NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

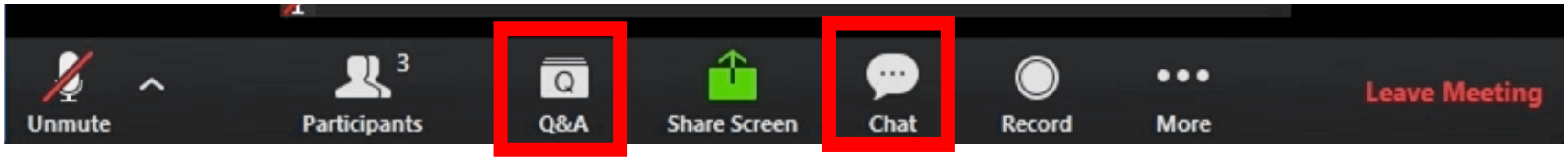
Responding to the Opioid Overdose Epidemic

Wednesday, August 26, 2020

2:00 – 3:00pm ET

Center of Excellence for Integrated Health Solutions
Funded by Substance Abuse and Mental Health Services Administration
Operated by the National Council for Behavioral Health

How to Ask a Question/Make a Comment



Type in a **question** in the **Q&A box**
Type in a **comment** in the **chat box**

Both are located at the bottom of your screen.
We'll answer as many questions as we can at the end of the presentation.

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

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Substance Abuse and Mental Health Services Administration

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Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)

Poll #2: What best describes your organization? (check all that apply)

- Behavioral Health Provider
- Primary Care Provider
- Mental Health Provider
- Substance Abuse Provider
- Other (specify in chat box)

Poll #3: What's your organization's experience with integrating primary care and behavioral health?

- We're interested and researching what's involved
- We have a referral relationship where we can send patients
- We have a co-located with another organization to provide services
- We offer both primary care and behavioral health services within our organization
- We offer integrated primary care and behavioral health using a defined model (e.g., Collaborative Care Model, Primary Care Behavioral Health Model)

Today's Presenters

Aaron Williams, MA
Integrated Care Consultant
Center of Excellence for Integrated Health Solutions
National Council for Behavioral Health

Tom Hill, MSW
Senior Advisor
Practice Improvement & Consulting
National Council for Behavioral Health

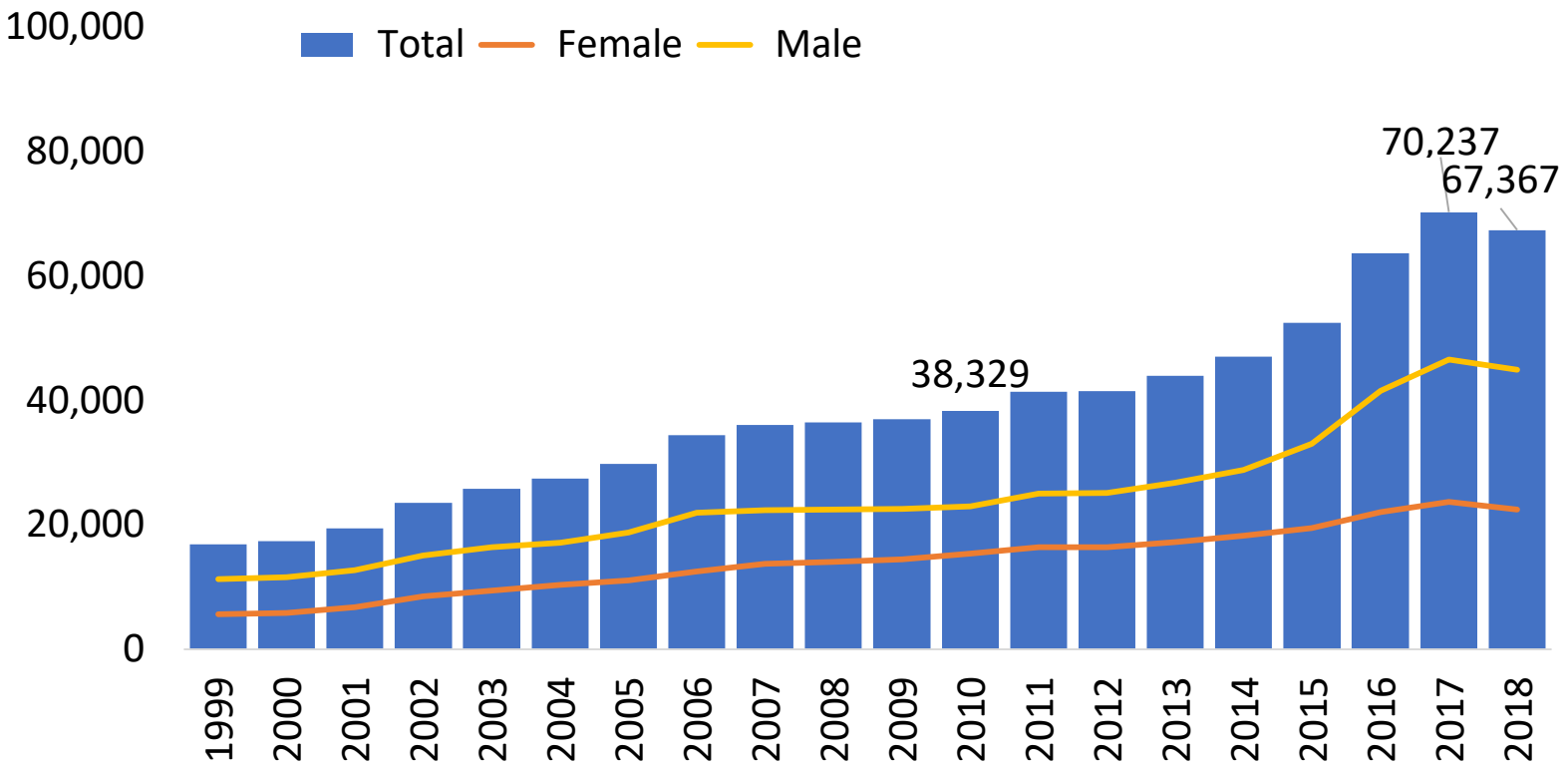
What has the opioid crisis looked like in your community?

"**It is terrible, a true epidemic.** Here in Maryland, specifically, Baltimore City, **I don't think it could look worse.** We have one of the highest overdose fatality rates of any city in the United States." – *Mosaic (MD)*

"It continues to increasingly grow **especially among adolescents**." – *Western MH Center (MN)*

"**The opioid crisis in our community is not often discussed** in the news or often discussed by others outside of people that work in this field. **We have heard staff mention their experiences in the community and just being out shopping or at the gas station an having to use Naloxone."** – *Abbe Center for BH (IA)*

Figure 1. National Drug Overdose Deaths Number Among All Ages, by Gender, 1999-2018



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2018 on CDC WONDER Online Database, released January, 2019

