anterior Cingulate Cortex (ACC)



- Just as with OFC damage: causes a loss of a crucial behavioral guidance system
- Inflexibility/Inability to respond to errors in the past with regard to rewards/punishments
- Deficits in social responding due to decreased awareness of social cues

Tips for the First Year of Recovery

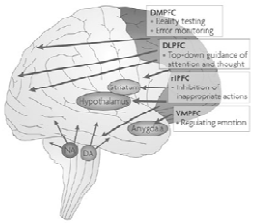
1. Residential Treatment (Inpatient or Residential Day)

Benefits of inpatient care

Medical detoxification
Baseline psychiatric evaluation & treatment
Intensive daily structure
Solidification of abstinence
Removal from codependent family/social system
Incapacitation of use
Patient “takes it seriously”

Finney et al. Addiction 1996 91(12), 1773-1796

damage to Prefrontal Cortex (PFC)



- FAILURE OF EXECUTIVE FUNCTIONING
- Premature, unduly risky, poorly conceived actions
- Rapid, impulsive responses without reflection or premeditation
- Urgency
- Sensation seeking
- Expressed emotions inappropriate to the situation
- Deficits in attention
- Lack of perseverance
- Insensitivity to consequences

What happens when people leave inpatient treatment?

Treatment Outcome Subgroups

1. Continued, uninterrupted abstinence after D/C

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Treatment Outcome Subgroups

1. Continued, uninterrupted abstinence after D/C
2. No effect (no interruption of drug use)
3. Early period of recovery, then rapid deterioration
4. Period of recovery, relapse, then stable recovery
5. Precariously balanced between relapse and recovery for 12 – 18 months after D/C (with unclear prognosis)

Tips for the First Year of Recovery

1. Residential Treatment (Inpatient or Residential Day)
2. Immediate Aftercare following Residential Treatment

Recovery Management Checkups (RMCs) (Dennis & Scott)

Studying effects of on-going monitoring & early re-intervention

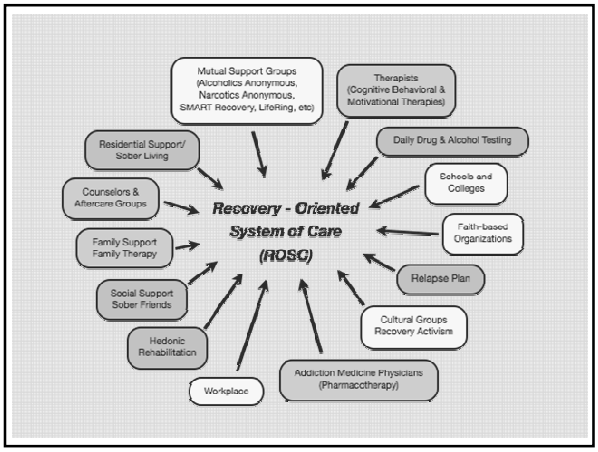
Quarterly Recovery Management "check-ups"

Four year outcomes, 446 subjects

Over controls, RMC participants showed:

- reduced time to readmission (from 45 to 13 mo.)
- greater likelihood of receiving more treatment
- reduced substance use frequency and problems
- more total days abstinent

Dennis ML, Scott CK. Four-year outcomes from the early re-intervention (ERI) experiment using recovery management checkups (RMCs). Drug and Alcohol Dependence 121 (2012) 10-17.



Tips for the First Year of Recovery

1. Residential Treatment (Inpatient or Residential Day)
2. Immediate Aftercare following Residential Treatment
3. Sober Living Environment

What is "recovery"?

Betty Ford Consensus Panel (2007)

Recovery is a voluntarily maintained lifestyle characterized by:

1. Sobriety: abstinence from alcohol and non-prescribed drugs
2. Personal Health: improved quality of life for the individual (and their family) composed of defined and measurable physical, psychological, social, and spiritual components
3. Citizenship: living with regard and respect for those around you; working towards the betterment of one's community through participation, volunteer word, and efforts to improve life for all citizens ("giving back")

What is "sober living"?

- Myriad of names: halfway house, three-quarter house, sober living, extended care, dry house
- Most of these lack clarity and have a variable meaning depending on mission, clientele, regional differences in policies, licensing and funding
- Creates confusion in trying to match appropriate living environment to individual client needs

"Recovery Residence"

A broad term describing a safe, sober, healthy living environment that promotes individual recovery from alcohol and other drugs as well as associated problems.

At a minimum, recovery residences provide peer recovery support and facilitate abstinence-based, long-term recovery.

Recovery residences have published policies on relapse sanctions and re-admission criteria.

