

Substance Abuse Treatment: The Next Generation



Richard A. Rawson, Ph.D, Professor
Semel Institute for Neuroscience and Human Behavior
David Geffen School of Medicine
University of California at Los Angeles
www.uclaisap.org
rrowson@mednet.ucla.edu




Prescription Drugs: The Next Challenge



- Good morning Dr. Rawson:
- I just finished reading David Sheff's book "Beautiful Boy" and while reading it, found 16 Percocet tablets hidden in my 19 year old son's drawer.
- I have been drug testing him for 1 ½ years now and he still takes Percocet. I think my drug testing him has greatly reduced his usage, but it has not stopped totally.
- My husband and I are united in our desire to help our son. Our decision today is to take him privately to a drug addiction specialist who can legally prescribe short-term suboxone medication and give him drug counseling.
- In your opinion, are we doing the right thing or should we go for in-patient treatment without medication? He is also a beautiful, smart, loving, boy and we will do anything necessary to help him.
- Thanks for reading this email.



- Hi Rick Rawson,
We haven't spoken in 35 years and I apologize for contacting you to ask for your help.
- I recently learned that my beautiful 22 year old daughter has been addicted to heroin for the past four years. She did a wonderful job hiding this from her family and I only found out when I received a phone call from the police who were attempting to find her as she was implicated in a major Rutland County drug bust. She recently completed 40 days in a drug treatment facility and is involved in an intensive outpatient program while she awaits legal procedures. She is motivated and excited to have a chance to have a clean and sober life, but I know we are only at the beginning of a very long road.
- So why am I bothering you with all this? Last night I was in a parent support group, one started by XXXXXX and his wife after they lost a child to a heroin overdose, and I learned about the work that you have done with addiction. I guess I just needed to reach out to old friend and share my story. I would appreciate a point in the right direction as I help my daughter navigate a course through this swamp.

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The Bad News...



Teens "getting high" using Rx or OTC drugs

Generation "Pharming"





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"Generation Rx"

- ✓ Today's teens are more likely to have abused Rx and OTC drugs than most illicit drugs.
- ✓ Every day 2,500 teens 12 -17 try a painkiller for the 1st time.
- ✓ Rx drugs are the "drugs of choice" for 12 & 13 yr olds.



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Epidemiology of Rx and OTC Drug Misuse Among Youth

UCLA PTTC

New Landscape of Drug Abuse among Teens

Marijuana	8.6 million
Prescription Medicine	4.5 million
Cough Medicine	2.4 million
Crack/Cocaine	2.4 million
Ecstasy	1.9 million
Meth	1.9 million
LSD	1.3 million
Heroin	1.1 million
Ketamine	1 million
GHB	1 million

UCLA NSDUH 2006; MIE 2006

Commonly Misused Rx Drugs

Classified in 3 classes

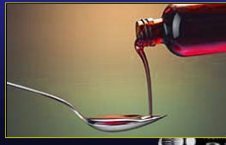
- Opiates: pain-killers
 - Ex) Vicodin, Oxycontin, Tylenol Codeine
- CNS Depressants (Sedatives/Tranquilizers) treat anxiety and sleep disorders
 - Ex) Xanax, Ativan, Valium, Soma
- Stimulants: ADHD, weight loss
 - Ex) Aderall, Ritalin, Concerta, Dexedrine, Fastin

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OTC Medicine Abuse

•Dextromethorphan DXM (narcotic codeine) is the active ingredient in over 100 cold/cough remedies.

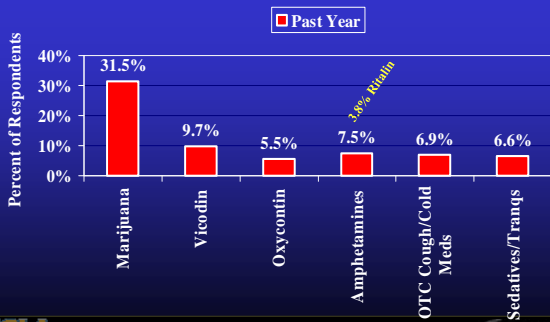
•Found in tablets, capsules, gel caps, lozenges & syrups, teens discovered: using mass quantities of DXM-containing products get them “high”.



