THE DIMOCK CENTER

MassHousing/Community Services Conference

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MASSHOUSING

At the end of this session each participant will be able to:

- Discuss the language and appropriate terminology of substance use disorders
- State the incidence, prevalence and death rates of opioid use
- Identify psychological factors contributing to SU
- Identify available FDA approved medications for treatment of opioid use disorders & their mechanisms of action
- Identify treatment resources

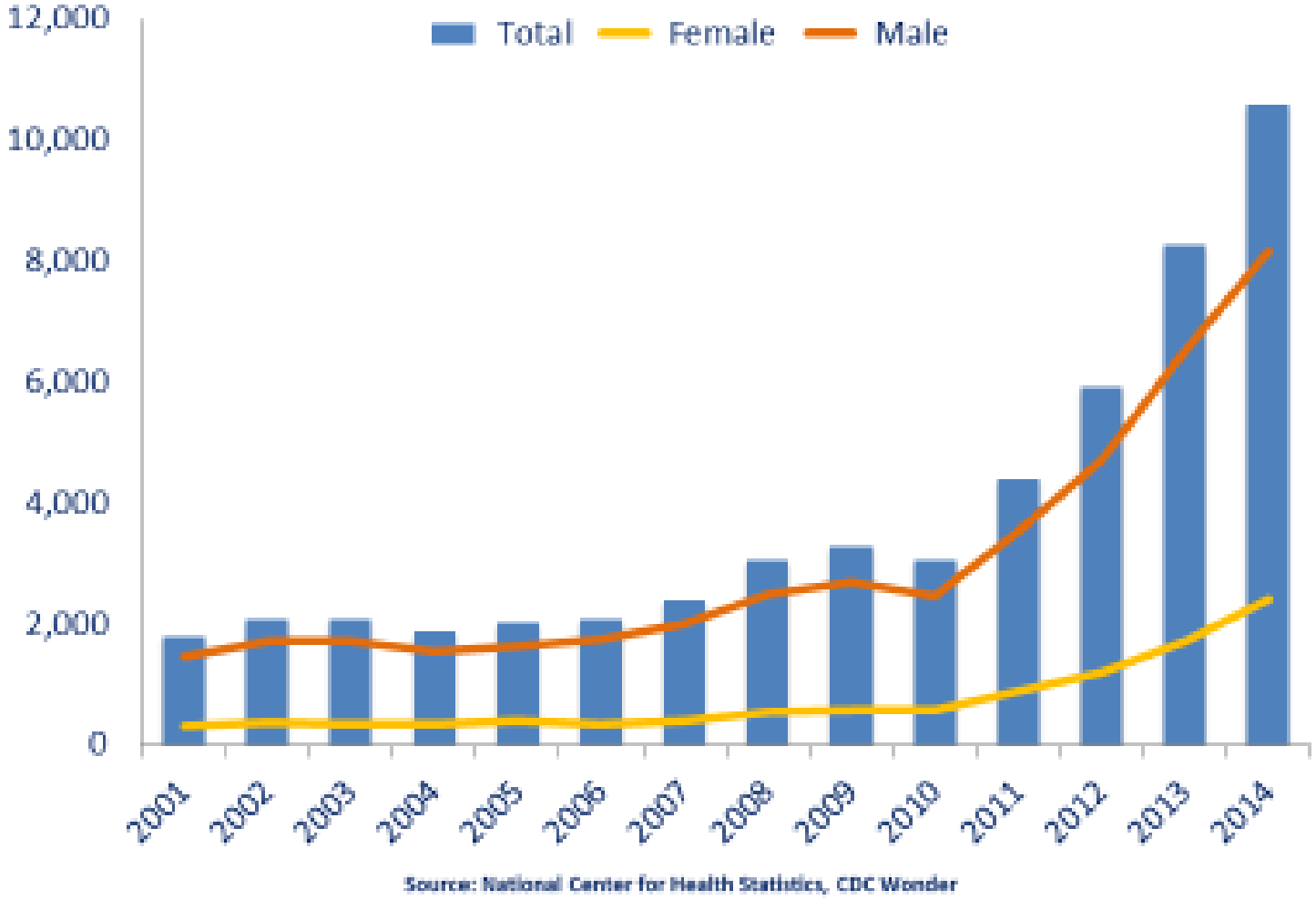
Daughters, Sons, Parents, Relatives, Friends, Neighbors