Civil Rights Act (1964)

Civil Rights Act (1964)

Fair Housing Act of 1968 (FHA) (42 U.S.C. § § 3601-3631)

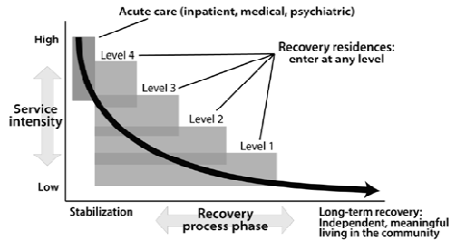
[aka Title VIII of the Civil Rights Act (1968)]

- Passed by Congress and signed by President Lyndon Johnson one week after the assassination of Martin Luther King, Jr
- Regulates housing-related transactions including advertising, mortgage-lending, homeowner's insurance and zoning
- Designed to protect against/outlaw discrimination and "restrictive covenants" (to refuse to sell to/rent to/negotiate with a person in a protected class)
- Outlawed "blockbusting" – the practice of frightening homeowners by telling them that people in a protected class are moving in and property values will decline as a result
- Judges can award actual damages, equitable relief, and attorney's fees to the prevailing party (but not punitive damages)

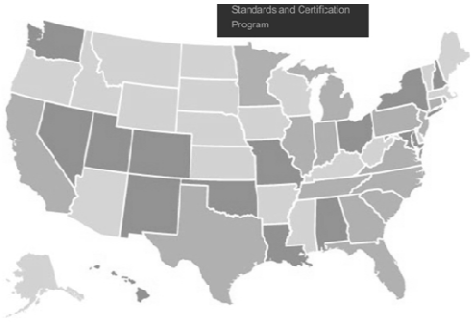
NARR
National Association of Recovery Residences

The mission of the National Association of Recovery Residences (NARR) is to create, evaluate and improve standards and measures of quality for all levels of recovery residences. NARR provides a forum for exchanging ideas to include developing uniformity of nomenclature for our field, problem solving and advocacy. We assist existing regional associations in their growth, and foster the development of recovery residence associations where none exist. NARR is the national resource for recovery residence providers seeking standards, protocols for ethical practice, training, and state of the art information pertaining to all levels of residential recovery operations.

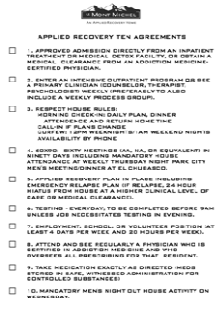
Recovery Residences in the Continuum of Recovery



NARR Affiliates



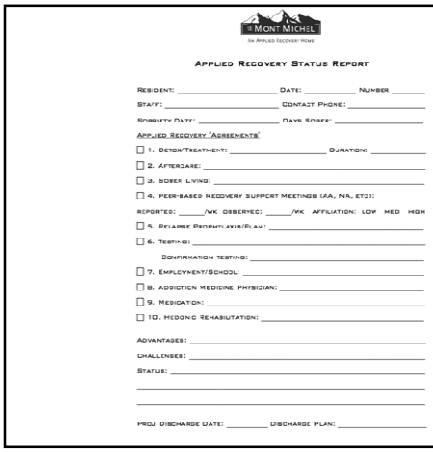
Le Mont "Agreements"



APPLIED RECOVERY TEN AGREEMENTS

1. APPROVED ADMISSION DIRECTLY FROM AN INPATIENT TREATMENT OR MEDICAL DETOX FACILITY, OR OBTAIN A MEDICAL CLEARANCE FROM AN ADDICTION MEDICINE CERTIFIED PHYSICIAN.
2. ENTER AN INTENSIVE OUTPATIENT PROGRAM OR SEE A PRIMARY CLINICIAN (COUNSELOR, THERAPIST, PSYCHOLOGIST) WEEKLY (PREFERABLY TO ALSO INCLUDE A WEEKLY PROCESS GROUP).
3. RESPECT HOUSE RULES: MORNING CHECK-IN/ DAILY PLAN, DINNER ATTENDANCE AND RETURN HOME TIME CALL-IN IF PLANS CHANGE (CURFEW) FOR RESIDENTS W/ AM WEEKEND NIGHTS AVAILABILITY BY PHONE
4. GOING 90/90 MEETINGS (AA, NA, OR EQUIVALENT) IN NINETY DAYS INCLUDING MANDATORY HOUSE ATTENDANCE AT WEEKLY THURSDAY NIGHT PARK CITY MEN'S MEETING/DINNER AT EL CHUEASCO.
5. ATTEND RESIDENT PLAN IN PLACE INCLUDING EMERGENCY RELAPSE PLAN OF RELAPSE, 24 HOUR HIATUS FROM HOUSE AT A HIGHER CLINICAL LEVEL OF CARE OR MEDICAL CLEARANCE.
6. TESTING - RANDOM, TO BE COMPLETED BEFORE 9AM UNLESS JOB NECESSITATES TESTING IN EVENING.
7. EMPLOYMENT, SCHOOL OR VOLUNTEER POSITION AT LEAST 4 DAYS PER WEEK AND 20 HOURS PER WEEK).
8. ATTEND AND SEE REGULARLY A PHYSICIAN WHO IS CERTIFIED IN ADDICTION MEDICINE AND WHO OVERSEES ALL PRESCRIBING FOR THAT RESIDENT.
9. TAKE MEDICATION EXACTLY AS DIRECTED. MEDS STORED IN SAFE, WITNESSED ADMINISTRATION FOR CONTROLLED SUBSTANCES)
10. MANDATORY MENS NIGHT OUT HOUSE ACTIVITY ON