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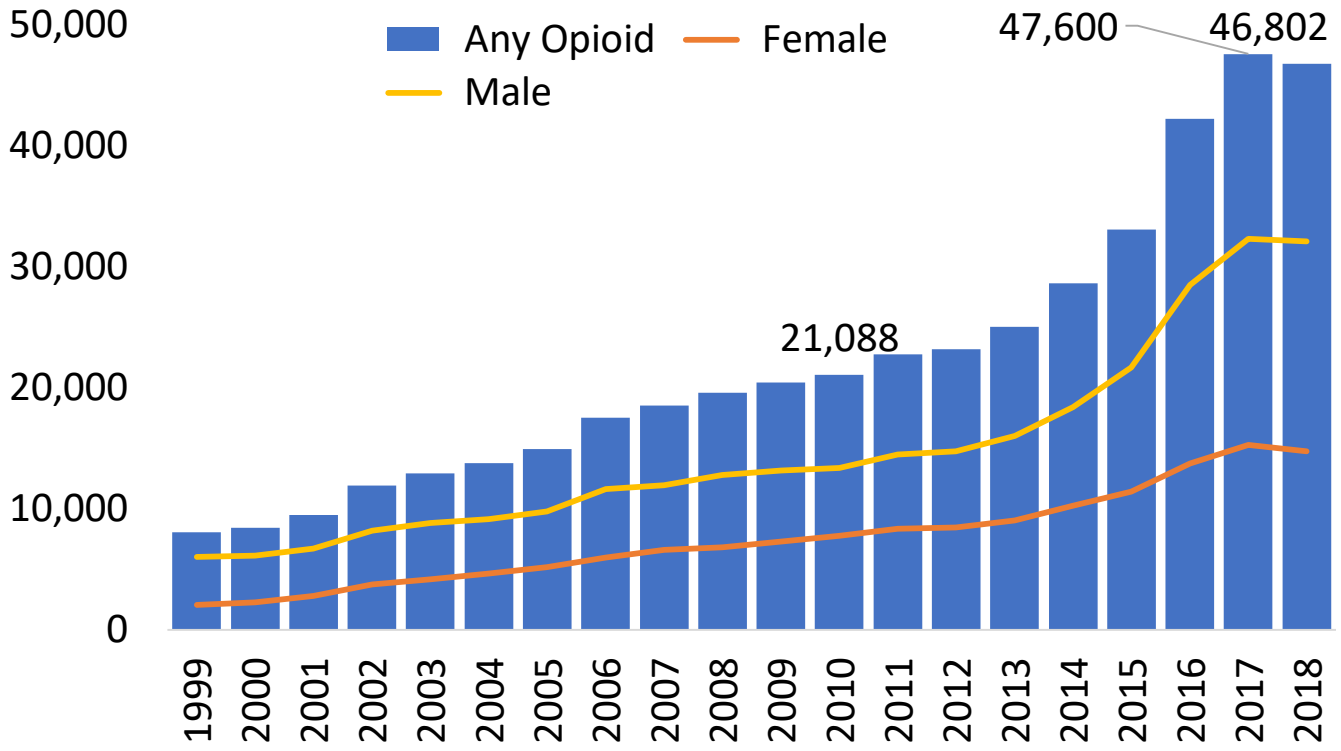
Figure 3. National Drug Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2018



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2018 on CDC WONDER Online Database, released January, 2019

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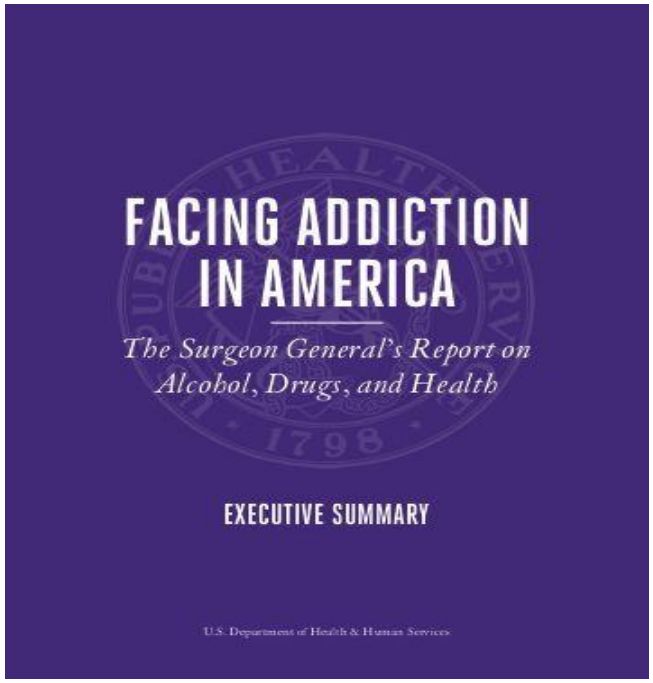
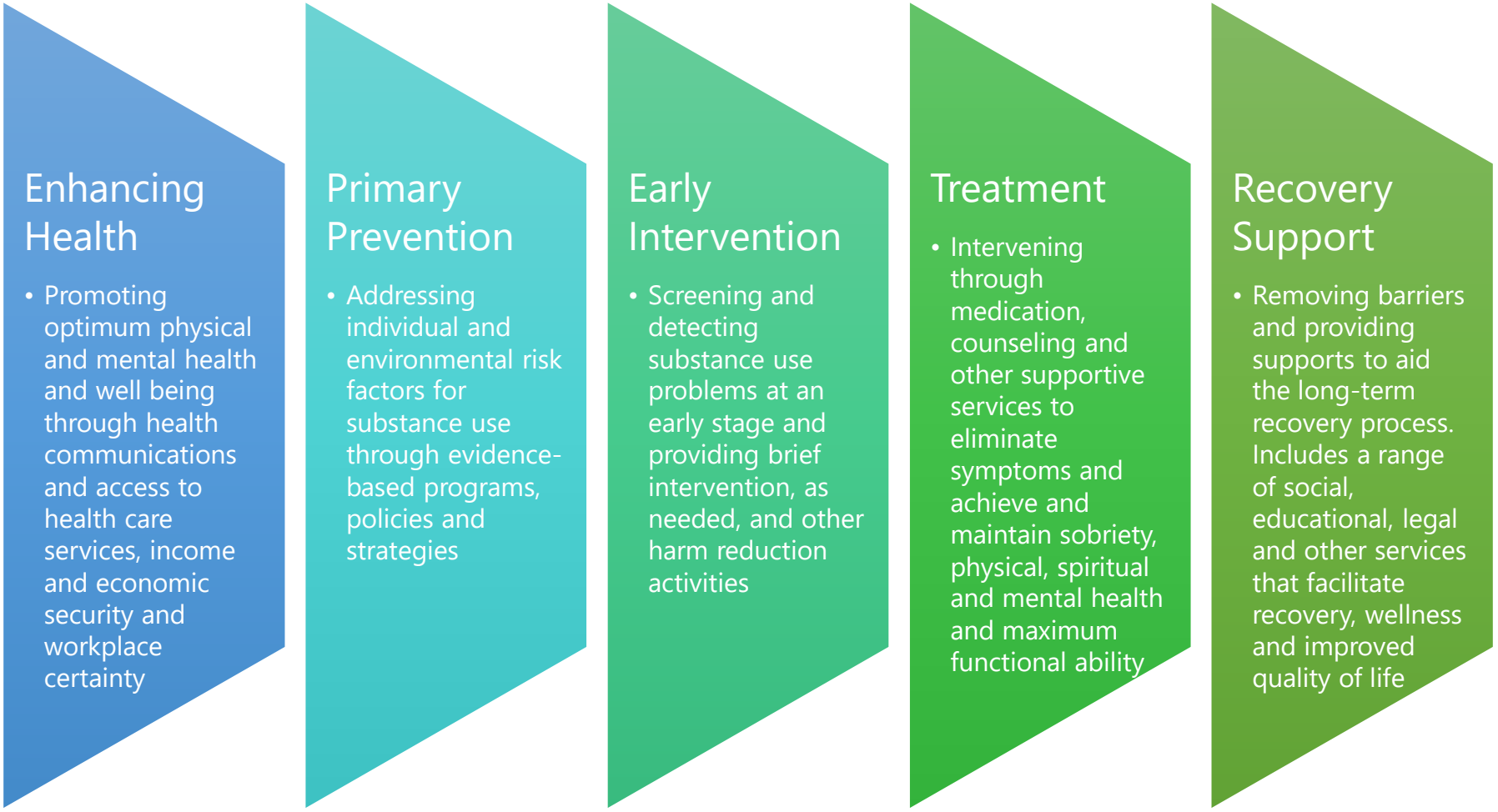
Changing the Addiction Paradigm