- Over 100 Americans died from overdose deaths each day in 2013.
- 46 Americans die each day from prescription opioid overdoses; two deaths an hour, 17,000 annually. Average age is 40 y.o.
- Drug overdose was the leading cause of injury death in 2013, greater than car accidents and homicide.
- Massachusetts: 1400 deaths in 2015. 7% increase from 2014.

NIH National Institute on Drug Abuse

National Overdose Deaths

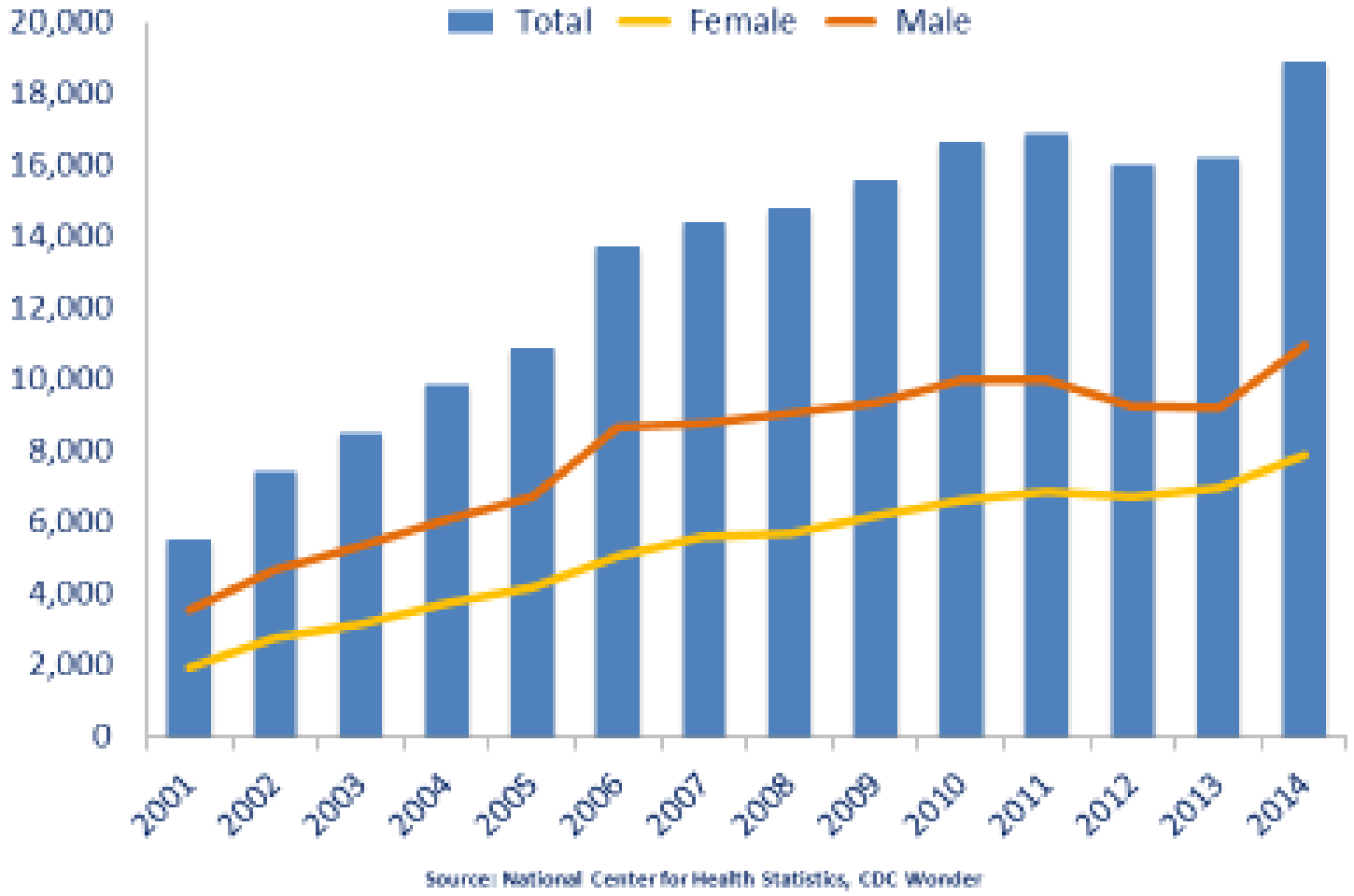
Number of Deaths from Heroin



Source: National Center for Health Statistics, CDC Wonder

National Overdose Deaths

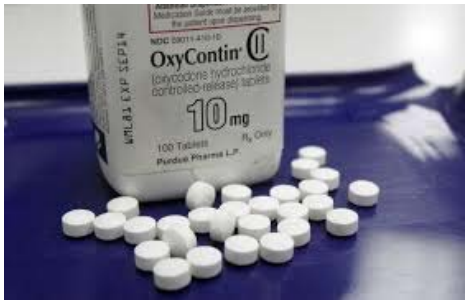
Number of Deaths from Prescription Opioid Pain Relievers



Source: National Center for Health Statistics, CDC Wonder

American Society of Addiction Medicine (ASAM) Opioid Addiction 2016 Facts & Figures

- Opioids are a class of drugs that include the illicit drug heroin as well as the licit prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others.
- Opioids are chemically related and interact with opioid receptors on nerve cells in the brain and nervous system to produce pleasurable effects and relieve pain.
- **23 million** Americans 12 or older have a substance use disorder in 2014. **Only 2 million receive tx.**
- 1.9 million had a substance use disorder involving prescription pain relievers and 586,000 had a substance use disorder involving heroin.



American Society of Addiction Medicine (ASAM) Opioid Addiction 2016 Facts & Figures

- In 2012, **259 million prescriptions** were written for opioids.
- Four in five new heroin users started out misusing prescription painkillers.
- 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”

American Society of Addiction Medicine (ASAM)

Opioid Addiction 2016 Facts & Figures

- According to the Feds Opioid addiction is as a progressive, treatable brain disease.
- ASAM Addiction Definition: Chronic, relapsing brain disease characterized by compulsive drug-seeking behavior and drug use despite harmful consequence.