1. Foundation in treatment
   - safe admission protocol
2. Clinical oversight/monitoring
3. Sober living environment
4. Peer-based sobriety support
   - Thurs night PC Men's mtg/dinner
5. Relapse contingency plan
6. Daily testing
7. Employment / School
8. ASAM/ABAM Physician
9. Medication (as necessary)
   - safe handling
10. Tues night "Men's Night Out"



APPLIED RECOVERY STATUS REPORT

RESIDENT: _____ DATE: _____ NUMBER _____
STAFF: _____ CONTACT PHONE: _____
SOBRIETY DATE: _____ DAYS SOBER: _____
APPLIED RECOVERY 'AGREEMENTS'
☐ 1. DETOX/TREATMENT: _____ DURATION: _____
☐ 2. AFTERCARE: _____
☐ 3. SOBER LIVING: _____
☐ 4. PEER-BASED RECOVERY SUPPORT MEETINGS (AA, NA, ETC):
REPORTED: _____/WK OBSERVED: _____/WK AFFILIATION: LOW MED HIGH
☐ 5. RELAPSE PREVENTION/EMERG PLAN: _____
☐ 6. TESTING: _____
CONFIRMATION TESTING: _____
☐ 7. EMPLOYMENT/SCHOOL: _____
☐ 8. ADDICTION MEDICINE PHYSICIAN: _____
☐ 9. MEDICATION: _____
☐ 10. MEDONC REHABILITATION: _____
ADVANTAGES: _____
CHALLENGES: _____
STATUS: _____
PROJ DISCHARGE DATE: _____ DISCHARGE PLAN: _____

Population served

- Time Period: 2 years
- Number of Residents: 39 men
- Range of Duration of Stay: 14 to 267 days
- Average Length of Stay: 98.0 days
- Age distribution: x = 28.9, bimodal
- 34.4% stayed longer than originally intended
- 40.6% stayed shorter than originally intended
- 23% re-admission rate (half for relapse, half for relapse prevention)

Performance data:

- Total Delivery: 3619 resident-days
- Days Positive Test: 81 days (2.3%)
- Days Intoxicated: 83 (2.3%)
- Relapsed post-Tx: 48.7%
- Readmit Rate: 23%
- **In contact/Doing well: 46.9%**
- **In contact/improved: 25.0%**

Population served

- Time Period: 4 years
- Number of Residents: 91 men
- Range of Duration of Stay: 14 to 267 days
- Average Length of Stay: 95.0 days
- Age distribution: x = 29.0 years
- 30% stayed longer than originally intended
- 45% stayed shorter than originally intended
- 19% re-admission rate (half for relapse, half for relapse prevention)

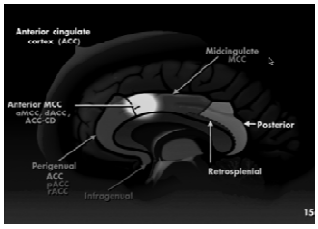
Performance data:

- Total Delivery: 7,619 resident-days
- Days Positive Test: 137 days (1.8%)
- Days Intoxicated: 149 (2.0%)
- Relapsed post-Tx: 49%
- Readmit Rate: 19%
- **In contact/Doing well: 35%**
- **In contact/improved: 30%**

Tips for the First Year of Recovery

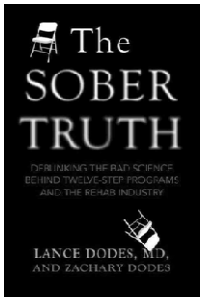
1. Residential Treatment (Inpatient or Residential Day)
2. Immediate Aftercare following Residential Treatment
3. Sober Living Environment
4. Ninety A.A. meetings in ninety days (90x90)

damage to Anterior Cingulate Cortex (ACC)



- Just as with OFC damage: causes a loss of a crucial behavioral guidance system
- Inflexibility/Inability to respond to errors in the past with regard to rewards/punishments
- Deficits in social responding due to decreased awareness of social cues

Lance Dodes, MD



Lance Dodes, MD

- AA doesn't work
- No evidence to support AA
- "Surrender" and "powerless" concepts are harmful
- People with SUD have "character defects"
- Denial is the central feature of addiction
- SUD is a symptom of underlying, unresolved emotional problems
- Individual counseling is the best treatment

Does A. A. work?