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Top 5 Drugs Used by 12th Graders

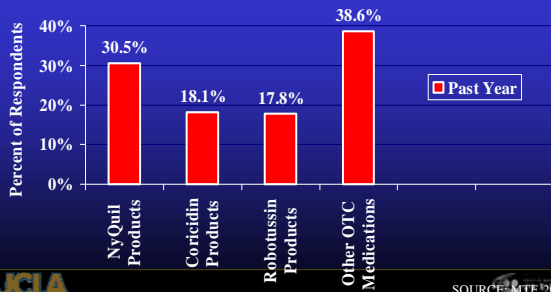


SOURCE: MITF, 2006

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OTC Medications Misused by Teens

3 million misused OTC ever and 1 million in past year



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SOURCE: MITF, 2006

Use of Rx drugs by CA Adolescents



Taking painkillers without a prescription:

- ✓ 15% of 11th graders
- ✓ 9% of 9th graders
- ✓ 4% of 7th graders

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California Student Survey 05/06

Recent Research: Why Teens Use?

- When teens abuse Rx drugs, they often characterize their use as “responsible” or “controlled” (Friedman, 2006).
- Teens admit to abusing Rx medicine for reasons other than getting high, including to relieve pain or anxiety, to sleep better, just to experiment, to help with concentration or to increase alertness. (Boyd, McCabe, Cranford & young, 2006).
- More than 1/3 of teens say they feel pressure to abuse Rx drugs and say using these drugs to get high is an important part of fitting in with their friends. (Seventeen, 2006).

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California Student Survey 05/06

Teens Don't Understand the Risks & Effects of Abusing Rx and OTC Medicines

Over 50% believe that abusing these medicines to get high is **NOT risky...**



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Join Together, 2006

Combinations and Risk

- Opiates, benzodiazepines and alcohol all reduce respiration (breathing rate).
 - OD risk comes from reduction of respiration to levels that cannot sustain heart and brain activity.
 - Narcan (naloxone) can reverse opiate component.
 - CPR and 911

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Side effects can be Lethal if...



- Combining Rx drugs & OTC medications.
- Taking Rx and OTC meds with alcohol.
- Using Rx and OTC with other illicit drugs.



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Parents Don't Know About Dangers & Risks


- Only 8% of parents are aware of Rx & OTC abuse.
- 75% don't talk to their kids about the problem.
- Unaware that the drug supply can come from their own home.



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Los Angeles



- Sales sharply increased for **oxycodone** (84%) and **hydrocodone** (47%) between 2001 and 2005.
- **Codeine, hydrocodone, and morphine** were distributed in the **largest amounts** when compared with the grams of other opiates distributed .

UCLA CEWG, 2006

Pain Management

- Increasing focus for past decade
- Historical under-prescribing of opioids
 - Fear of creating addiction
 - Fear of legal sanctions
- Liberal use of opioids for end of life comfort E.g.: terminal cancer
- Treatment of Acute Pain Syndromes

UCLA CEWG, 2006

Model Policy for the Use of Controlled Substances for the Treatment of Pain*

- Pain management is integral to medical practice
- Opioids may be necessary
- Physicians will not be sanctioned for prescribing opioids for legitimate medical purposes
- Under-treatment of pain will be considered a deviation from the standard of care
- Use of opioids for purposes other than analgesia threaten individuals and society
- Physicians have a responsibility to minimize abuse and diversion

UCLA Federation of State Medical Boards, 2003

The Dilemma

- Need to accurately diagnose disease and provide effective analgesia
- Some illnesses have no diagnostic test, but are frequently cited as reasons for pain syndromes needing medication treatment(s)
 - Headache
 - Low back pain
 - Pelvic pain
 - Arthritis
 - Fibromyalgia
 - Chronic Fatigue Syndrome
- Has contributed to misuse of pain pills and addiction

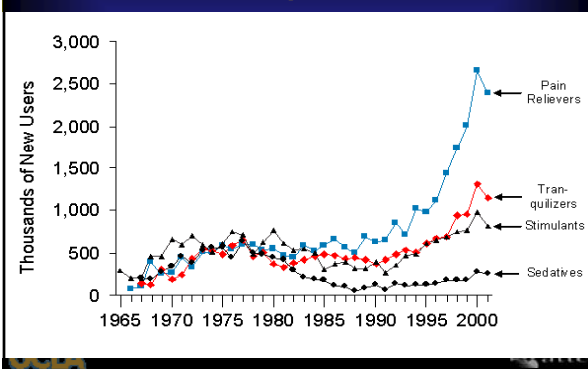
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Number of New Non-medical Users of Therapeutics