- Any type of opioid can trigger latent chronic addiction brain disease.
- Opioid addiction disease occurs in every American State, County, socio-economic and ethnic group.

Substance Use Disorders are Diseases

Holy Grail – understanding the neurological structures & processes that cause addiction & shape the addicts' behavior.

Two main facts to support the idea that all addictions are diseases:

1. **A definitive and unique pattern of behavioral and physiological symptoms has been identified for substance use disorders.**
2. **A definitive and unique pattern of neurobiological adaptations that take place in the brain has been identified for substance use disorders.**

Impact on Special Populations Adolescents (12 to 17 years old)

- In 2014, 467,000 adolescents were current nonmedical users of pain reliever, with 168,000 having an addiction to prescription pain relievers.
- In 2014, an estimated 28,000 adolescents had used heroin in the past year, and an estimated 16,000 were current heroin users.
- People often share their unused pain relievers.Most adolescents who misuse prescription pain relievers are given them for free by a friend or relative.
- The prescribing rates for prescription opioids among adolescents and young adults nearly doubled from 1994 to 2007.

Impact on Special Populations: Women

- Women are more likely to have chronic pain, be prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men.
- 48,000 women died of prescription pain reliever overdoses between 1999 and 2010.
- Prescription pain reliever overdose deaths among women increased more than 400% from 1999 to 2010, compared to 237% among men.
- Heroin overdose deaths among women have tripled in the last few years. From 2010 through 2013, female heroin overdoses increased from 0.4 to 1.2 per 100,000.

The Heroin Epidemic

Why is heroin use growing?

- Lower price
- Longer “high”
- Increasing purity
- Increased availability
- Reduced social stigma around use
- 2002-2013:Some of the highest increases in people with higher incomes and people who are privately insured.