- A.A. confers short- and long-term therapeutic benefits on a par with professional interventions
- A.A. decreases health-care costs
- A.A. improves treatment outcomes
- A.A. attendance during the first three months of sobriety was associated with recovery-related benefits one year later over and above treatment effects.

Kelly JF, Hoeppner B, Stout RL, Pagano M (2011). Determining the relative importance of the mechanisms of behavior change within Alcoholics Anonymous: a multiple mediator analysis. Addiction, 107, 289-299.

AA, abstinence and anger

- AA singles out anger as a high-risk emotion for relapse
- "If we were to live, we had to be free of anger." (p. 66, B.B of A.A.)
- Detailed, column-based worksheet to help document, analyze, and remediate anger
- Increased anger = increased drinking intensity
- AA attendance, alcohol abstinence, and anger are … UNRELATED

Kelly JF, Stout RL, Tonigan JS, Magill M (2010) Negative affect, relapse, and Alcoholics Anonymous (A.A.): does A.A. work by reducing anger? Journal of Studies on Alcohol and Drugs.

AA Mediating Variables

1. Depression (decreased)
2. Spirituality
3. Self-efficacy in coping with negative affect
4. Self-efficacy in coping with high-risk social situations
5. Social network: number of pro-abstinence members
6. Social network: number of pro-drinking members

AA: using NON - Rational Concepts

- ***TRIBE*** *("the fellowship of alcoholics")*
- ***MYTH*** *(Bill's Story, etc.)*
- ***RITUAL*** *("what it was like, what happened, and…")*
- ***FAITH*** *("Keep coming back, it works")*
- ***HOPE*** *(The Promises)*
- ***ACCEPTANCE*** *("…the answer to all my problems")*

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4. Ninety A.A. meetings in ninety days (90x90)
5. Automatic Relapse Plan

Relapse Plan

- "DO NOT PANIC!"
- Have an Automatic Relapse Plan
  (previously agreed upon/no discussion)
- Detox (incapacitation)
- Return to Treatment (residential vs. outpatient)
- Review Testing Protocol
- Validate success

Characteristics of Physician Health Programs

- Self-Reporting ("safe harbor") or Workplace Referral
- Comprehensive Evaluation
- Signed Contract specifying in detail the elements of care and monitoring as well as consequences for non-compliance Contingency Mgmt
- Inpatient Tx for 60–90 days (69%)
- Intensive Outpatient Tx (31%)
- Agonist pharmacotherapy rare (but 1/3 received antidep/antianx Rx)
- Facilitated groups (Caduceus meetings) Monitoring/Prof Norms
- Return to work Professional Norms
- Drug testing (random call-in, approx. four times/month) Monitoring
- Required participation in abstinence-based peer support groups (AA, NA, other) Social Norms
- Monitoring for five years, reporting to board of progress **Monitoring**
- Family, colleague, employer involvement Professional Norms
- Rapid response to relapse, usually clinical reevaluation & intensification of care (but not administrative discharge) **Contingency Mgmt**

(Dupont RL, McLellan AT, Skipper GE. How are physicians treated? A national survey of physician health programs. J Sub Abuse Tx (2009) 37:1-7.

Tips for the First Year of Recovery

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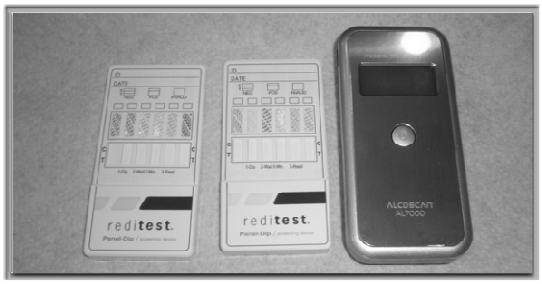
5. Automatic Relapse Plan
6. Testing