- Moving from addiction as a moral failing to a chronic brain disorder
- Moving from criminal justice approaches to public health strategies
- Dropping old, stigmatizing language and developing new terminology
- Developing a science base that informs policy and practice
- Addressing substance use, misuse, and disorders across a full continuum and the lifespan: *prevention, treatment, recovery management*

Substance Use Disorder Treatment Continuum of Care



U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

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Medication-assisted Treatment (MAT)

"We have highly effective medications, when combined with other behavioral supports, that are the standard of care for the treatment of opiate addiction."

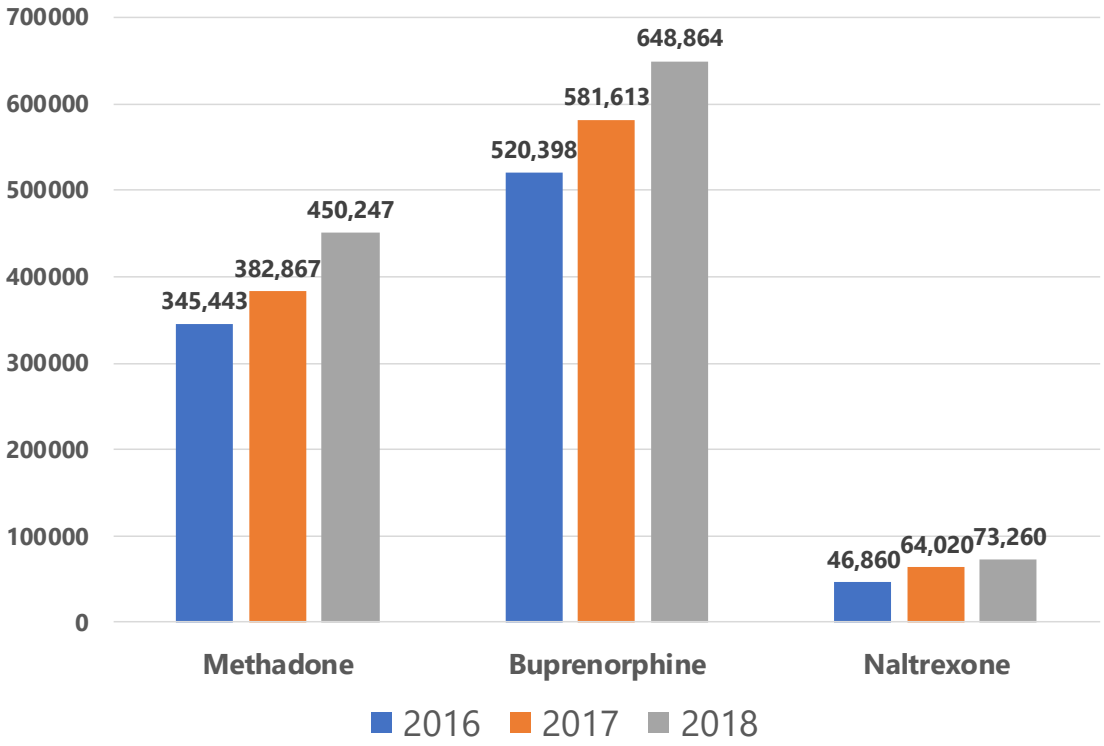
- *Michael Botticelli, Former Director ONDCP*

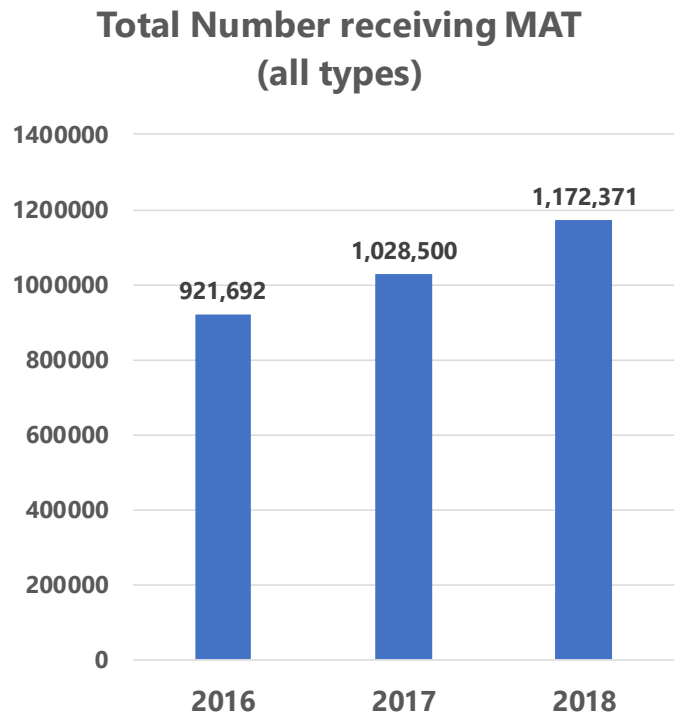
Medications/Pharmacotherapy for Opioid Use Disorder

Medication	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
Methadone	Daily	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	SAMHSA-certified outpatient treatment programs (OTPs) dispense methadone for daily administration either on site or, for stable patients, at home.
Buprenorphine	Daily for table or film (also alternative dosing regimens)	Oral tablet or film is dissolved under the tongue	Physicians, NPs and PAs with a federal waiver. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.
Probuphine (buprenorphine implant)	Every 6 months	Subdermal	
Sublocade (buprenorphine injection)	Monthly	Injection (for moderate to severe OUD)	
Naltrexone	Monthly	Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional.	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.

Adapted from Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SMA14-4892R)