Opioid Dependence Is Costly

- **Medical Costs**
  - Mental illness
    - An environmental and disease stressor
    - Co-morbid interactions
  - Trauma and infections
  - Hepatitis and HIV
  - $20 billion per year total costs
  - $1.2 billion per year health care costs
- **Non-medical costs-** work, legal, prison

Contributing Factors to Opioid OD Epidemic

- Changes in pain management guidelines 1990's
- PHARMA Aggressive marketing of ER opioids
- 1997-2011: 643%↑ Rx opioids
- Direct consumer marketing
- Over-prescribing in general
- Unscrupulous MDs / 'Pill Mills'
- Widespread diversion

Meanwhile……

- Stigma
- Addiction creates a host of negative effects to the dependent patient, his/her family and friends and society as a whole.
- Not likeable…..
- Don’t understand…..
- What’s going on?
  Trauma
  Negative Cognitions
  Cognitive Distortions
  Lack of Skills

Components of Recovery

Governor's Opioid Working Group

- Acknowledge that addiction is a chronic medical condition.
- Create new pathways to treatment.
- Increase access to medication-assisted tx (MAT).
- Reduce stigma of SU disorders.
- Support SU prevention is schools.
- Training to practitioners re: addiction and safe prescribing practices, pain management.
- Acknowledgement that punishment is not the appropriate response to a SU disorder.
- Increase distribution of narcan (naloxone) to prevent overdose deaths.
- Eliminate insurance barriers. Chapter 258
- Require manufacturers/pharmacies to dispose of unused prescription meds.

Governor's Opioid Working Group

- Increase prevention education.
- Improve safe prescribing & dispensing of controlled substances. Prescribers using the PMP.
- Centralize treatment resources, i.e., 800 number.

  May, 2015: Mayor's Office of Recovery Services (ORS), the first-ever municipal-based office to focus on this issue. The Mayor also announced that Jennifer Tracey, a highly respected and experienced recovery expert, will head ORS.
- Increase peer support in the recovery process. Recovery Coaches.
- Expand the number of Recovery Support Centers.

- The Office of Recovery Services will be under the oversight of the Boston Public Health Commission, and is part of Mayor Walsh's Fiscal Year 2015 budget, which identified $300,000 in new funding to help support its creation. The office will work to improve existing addiction and recovery services and create a continuum of high quality services for those battling addiction, help those fighting addiction navigate the city's available resources, and advocate for treatment options. Today's addiction and recovery study will be fundamental to the development, mission and function of the office.

Detox and "Drug-free" Approach

- Traditional model: Detox
- Detox without subsequent medication support
  - Effective for small subgroup: high motivation & stable

    (Flynn et al., 2003; Van den Brink and Hassen, 2006)
- Otherwise without medications
  - Up to 90% of detox'd pts relapse in first 1-2 mos

    (Weiss et al., 2011; Smyth et al. 2010)

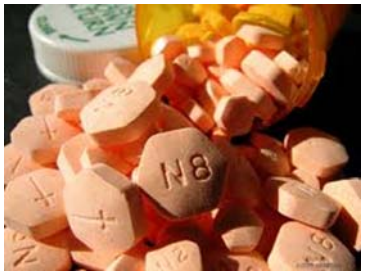
    -- 40 to 60 percent within the first 12 months
  - Of those relapse – OD

    (Kakko et al., 2003)

Frequently Discussed Interventions

- CBT – including Trauma Focused Treatment
- Expanding access to naloxone (narcan)
- Expanding access to medication assisted treatment (MAT)
- PDMP-based interventions
  (Prescription Drug Monitoring Program Training)
- Mandatory prescriber education
- AA\NA\SmartRecovery
- Peer Supports

FDA-Approved Pharmacotherapies



Alcohol Dependence:

- Antabuse® (disulfiram) [1951]
- ReVia/Depade (naltrexone) [1994]
- Campral (acamprosate) [2004]
- Vivitrol (naltrexone extended-release injectable) [2006]

Opioid Dependence:

- Methadose/Dolophine (methadone) [1964]
- LAAM {1993]

LAAM (Levomethadyl acetate) works very much like methadone. LAAM and methadone are both synthetic opiates, and when given to opiate-dependent drug users, they both take away feelings of withdrawal and drug cravings. They also both block opiate receptors, limiting the effects of other opiate drugs.