a good testing bathroom



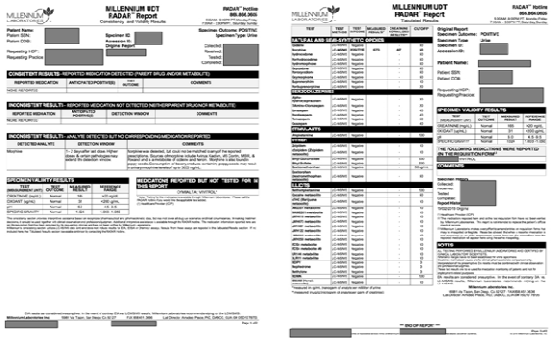
Immunoassay & Breathalyser

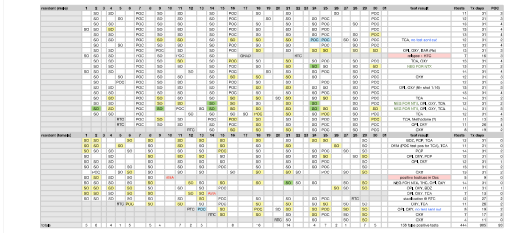
•daily screening tests

Two Kinds of Tests in Addiction Medicine

SCREENING Tests	CONFIRMATION Tests
Immunoassay	GC/MS
Very sensitive	Very, very specific
Not very specific	Not very sensitive
Not an insignificant false positive rate	Forensic standard

LC/MS/MS Confirmation





NEW ROADS (TRANS) - DRUG TESTING (JANUARY 2014)

985 resident-days of care provided (5,4% increase over December 2013)

444 tested days — 44,8% of days provided
93 Point-of-Care (POC) tests performed — 21%
351 Send-Out (SO) tests performed — 79%

0 positive results — 158/444 false pos rate (35,6%)
(100,0% negative days by testing)

Tips for the First Year of Recovery

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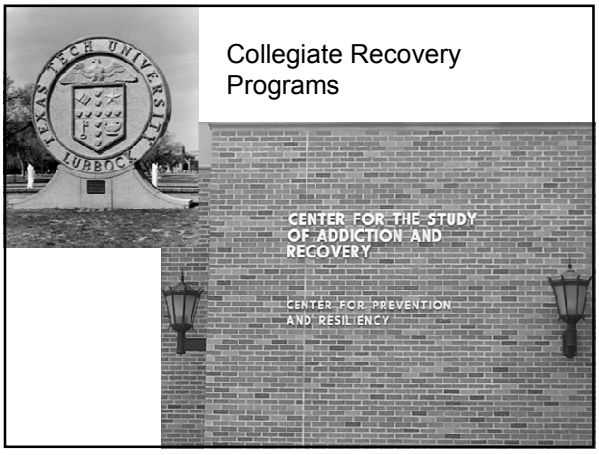
4. Ninety A.A. meetings in ninety days (90x90)
5. Automatic Relapse Plan
6. Testing
7. Rapid but Gradual Return to Duty

HIMS Program



Collegiate Recovery Programs

Recovery Schools

Tips for the First Year of Recovery

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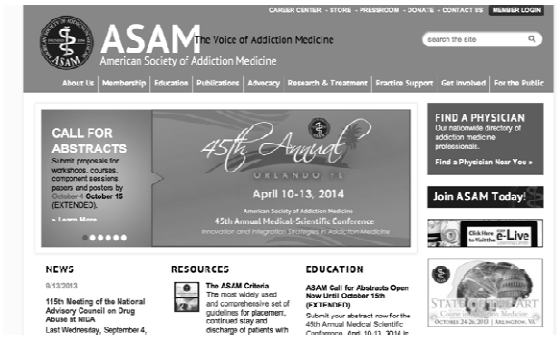
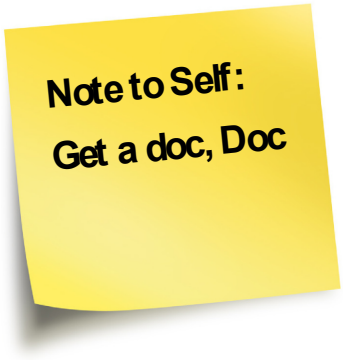
3. Sober Living Environment
4. Ninety A.A. meetings in ninety days (90x90)
5. Automatic Relapse Plan
6. Testing
7. Rapid but Gradual Return to Duty
8. Addictionologist

Addictionologists

- Certified by the American Society of Addiction Medicine
- Understand the special needs of recovering patients
- Not likely to make stupid mistakes
- Doctors who *LIKE* addicts, Offices that are safe places
- www.asam.org www.abam.net
- www.csam-asam.org