Number of Individuals Receiving MAT for Opioid Use Disorder





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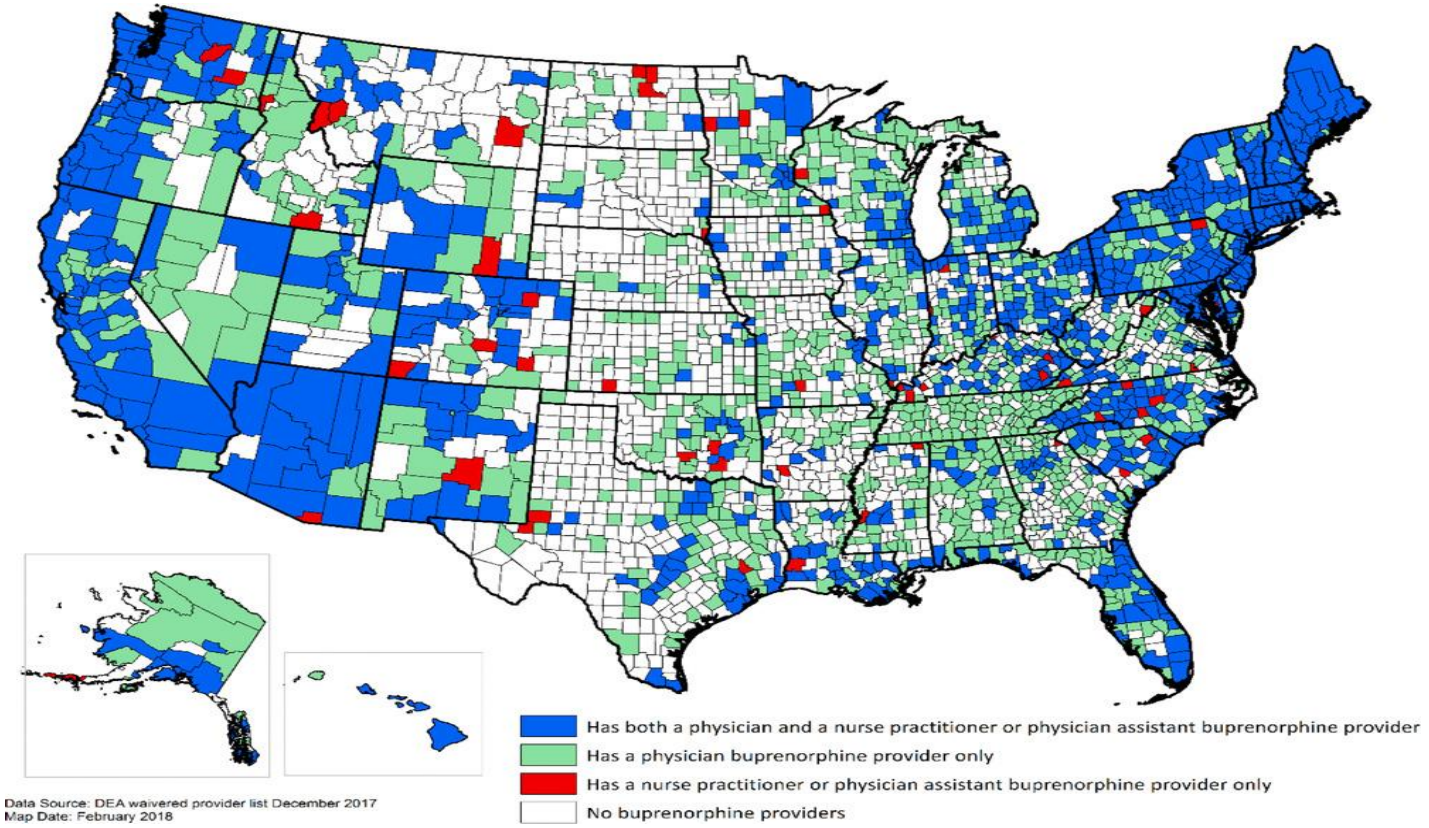
Geographic Distribution of Providers With a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update



The Journal of Rural Health, Volume: 35, Issue: 1, Pages: 108-112, First published: 20 June 2018, DOI: (10.1111/jrh.12307)

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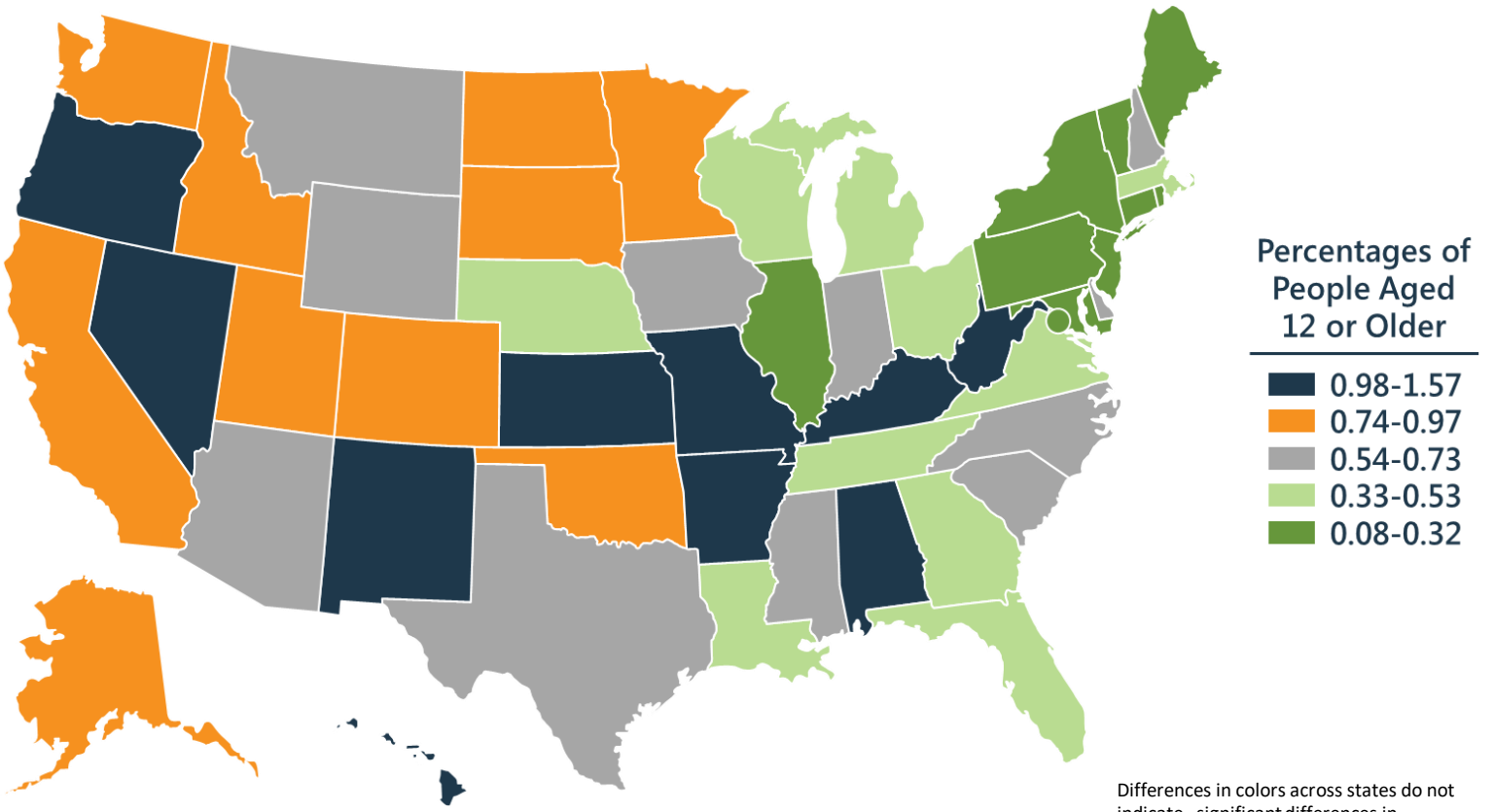
Methamphetamine Use by State

PAST YEAR, POOLED 2016-2017 NSDUH, 12+



Differences in colors across states do not indicate significant differences in estimates.