- ReVia/Depade (naltrexone) [1984]
- Subutex/Suboxone (buprenorphine) [2002]
- Vivitrol (naltrexone extended-release injectable) [2010]

Medication-Assisted Recovery

- Medications are a part of treatment, but only one part.
- Medications should always be used in conjunction with bio-psycho-social-spiritual therapy.
- Medications support the therapeutic process. Modern science has identified several changes that take place in a dependent's brain. These changes do not instantaneously correct themselves after a patient stops drinking/using. The patient can think more clearly without so many physiological distractions taking away from counseling objectives.

- The single most accurate predictor of successful treatment outcome is the length of time in treatment.

- Pharmacotherapies can:
  - help patients remain in treatment longer
  - achieve complete abstinence
  - help prevent relapse
  - reduce frequency and amount of consumption
  - help them continue to stay committed to meeting their treatment goals and maintain long-term recovery.
  - Medications can serve as a tool to initiate treatment.

Why Do People Change?

Typically, people change voluntarily only when...

- ...they become interested in or concerned about the need for change
- ...they become convinced that the change is in their best interests or will benefit them more than cost them
- ...they organize a plan of action that they are committed to implementing
- ...they take the actions that are necessary to make the change and sustain the change

Assessing Readiness to Change

However, patients enter treatment at varying stages of readiness for treatment and openness to counseling.

Some are eager, and some are looking for the door as soon as they sign in.

And experience has shown that some treatment interventions are better suited for particular types of patients, while others are best used at specific time periods during the treatment process.

Stages of Change Model

The Stages of Change Model identifies six independent stages of behavior and thinking that patients can experience during the treatment process.

By identifying which stage of change a patient is currently in, addiction professionals can better understand the treatment needs of that patient and which treatment options are most appropriate.

Stages of Change

- *Precontemplation* - The patient is not ready to change. He has little or no thought or interest in changing the behavior.
- *Contemplation* - The patient is thinking about change. He is assessing the risks and benefits of changing.
- *Preparation* - The patient is ready to change. He is getting ready to make the change and tests the waters by creating a plan of action.
- *Action* - The patient is making the change and is incorporating the action plan.
- *Maintenance* - The patient is sustaining the change. They continue the action plan until the change has been integrated into the client's lifestyle.
- *Relapse* - The patient slips back into previous behavior. He must reenter the cycle of change at a point that is appropriate given the new level of readiness to change.

Igniting Internal Motivation to Change

- Motivation, willingness and ability to change all belong to the patient.

- The tasks of the counselor is to help the patient find the internal motivation to change, make the decision to change and take the action needed to travel the road of recovery.

- Pharmacotherapies can help with this.

Language of Recovery

Language that is commonly used within the behavioral health system can often be improved. The following are examples of simple, practical ways to reframe the conversation in recovery-oriented ways.

Rather than these words:	**Use words that promote recovery:**
• Addict, alcoholic, junkie	• Man/woman in recovery, person with a substance use disorder, patient
• Substance abuse	• Substance use disorder, risky use of substances
• Drug Seeker • Recreational	• Relief seeking • Non-medical use

Language of Recovery

• Habit of drug Use misuse disorder	Active addiction, substance
• Relapse	Reoccurrence, resume use
• Clean negative test	In recovery, substance free,
• Dirty	Active use, positive screen
• Suffering from	Working to recover

VOICES OF RECOVERY

Over 23 million Americans are in recovery from addiction to alcohol and other drugs according to a nationally representative survey from The New York State Office of Alcoholism and Substance Abuse Services (OASAS) and The Partnership at Drugfree.org

http://www.facesandvoicesofrecovery.org/

FACES & VOICES OF RECOVERY

VOICES OF RECOVERY

a social movement led by people in recovery and their allies aimed at altering public and professional attitudes toward addiction recovery, promulgating recovery-focused policies and programs, and supporting efforts to break intergenerational cycles of addiction and related problems.