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Highest Prevalence in Young Adults

- Lifetime Nonmedical Use of Prescription Opioids (2006):
 - Pain Relievers:

Age 12-17	Age 18-25	Age 26 +
10.4%	25.5%	12%
 - OxyContin:

Age 12-17	Age 18-25	Age 26 +
1.3%	5.1%	1.1%
- Between 2004 and 2005, the proportion of teens who thought there was a great risk in trying prescription pain relievers fell from 48% to 44%

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Rates of Prescription Narcotic Abuse

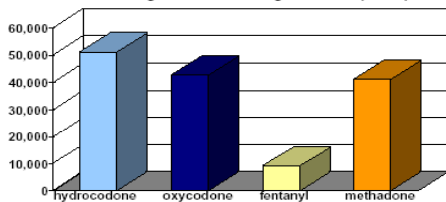
- Nonmedical use of prescription narcotics:
- 2006: 33.5 million (13.6%) over age 12
- 1.64 million prescription narcotic users meet diagnostic criteria for opioid abuse or dependence (second only to marijuana (4.17 million))
- Hydrocodone (Vicodin) is most widely prescribed drug in US.

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DAWN Emergency Department Visits, 2005

Source: Drug Abuse Warning Network (NIDA)



Methadone ranked 3rd among all opioid analgesics, 4th among all controlled pharmaceuticals, and 8th among all controlled substances.

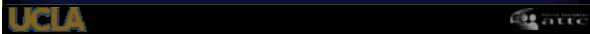
Source: Methadone Mortality
– A Reassessment: Report of the Meeting
and Follow-up Activities 7-20-07

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Fatal Drug Poisoning

- Between 1999 and 2002, the number of opioid analgesic poisonings on death certificates rose 91.2% *
 - During this time period, poisoning from opioid analgesics surpassed both cocaine and heroin poisoning as the most frequent type of drug poisoning found on death certificates in the U.S.*
 - In Florida 2007, 3 times more deaths from prescription drugs than from all illicit drugs combined. **
- * Source: Paulozzi, L.J., Budnitz, D.S., Xi, Y. 2006. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiology and Drug Safety 15, 613-7.
** New York Times, June 14, 2008.

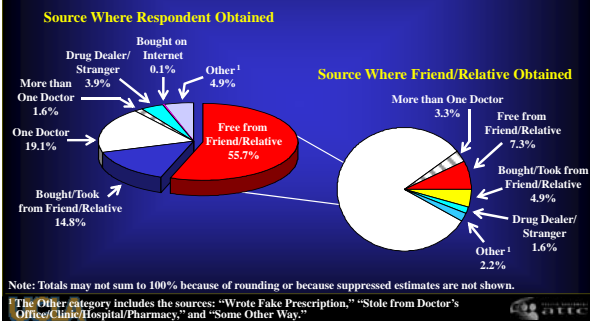


Etiology of Prescription Opioid Abuse

- Access
- Theft of prescription narcotics (shipments of drugs/robberies of pharmacies, diversion)
- Prescription of opioids

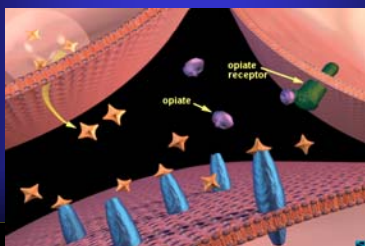


Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2006



Etiology of Prescription Opioid Abuse: Neurobiology of Addiction

- Opiates bind to opiate receptors in the nucleus accumbens: increased dopamine release



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Consequences of Opioid Use and Abuse

- Tolerance
- Abuse/Dependence (addiction)
- Fluctuating blood levels:
- Intoxication: altered mental state, euphoria, sleepiness, poor attention
- Alternating with
- Withdrawal: nausea, muscle/joint pain, shakiness, anxiety, restlessness, craving

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Prescription Opioid Addiction: Treatment Settings