Tips for the First Year of Recovery

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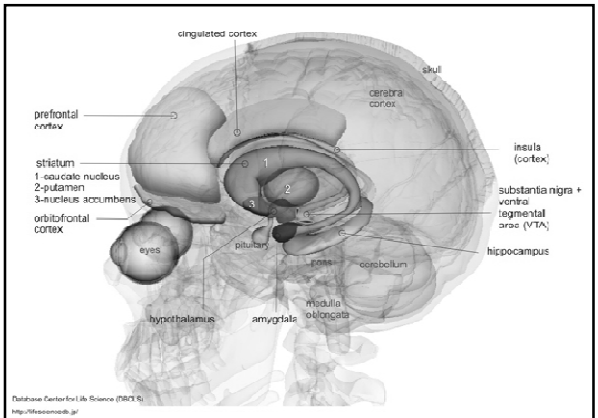
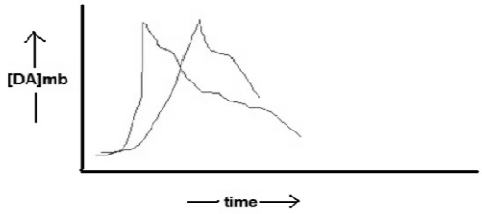
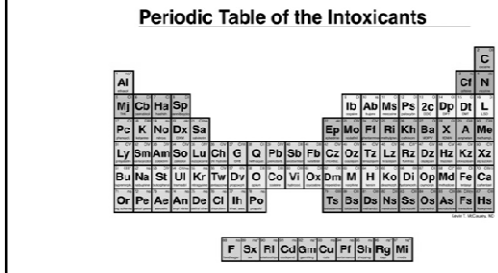
7. Rapid but Gradual Return to Duty
8. Addictionologist
9. Medication

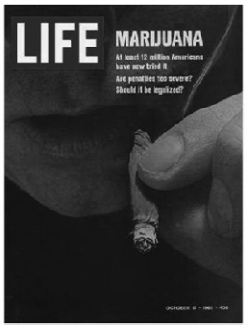


The Full Spectrum of Addiction

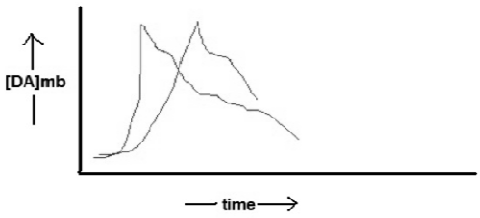
- Alcohol & Sedative/Hypnotics
- Opiates/Opioids
- Cocaine
- Amphetamines
- Entactogens (MDMA)
- Entheogens/Hallucinogens
- Dissociants (PCP, Ketamine)
- Cannabinoids
- Inhalants
- Nicotine
- Caffeine
- Anabolic-Androgenic
- Food (Bulimia & Binge Eating)
- Sex
- Relationships
- Other People ("Codependency," Control)
- Gambling
- Cults
- Performance ("Work-aholism")
- Collection/Accumulation ("Shop-aholism")
- Rage/Violence
- Media/Entertainment

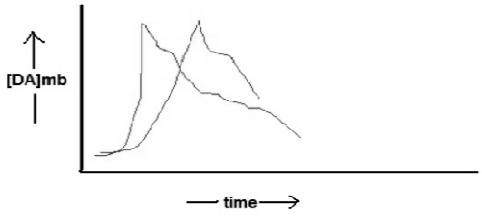


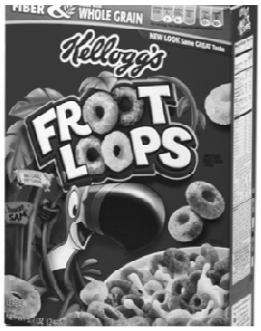



LIFE
MARIJUANA


of "dabbing"
continues to grow.

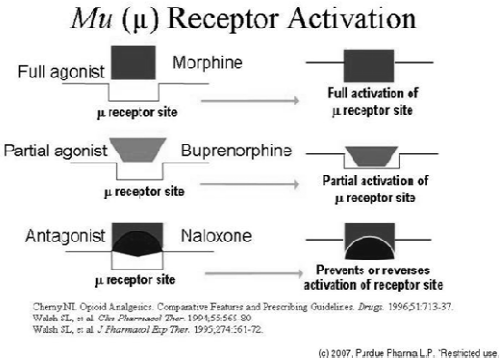

[DA]mb
time





Note to Self:

You need to quit



Extended-release Naltrexone (NTX)

- Federally approved for the treatment of alcohol dependence since 2006
- Federally approved for the treatment of opioid dependence since 2010
- No diversion or abuse potential
- Not a controlled substance

Naltrexone depot

Extended-release injectable suspension of a

Mu-opioid receptor antagonist (blocker) to …

1. prevent relapse to opioid dependence after detox
2. treat alcohol dependence

Administered monthly

To be effective, must be used with recovery programs or counseling

New Roads RTC as of today (27AUG)

- 37 individuals
- 26/37 with DOC of RxOpioids/Heroin
  70%
- 14/37 with DOC of IV Heroin
  40%
- 5/37 with DOC of EtOH
  14%
- 4/37 with DOC of "other"
  11%
- 2/37 with little/no SUD Hx

Risks

Physicians have an obligation to educate patients who are treated with naltrexone-containing products about mortality risks that exist during and after leaving treatment for opioid dependence.