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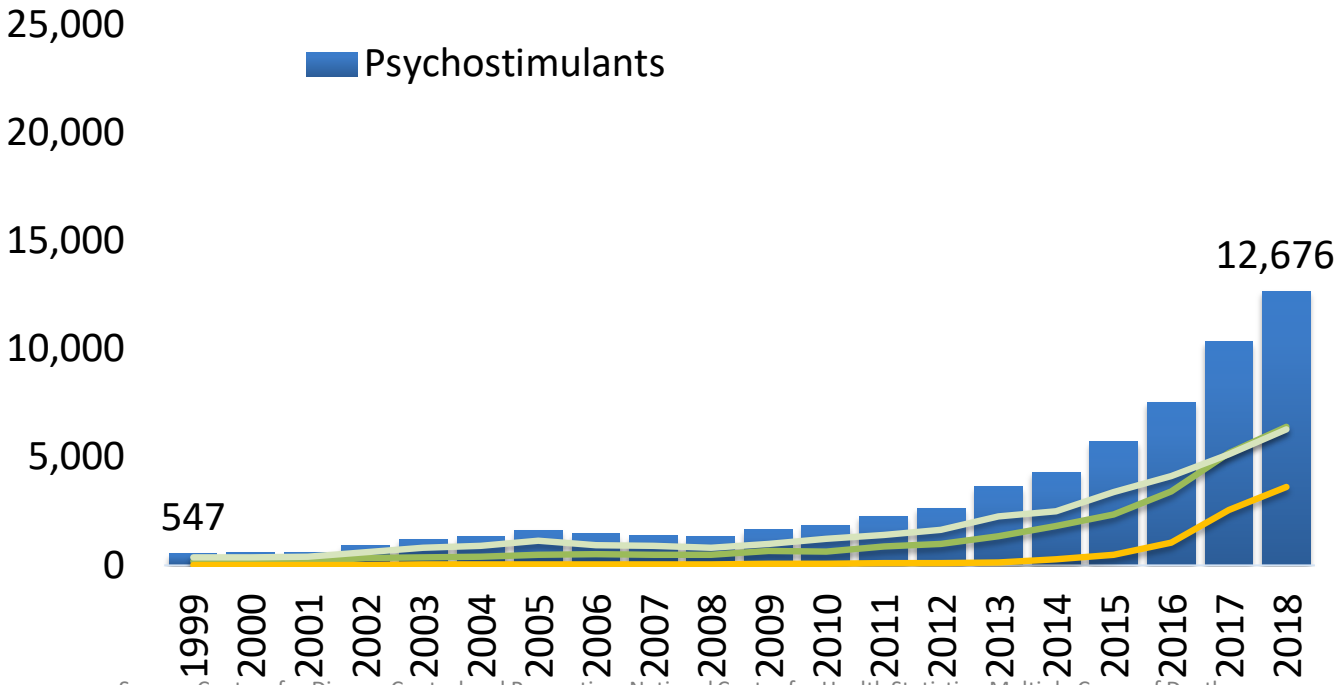
National Drug Overdose Deaths Involving Psychostimulants With Abuse Potential (Including Methamphetamine), by Opioid Involvement
Number Among All Ages, 1999-2018



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2018 on CDC WONDER Online Database, released January, 2019

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Methamphetamine Facts

- According to the 2017 National Survey on Drug Use and Health (NSDUH), approximately 1.6 million people (0.6 percent of the population) reported using methamphetamine in the past year.
- The average age of new methamphetamine users in 2016 was 23.3 years old.

- An estimated 964,000 people aged 12 or older (about 0.4 percent of the population) had a methamphetamine use disorder in 2017.

- This number is significantly higher than the 684,000 people who reported having methamphetamine use disorder in 2016.

Short-term Effects of Methamphetamine Use

Taking even small amounts of methamphetamine can result in many of the same health effects as those of other stimulants, such as cocaine or amphetamines. These include:

- **increased wakefulness and physical activity**
- **decreased appetite**
- **faster breathing**
- **rapid and/or irregular heartbeat**
- **increased blood pressure and body temperature**

https://www.drugabuse.gov/publications/drugfacts/methamphetamine

Long-term Consequences of Methamphetamine Use*

Long-term methamphetamine use has many other negative consequences, including:

- extreme weight loss
- addiction
- severe dental problems ("meth mouth")
- intense itching, leading to skin sores from scratching
- anxiety
- changes in brain structure and function
- confusion
- memory loss
- sleeping problems
- violent behavior
- *paranoia*—extreme and unreasonable distrust of others
- *hallucinations*—sensations and images that seem real though they aren't

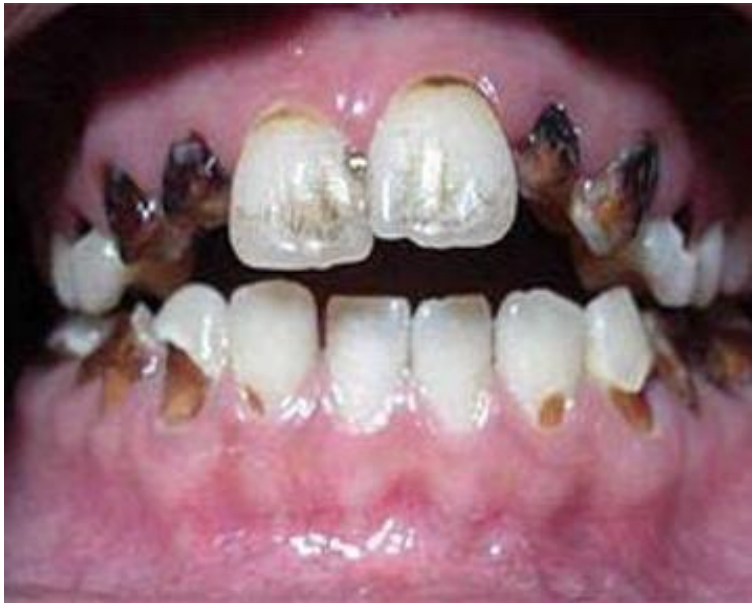

Photo by Dozenist(link is external)/CC BY-SA

*https://www.drugabuse.gov/publications/drugfacts/methamphetamine

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Treatments for Methamphetamine Use

Contingency management

Interventions which provides tangible incentives in exchange for engaging in treatment and maintaining abstinence, have also been shown to be effective.

The Matrix Model(Cognitive Therapy)

A 16-week comprehensive behavioral treatment approach that combines behavioral therapy, family education, individual counseling, 12-step support, drug testing, and encouragement for non-drug-related activities—has been shown to be effective in reducing methamphetamine misuse.

Medications

There are currently no FDA approved medications that counteract the specific effects of methamphetamine