- Substance abuse treatment modalities:
- Combination of medication treatment plus psychosocial/psychotherapeutic interventions:
 - Inpatient (usually medical withdrawal)
 - Outpatient and residential
 - Intensive outpatient
 - Individual/Group Drug Counseling
 - +/- Maintenance pharmacotherapy

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Prescription Opioid Addiction and Pain

- How best to medically treat this population?
 - Methadone: A full opiate
 - Long time, high dose addiction.
 - Buprenorphine: A partial opiate
 - May be most effective alternative, available from certified MDs.
 - Medication duration (days/weeks) can be varied on treatment based on response
 - Clonidine and symptomatic medication
 - Less effective, but a non-opiate. Fewer restrictions and no abuse potential.

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Treatment for Prescription Opioid Dependence

- Medical Withdrawal
- Antagonist Treatment
 - Naltrexone
- Agonist Treatment
 - Methadone
 - Buprenorphine (buprenorphine/naloxone combo tablet)
- Psychotherapies
 - Relapse Prevention (Cognitive Behavioral Treatment)
 - Motivational Enhancement
 - 12-Step Facilitation

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Conclusions



- Prescription drug abuse is serious public health problem in the U.S.
- Best practices for such patients currently under study
- Clinical experience says that buprenorphine is effective to treat heroin addiction; effectiveness for prescription opioid dependence under study
- Question of length of treatment remains an issue (for all addiction pharmacotherapies)

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Is Addiction a Chronic Disease?

 PACIFIC ENVIRONMENTAL 





Long-term Consequences of Narcotics Addiction

Christine Grella, Yih-Ing Hser
and M. Douglas Anglin

UCLA Integrated Substance Abuse Programs


Supported by the National Institute on Drug Abuse (DA09169, K02DA00139 to Hser, and K05DA00146 to Anglin)




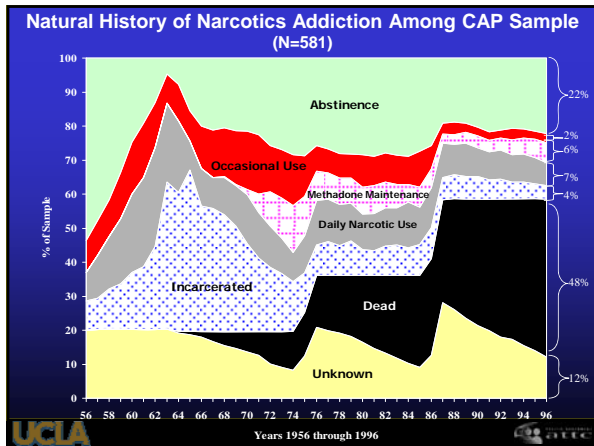


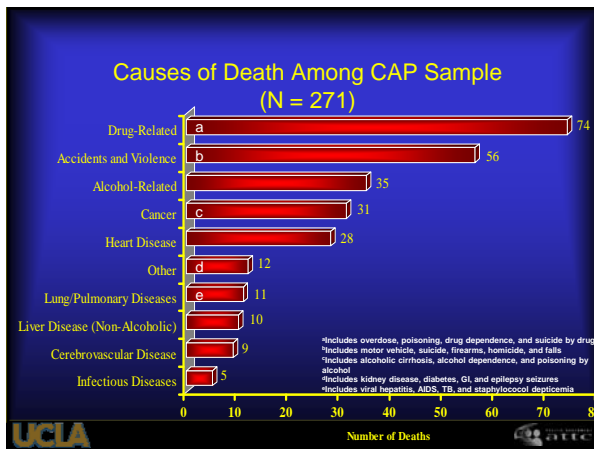
California Civil Addict Program Follow-up

- A cohort of 581 male heroin addicts admitted to the California Civil Addict Program (CAP) in 1962-64 has been followed-up and interviewed over more than 30 years
- The CAP was the only major publicly-funded drug treatment program available in California in the 1960s
- The CAP provided a combination of inpatient and outpatient drug treatment to narcotics-dependent criminal offenders committed under court order