Behavioral health providers may play a role in reminding patients of these risks.

It is recommended that providers and patients develop a relapse prevention plan that includes strategies to decrease the risks if relapse occurs.

(SAMHSA)

Risks

- Precipitation of severe withdrawal symptoms
- Accidental overdose & Overdose-related deaths in those who:
  - used opioids at or near the end of the 1-month dosing interval
  - used opioids after missing a dose of depot naltrexone
  - attempted to overcome the opioid

Adverse Effects

- Injection site reactions: pain, hardness, swelling, blisters, abscesses, tissue necrosis
- Hepatotoxicity: abnormal liver enzyme levels
- Symptoms of "cold"
- Insomnia
- Toothache

Reversal in emergencies

- Difficult
- Recommend delaying elective surgeries, or using regional or non-opioid analgesia
- Can reverse naltrexone blockade with higher doses of opioid, but risk of respiratory depression
- Suggest wearing medical alert jewelry or carrying a disclosure card

People most likely to benefit

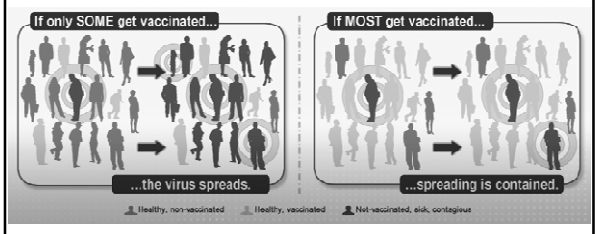
- Hard to determine/no definitive research available, but …
- People at high risk for relapse after detox
- People under high stress
- People with a shorter or less severe history of dependence
- People who need to demonstrate to overseeing authorities that their risk of use is low
- People who have not had success with methadone or buprenorphine, or those want to stop agonist therapy
- People with a high level of motivation for abstinence
- Adolescents or young adults who cannot obtain agonist treatment

New Roads AMA Discharge Prevention Committee

- Three main reasons for AMA treatment departures
  1. Severe craving + means to depart treatment
  2. Peer-related discharge (inside or outside facility)
  3. Parental assistance (usually following pt demands)
- Concern that opioid use among precipitously departing N/R clients could result in dangerous or fatal overdose
- Concern for "contagious" nature of AMA departure/relapse
- Strong advisory from SAMHSA of benefits of depot injection of extended-release natrexone (NTX) for

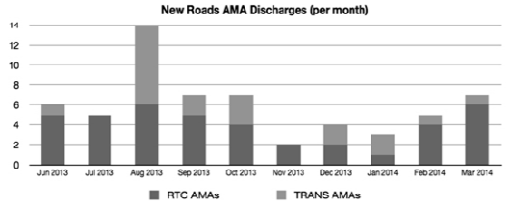
"Herd" Immunity

- Indirect protection from an "infection" of susceptible members of a population, and the protection of the population as a whole, which is brought about by the presence of immune individuals

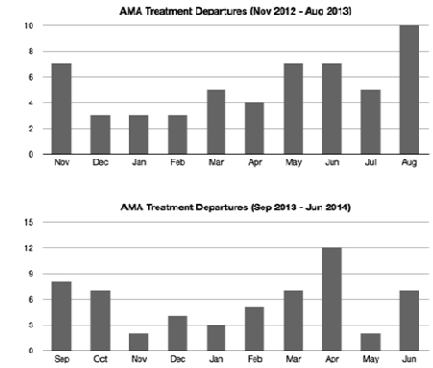


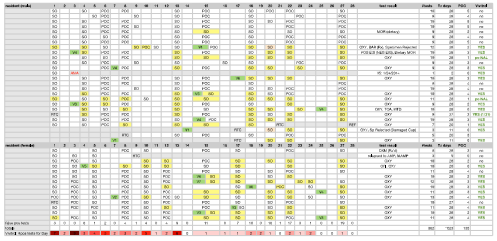
New Roads NTX Policy

- Explain what "right of informed consent is to all N/R clients"
- Educate N/R/ clients on benefits and risks of NTX; encourage questions and open discussion
- N/R Medical Director will review each patient's medical history to assess eligibility for NTX and provide counseling
- Offer similar NTX education to parents and referents
- Offer NTX to all eligible N/R clients with Alcohol and Opioid Use Disorders on arrival at RTC and following seven to ten day abstinence from opioids
- Facilitate insurance payment for NTX; For those N/R clients unable the out-of-pocket cost of NTX, N/R will pay for monthly placement of NTX
- Continue to advocate for placement of NTX throughout the RTC stay
- Require NTX placement in all eligible clients entering the TRANS Program
- Facilitate placement at an appropriate equivalent TRANS Program