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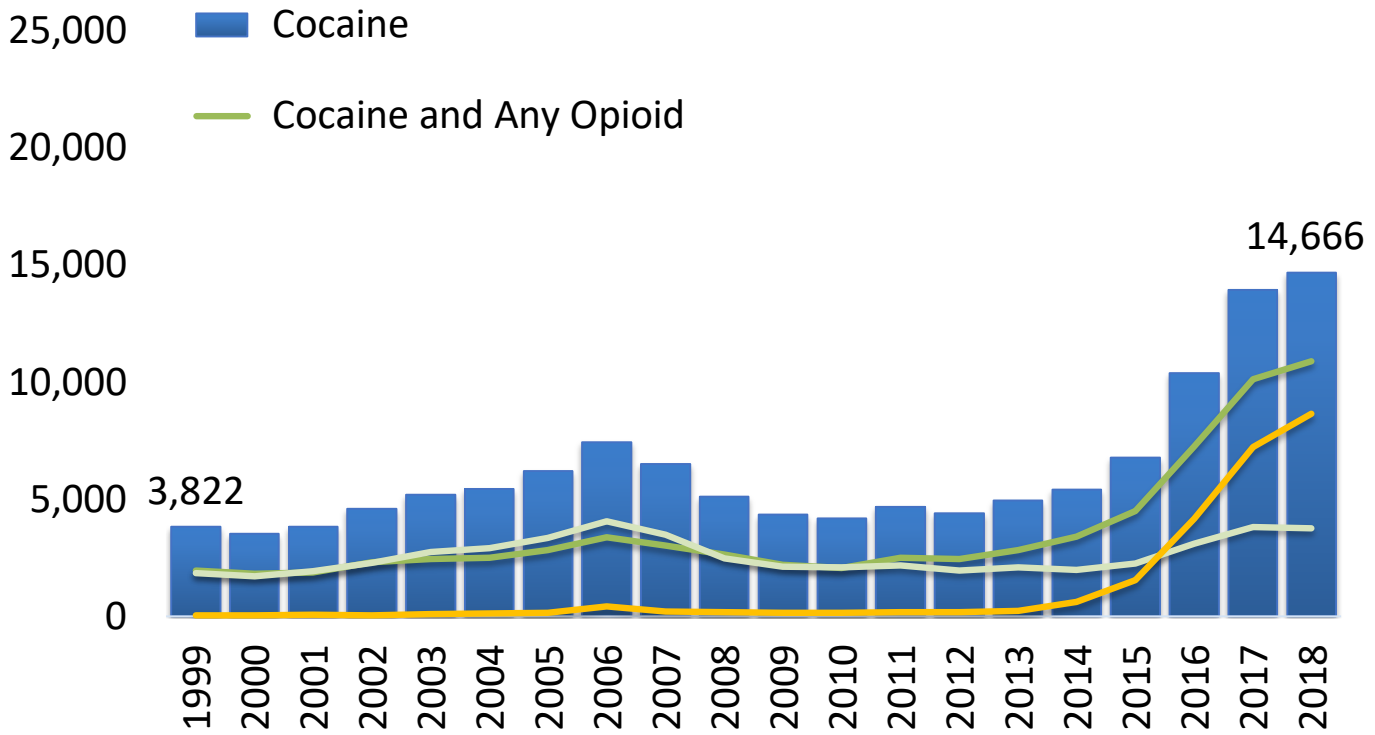
Cocaine Use Facts

- Cocaine is a type of psychostimulant that was involved in nearly 1 in 5 overdose deaths during 2017.
- Almost 5 million Americans reported current cocaine use in 2016, which is almost 2 percent of the population.
- In 2017, drug overdose deaths involving cocaine increased by more than 34 percent, with almost 14,000 Americans dying from an overdose involving cocaine.
- Non-Hispanic blacks also experienced the highest death rate for overdoses involving cocaine in 2017.

National Drug Overdose Deaths Involving Cocaine, by Opioid Involvement Number Among All Ages, 1999-2018



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Long-term effects of Cocaine Use

Some long-term health effects of cocaine depend on the method of use and include the following:

- *Snorting:* loss of smell, nosebleeds, frequent runny nose, and problems with swallowing
- *Smoking:* cough, asthma, respiratory distress, and higher risk of infections like pneumonia
- *Consuming by mouth:* severe bowel decay from reduced blood flow
- *Needle injection:* higher risk for contracting HIV, hepatitis C, and other bloodborne diseases, skin or soft tissue infections, as well as scarring or collapsed veins

However, even people involved with non-needle cocaine use place themselves at a risk for HIV because cocaine impairs judgment, which can lead to risky sexual behavior with infected partners.

Treatments for Cocaine Use

Contingency management

Interventions which provides tangible incentives in exchange for engaging in treatment and maintaining abstinence, have also been shown to be effective.

Cognitive- Behavioral Therapy

This approach helps patients develop critical skills that support long-term abstinence—including the ability to recognize the situations in which they are most likely to use cocaine, avoid these situations, and cope more effectively with a range of problems associated with drug use.

Therapeutic Communities

Drug-free residences in which people in recovery from substance use disorders help each other to understand and change their behaviors—can be an effective treatment for people who use drugs, including cocaine.

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Question:
What if there was a public health intervention that did the following…

- Eliminates drug overdose deaths, while reducing them in the surrounding areas
- Minimizes risk for abscesses, bacterial infections and endocarditis
- Minimizes the risk of HIV, hep B and hep C transmission
- Provides a gateway for entry to drug treatment, medical care and social services
- Reduces discarded syringes, litter, and other public disorder concerns related to injection drug use
- And…SAVES MONEY

Harm Reduction: A philosophy and public health approach

Naloxone Distribution

Syringe Exchange

Peer Support & Community Mobilization

Harm reduction refers to a range of services and policies that lessen the adverse consequences of drug use and protect public health. Unlike approaches that insist that people stop using drugs, harm reduction acknowledges that many people are not able or willing to abstain from illicit drug use, and that abstinence should not be a precondition for help.

Low Barrier Drop-In Spaces

Legal Support & Policy Reform

Open Society Foundations: "What is harm reduction?"
https://www.opensocietyfoundations.org/explainers/what-harm-reduction

Harm Reduction and Social Determinants of Health

Vitka Eisen, HealthRight 360

Harm reduction is a set of public health and social justice principles and practices aimed to reduce the harms that may result from drug and alcohol use. It also acknowledges that the harm and consequences of drug use are disproportionately applied to those who are low-income and people of color, many of whom are filtered into the criminal justice system.

The goal of harm reduction is to move people to the place where they are most realized, healthy and safe. For some people that place is abstinence, but for others it's not, because abstinence from drug use is not an actual requirement for full participation in society.

Landscape for People Who Use Drugs
Scenario #1

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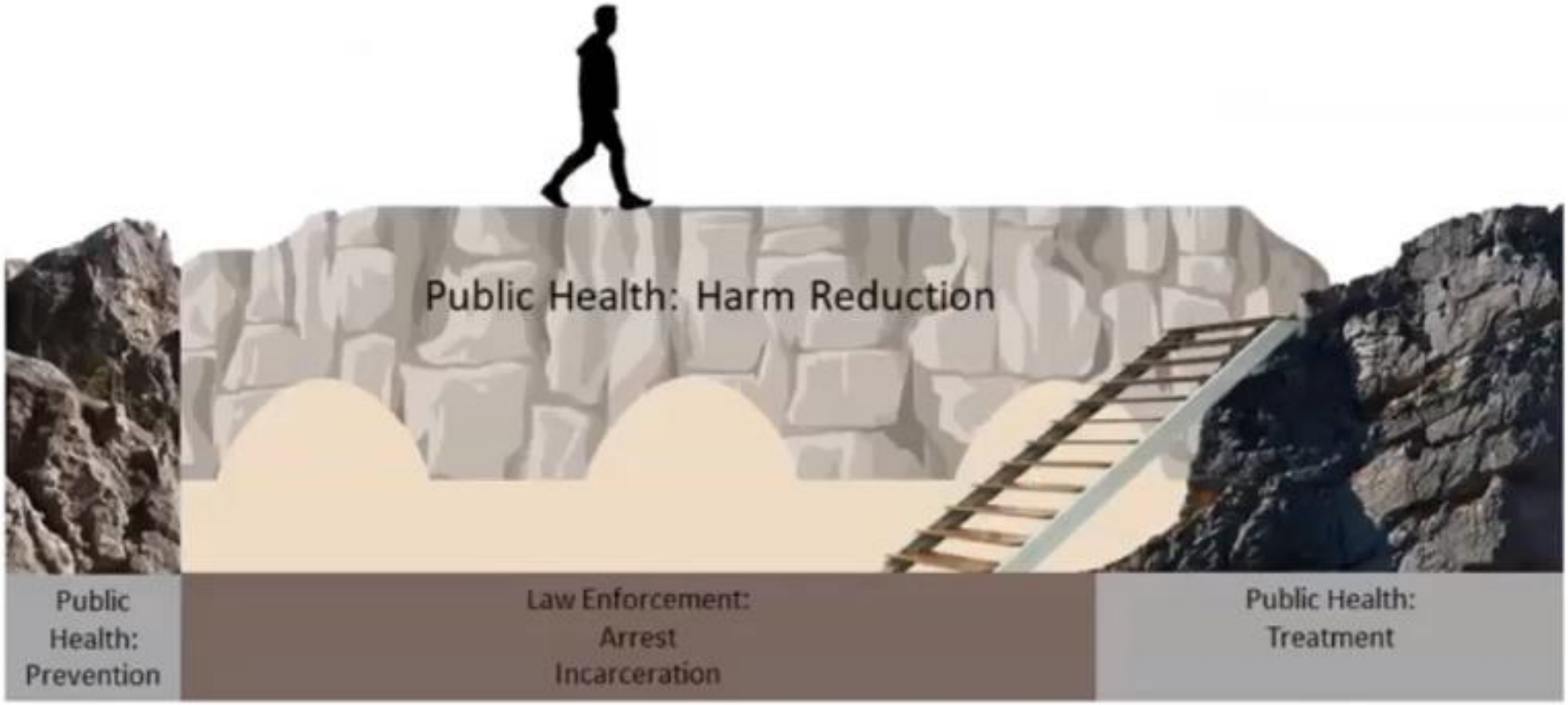
Landscape for People Who Use Drugs
Scenario #2