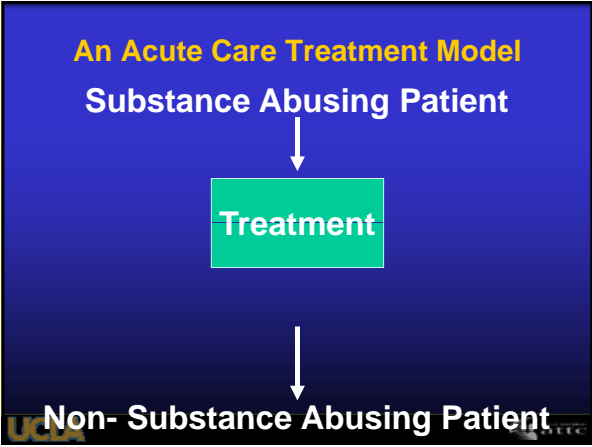
Conclusions

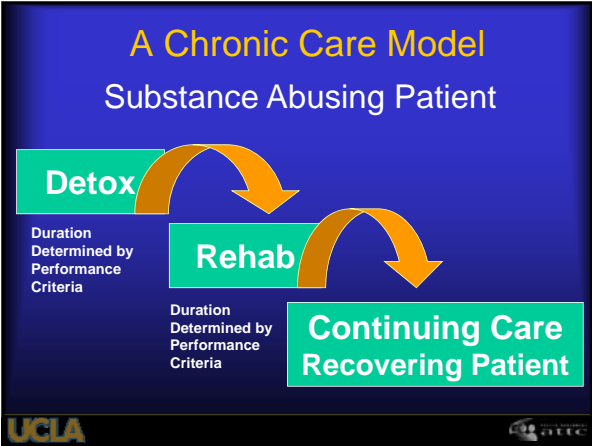
- The study findings show the long-term effects of heroin addiction in terms of morbidity, mortality, criminal justice system involvement, and overall level of functioning.
- Compared to a US Population sample, heroin addiction reduces life expectancy by an average of 18 years.

Other long term outcome studies

- **Alcohol:** Vallent: multiple studies reporting a majority of alcoholics who enter treatment experience multiple relapses and re-treatments with about 30-50% achieving stable abstinence.
- **Cocaine;** Hser: Ten year follow-up of cocaine dependent patients in treatment indicates that fewer than 50% achieve extended periods of abstinence. Most reenter treatment multiple times.
- **Methamphetamine:** Marinelli-Casey 3 year follow up indicates of a cohort of 600 MA dependent individuals about 50% continue to use MA at a moderate or severe level during the 3 year post treatment 36 month period.

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Effective Strategies During Treatment Engagement

- Medications
- Motivational Interviewing
- Voucher-based Techniques
- Counseling to Promote Transfer to Long Term Care
- NIATx Strategies



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Effective Strategies in Rehabilitation Phase

- Therapies
 - Cognitive Behavioral
 - Motivational Enhancement Treatment
 - Behavioral Couples Therapy
 - Multi Systemic Family Therapy
 - 12-Step Facilitation
 - Individual Drug Counseling



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Effective Strategies in Rehabilitation Phase

- Interventions/Services
 - Clinical Case Management
 - CRAFT
 - 12-Step Facilitation
 - Voucher Reinforcement
 - Matrix Model Treatment
- Medications
 - Alcohol (Naltrexone, Disulfiram, Citalopram)
 - Opiates (Naltrexone, Methadone, Buprenorphine)



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Types of Continuing Care

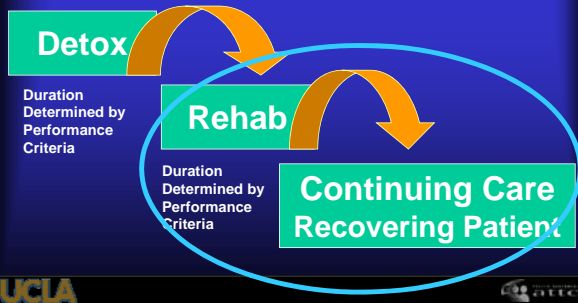
- Self/mutual help programs
- Medications
- Traditional counseling visits
- Home visits
- Recovery “check-ups”
 - Specialty care-based
 - Primary care-based
- Telephone-based protocols
 - Monitoring
 - Monitoring and counseling
- Other stuff



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A Chronic Care Model



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Considerations with the Continuum


- Sober housing plus outpatient care vs residential treatment
- Integration of medication (including methadone) into the continuum
- Determining when to transfer levels of care
- Remember, sometimes treatment intensity needs to be increased, not just decreased

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Do you really use the full continuum of care?