Those N/R residents who refused NTX were SIX TIMES more likely to leave treatment AMA compared to those who accepted NTX



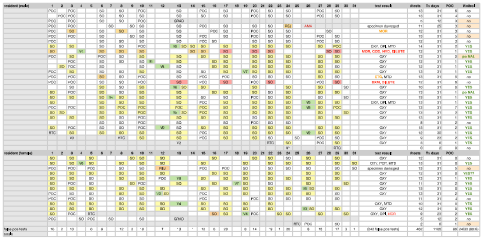


NEW ROADS (TRANS) - DRUG TESTING (FEBRUARY 2014)

1023 resident-days of care provided (3,8% increase (crude rate) over Jan 2014; 15,1% increase (adjusted rate) over Jan 2014)

382 tested days — 35,4% of days provided
- 130 Point-of-Care (POC) tests performed — 37,3%
- 227 Send-Out (SO) tests performed — 62,7%

0 positive results — 119/382 false pos rate (33%)
(100% negative days by testing)

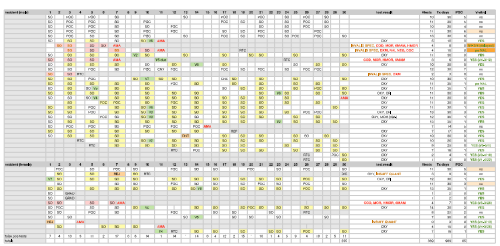


NEW ROADS (TRANS) - DRUG TESTING (MARCH 2014)

1165 resident-days of care provided (14% increase over Feb 2014)

462 tested days — 39,7% of days provided
- 86 Point-of-Care (POC) tests performed — 18,6%
- 376 Send-Out (SO) tests performed — 81,4%

9 positive results — 242/462 false pos rate (52%)
(98,1% negative days by testing)

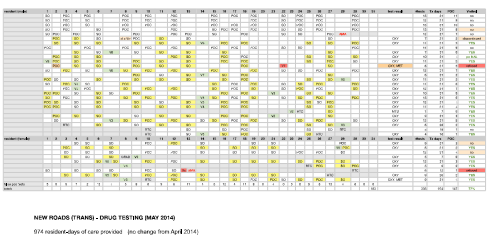


NEW ROADS (TRANS) - DRUG TESTING (APRIL 2014)

969 resident-days of care provided (17% decrease over Mar 2014)

369 tested days — 38,1% of days provided
- 65 Point-of-Care (POC) tests performed — 17,6%
- 304 Send-Out (SO) tests performed — 82,4%

17 positive results (in 5 residents) — 209/369 false pos rate (56%)
(95,4% negative days by testing)

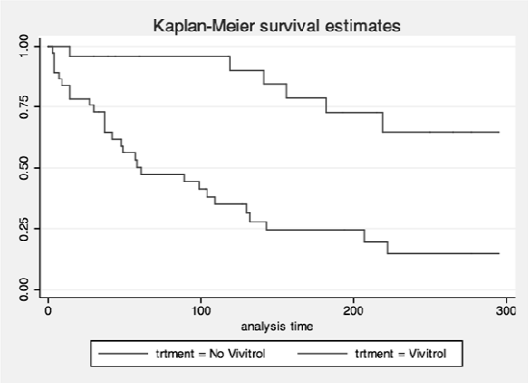


NEW ROADS (TRANS) - DRUG TESTING (MAY 2014)

974 resident-days of care provided (no change from April 2014)

336 tested days — 34,5% of days provided
- 147 Point-of-Care (POC) tests performed — 43,8%
- 189 Send-Out (SO) tests performed — 56,3%

0 positive results — 183/336 false pos rate (55%)
(100% negative days by testing)



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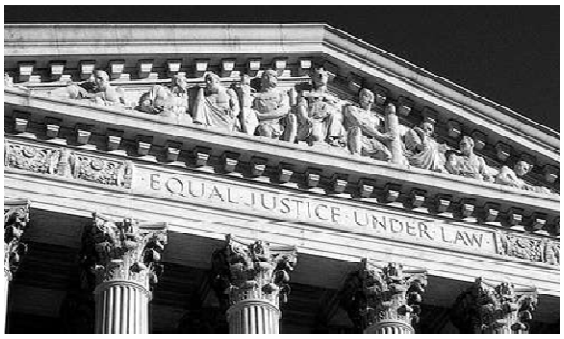
2. Immediate Aftercare following Residential Treatment
3. Sober Living Environment
4. Ninety A.A. meetings in ninety days (90x90)
5. Automatic Relapse Plan
6. Testing
7. Rapid but Gradual Return to Duty
8. Addictionologist
9. Medication
10. Fun! (Hedonic Rehabilitation/Pleasure



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