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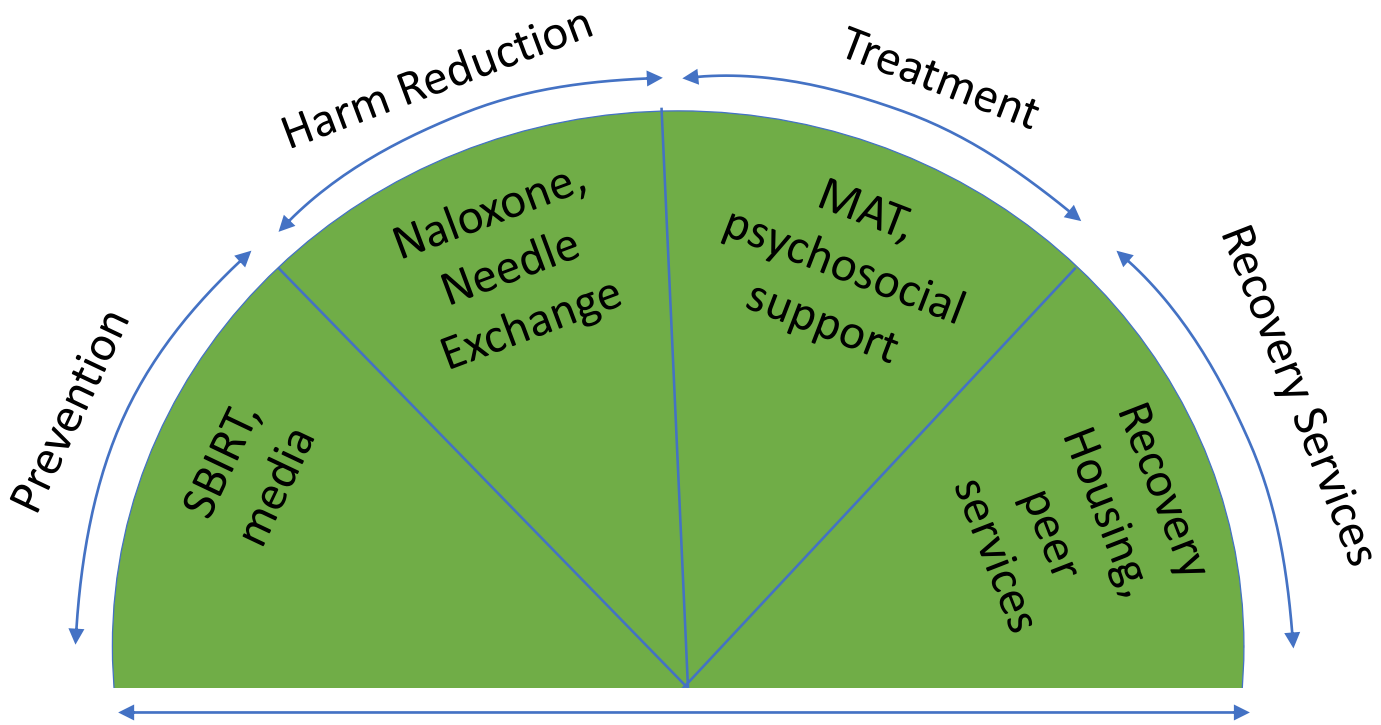
An Enhanced and Extended Continuum of Care



Individuals, families, and communities need access to all of these

Hepatitis C (HCV) New infections on the rise because of the opioid epidemic

Screening and Testing

- One-time testing for everyone 18+
- Annual testing for individuals who inject drugs

Treatment

- Majority of people can now be cured
- Medication adherence is vital
- Considerations for people HIV+, but HVC treatment can improve HIV regimens
- Warning: treatment and insurance access are sometimes denied, based on alcohol or drug use or degree of liver damage

Safer Injection Strategies

- Use sterile injection equipment
- Avoid Reusing or sharing
- Use a new sterile syringe to split drugs
- In you must reuse, then mark
- If you must share, then bleach it

Liver Care

- Reduce alcohol consumption
- Get Hepatitis A and B vaccinations
- Review all medications and supplements you are taking

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8 Principles of Harm Reduction

1. Because drug use is part of our world, we choose to minimize its harmful effects rather than simply ignore or condemn them
2. We acknowledge that some ways of using drugs are clearly safer than others
3. We base our criteria on the quality of individual and community life and well-being
4. We provide non-judgmental, non-coercive provision of services and resources
5. We ensure routine and authentic voice of drug users
6. We affirm drugs users as the primary agents of reducing the harms of their drug use
7. We recognize the realities of poverty, class, racism, social isolation, trauma on drug use
8. We do not minimize or ignore the harm and danger associated with licit and illicit drug use

You can't recover if you're dead.

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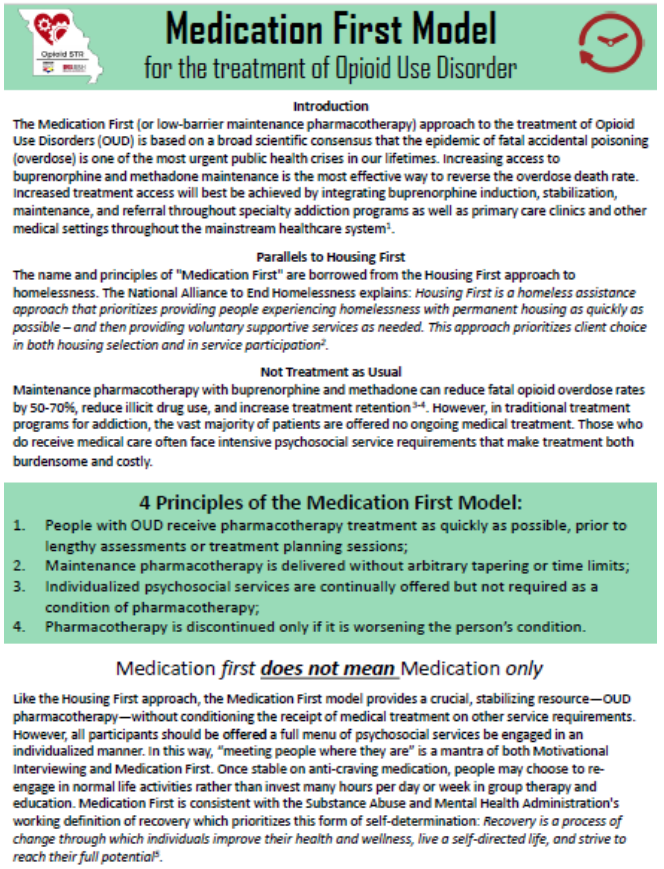
Medication First Model

- Relieves distress caused by withdrawal symptoms
- Stabilizes the person
- Decreases craving
- Creates mental ability for person to engage in psychosocial
- Increases treatment retention
- Decreases overdose deaths

Question:
If Medication is First, What Happens Next?