- If you work in a residential treatment program, when was the last time, you referred a client into an intensive outpatient program (other than your own) after they completed residential care?
- If you work in an NTP, when was the last time you ever referred a patient into a residential treatment program, if they were doing poorly on methadone?
- If you work in an outpatient treatment program, when was the last time you ever put one of your relapsing opiate addicts on buprenorphine, while they were in your outpatient program?

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Is Aftercare an After thought


- What % of your clients who “complete” your treatment program participate in your aftercare?

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Lessons from Chronic Illness:

1. Medications and discussions of feelings can relieve symptoms but.... behavioral change is necessary for sustained benefit

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Lessons from Chronic Illness:

2. Treatment effects usually don't last very long after treatment stops.





Lessons from Chronic Illness:

3. Patients who are not in some form of treatment or monitoring are at elevated risk for relapse.





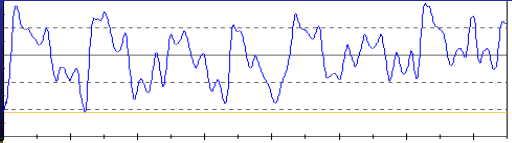
Lessons from Chronic Illness:

- Multiple Episodes of Acute Care IS NOT Chronic Care
- Patient Retention is Critical
- Monitoring in Treatment is Essential

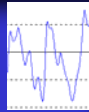


Measuring Program Performance: A Key to a Successful Continuum of Care

Program Performance: What is it and how will we measure it?

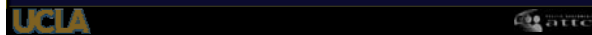


Measuring Program Performance



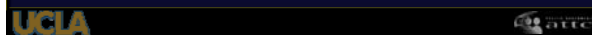
Definition:

AOD treatment program performance is evaluated by measuring the extent to which the clients of a treatment program achieve specific benchmarks.



How will California will use data to improve program performance?

- CalOMS data collection system that gives policymakers the ability to measure the performance of AOD programs.
- The CalOMS data can be used to:
 - 1. monitor treatment program performance
 - 2. improve the management of treatment services.
 - 3. establish performance benchmarks
 - 4. recognize better/poorer performing programs.
 - 5. rewarding performance of better performing programs and targeting technical assistance to struggling programs.



Measuring the Performance of California's AOD Treatment Programs

- Some specific issues for discussion
 - Which CalOMS data elements, alone and in combination, provide meaningful performance and outcomes measures?
 - Are there data elements that need to be added to CalOMS data set to optimally measure performance and outcomes?
 - Is it possible to operationally define “treatment success” and how can this issue be communicated to the public and policy makers?

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Possible Performance Measures

- Treatment Initiation (within 14 days)
- Treatment Engagement (within 30 days)
- Treatment Retention (90 days).
- Continuity of Care Measures (% of clients who successfully transfer to next level of care.
- Treatment “Completion”
- NIATx Measures
- Measures for different modalities may be different (eg. NTPs vs short term residential)

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Power of Performance Measurement


- There is a link between effective performance measurement and successful service results.
- Performance measurement is a necessary first step to using data to evaluate and improve program performance.
- There is no “one fits all” approach to using performance measures for different services.

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Methods to promote effective performance improvement

- Proceed in a step wise manner:
 - Monitor performance; give programs feedback
 - Manage; set benchmarks; acknowledge good performance and technical assistance for others
 - Improve performance: provide technical assistance.
 - Contract for performance; reimburse programs based on performance

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Methods to promote effective performance improvement

- Encourage staff to understand and use program data.
- Promote evidence-based practices as part of TA and training activity
- Employ process improvement techniques (eg. NIATx)
- Flexibility: allow room for innovation
- Don't forget to recognize and reward good performance

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Strategies for improving AOD program performance

- Reduce staff turnover
- Increase staff knowledge of other forms of care to promote a “system of care” rather than isolated programs
- Increase staff knowledge and use of evidence-based practices
- Employ process improvement (NIATx)

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Thank You

rrowson@mednet.ucla.edu
www.uclaisap.org
www.methinsideout.com