Medication First Model
for the treatment of Opioid Use Disorder

Introduction

The Medication First (or low-barrier maintenance pharmacotherapy) approach to the treatment of Opioid Use Disorders (OUD) is based on a broad scientific consensus that the epidemic of fatal accidental poisoning (overdose) is one of the most urgent public health crises in our lifetimes. Increasing access to buprenorphine and methadone maintenance is the most effective way to reverse the overdose death rate. Increased treatment access will best be achieved by integrating buprenorphine induction, stabilization, maintenance, and referral throughout specialty addiction programs as well as primary care clinics and other medical settings throughout the mainstream healthcare system[1].

Parallels to Housing First

The name and principles of "Medication First" are borrowed from the Housing First approach to homelessness. The National Alliance to End Homelessness explains: *Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed. This approach prioritizes client choice in both housing selection and in service participation*[2].

Not Treatment as Usual

Maintenance pharmacotherapy with buprenorphine and methadone can reduce fatal opioid overdose rates by 50-70%, reduce illicit drug use, and increase treatment retention[3-4]. However, in traditional treatment programs for addiction, the vast majority of patients are offered no ongoing medical treatment. Those who do receive medical care often face intensive psychosocial service requirements that make treatment both burdensome and costly.

4 Principles of the Medication First Model:

1. People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
2. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
3. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
4. Pharmacotherapy is discontinued only if it is worsening the person's condition.

Medication *first* ***does not mean*** Medication *only*

Like the Housing First approach, the Medication First model provides a crucial, stabilizing resource—OUD pharmacotherapy—without conditioning the receipt of medical treatment on other service requirements. However, all participants should be offered a full menu of psychosocial services be engaged in an individualized manner. In this way, "meeting people where they are" is a mantra of both Motivational Interviewing and Medication First. Once stable on anti-craving medication, people may choose to re-engage in normal life activities rather than invest many hours per day or week in group therapy and education. Medication First is consistent with the Substance Abuse and Mental Health Administration's working definition of recovery which prioritizes this form of self-determination: *Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential*[5].

Medication-Assisted Recovery: a 3-Legged Stool

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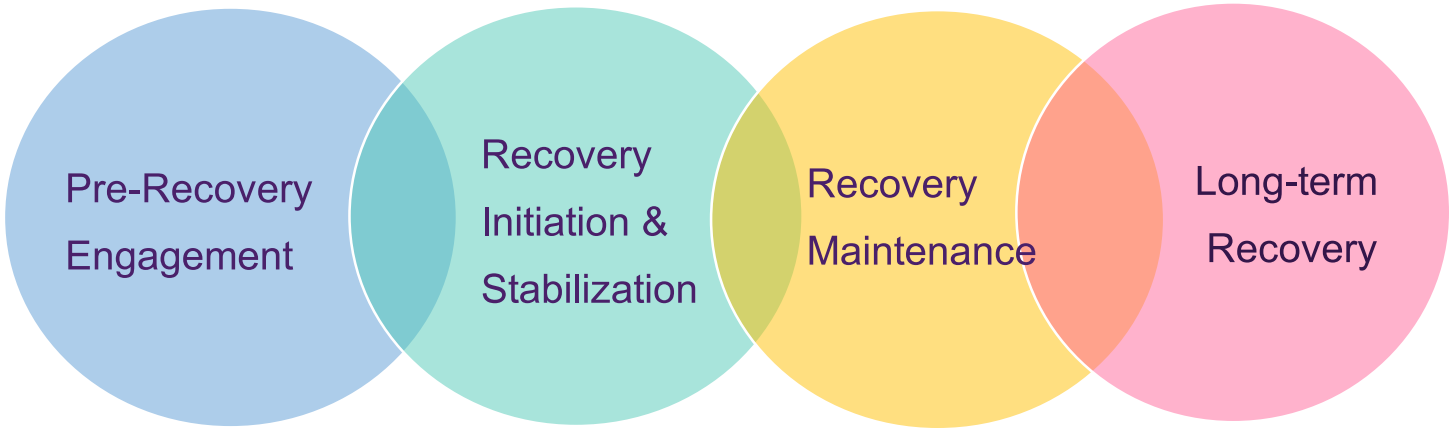
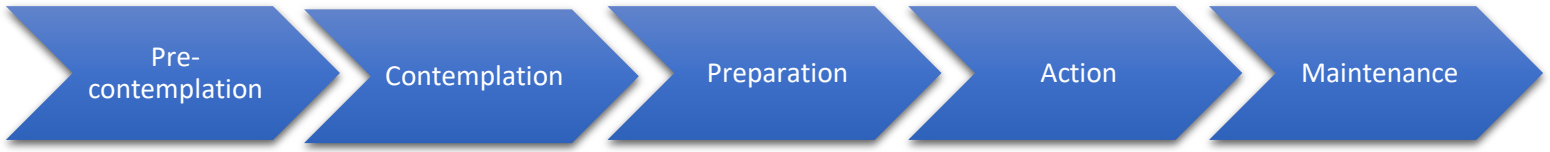
Continuum of Addiction Recovery



Adapted from William White



Stages of Change/ Prochaska & DiClemente

Recovery Capital

Recovery Capital is the sum of the strengths and supports – both internal and external – that are available to a person to help them initiate and sustain long-term recovery from addiction.

(Granfield and Cloud, 1999, 2004; White, 2006)

Creating and Reinforcing Recovery Capital

Essential Ingredients for Sustained Recovery:

- Safe and affordable housing
- Employment and job readiness
- Education and vocational skills
- Life and recovery skills
- Parenting and family skills
- Health and wellness
- Recovery support networks
- Community and civic engagement

Consequences of Addiction Deplete Recovery Capital

- Limited education
- Minimal or spotty work history
- Poor rental history
- Low or no income
- Criminal background
- Bad credit; accrued debt; back taxes
- Unstable family history
- Inadequate health care
- Child custody issues

Assessing Recovery Capital

Ten Domains	
1	Substance use and abstinence
2	Mental wellness and spirituality
3	Physical and medical health
4	Citizenship and community involvement
5	Meaningful activities: job/career, education, recreation, support
6	Relationships and social networks
7	Housing and safety
8	Risk taking and independence from legal responsibilities and institutions
9	Coping and life functioning
10	Recovery experience

Resources

- Decisions in Recovery: Treatment for Opioid Use Disorders Handbook
- BARC-10: Development and Validation of a Brief Assessment of Recovery Capital (BARC-10) for Alcohol and Drug Use Disorder

Questions & Discussion

Thank You

Questions?

Email integration@thenationalcouncil.org

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