- Recovery is a living reality for individuals, families, and communities.
- There are many (religious, spiritual, secular) pathways to recovery, and ALL are cause for celebration.
- Recovery flourishes in supportive communities.
- Recovery is a voluntary process.
- Recovering and recovered people are part of the solution:
  recovery gives back what addiction has taken from individuals, families, and communities.
- Recovery is contagious & is cool.

http://www.facesandvoicesofrecovery.org/

Recovery Support Centers

Funded by the Bureau of Substance Abuse Services at DPH

- Devine Recovery Center
  70 Devine Way, South
  Boston, MA 02127
  Celine Cannon/Director
- Everyday Miracles
  25 Pleasant Street
  Worcester, MA 01601
  Athena Haddon/Director
- The Recovery Connection
  31 Main Street
  Marlborough, MA 01752
  Angela Dalessio/Director
- STEPRox
  9 Palmer Street
  Roxbury, MA 02119
  Loretta Leverett/Director
- New Beginnings Peer Recovery Center
  487 Essex Street
  Lawrence, MA 01840
  Jennifer Burns/Director

Stairway to Recovery
142 Crescent Street
Brockton, MA 02301
Efrain Baez/Director

RECOVER Project
68 Federal Street
Greenfield, MA 01301
Linda Sarage/Director

Holyoke Recovery Ctr
100 Suffolk Street
Holyoke, MA 01040
Cathy Rosario/Director

Quincy Recovery
Support Center
85 Quincy Avenue
Quincy, MA 02169
George Traynor/Director

Conclusion

- We are in the midst of the worst drug epidemic in U.S. history.

- To end the epidemic we need to:
  - PREVENT new cases of opioid addiction
  - TREAT people who are already addicted


thank you
danke
謝謝
ngiyabonga
teşekkür ederim
спасибо
dank je
gracias
tapadh leat
mochchakkeram
bedankt
dziękuje
go raibh maith agat
obrigado
sukriya
kop khun krap
arigato
dakujem
merci
terima kasih
감사합니다
мерси

The Dimock Center
Behavioral Health Services

- OARS
- John Flowers Recovery Home
- Askia Academy
- Women's Renewal/CSS
- ATS/Detox
- 6 group residences for DD pts
- Ummi's Transitional Housing Program
- Sheila Daniels & Edgewood Permanent Housing
- Mary Eliza Mahoney House Family Shelter
- My Sister's House

DIMOCK SERVICES FOR PATIENTS WITH SUD

Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7) consist of 24-hour, seven-day-per-week, medically monitored inpatient detoxification treatment that provides evaluation and withdrawal management. 35 beds.

Clinical Stabilization Services (CSS) for Substance Use Disorders Level III.5 consist of 24-hour, clinically managed detoxification services that are provided in a non-medical setting. These services usually follow Acute Treatment Services (ATS) for Substance Use Disorders. Women's Renewal.

Structured Outpatient Addiction Program (SOAP) consists of short-term, clinically intensive, structured, day and/or evening substance use disorder services. SOAP provides multi-disciplinary treatment to address the sub-acute needs of patients with addictions and/or co-occurring disorders, while allowing them to maintain participation in the community, work or school, and involvement in family life.

DIMOCK SERVICES FOR PATIENTS WITH SUD, cont.

Medication-Assisted Treatment/MAT: consists of medically monitored administration of buprenorphine & Vivitrol to individuals who are opiate-addicted. This service, which combines medical and pharmacological interventions with counseling, educational, and vocational services, is provided on a short-term (detoxification) or long-term (maintenance) basis, depending on the clinical needs of the individual.

DIMOCK SERVICES FOR PATIENTS WITH SUD, cont.

Outpatient Services are behavioral health services that are rendered in an ambulatory care setting, such as an office, clinic environment, a patient's home, or other locations appropriate for psychotherapy or counseling. Services consist of time-effective, defined episodes of care that focus on the restoration, enhancement, and/or maintenance of a patient's optimal level of functioning, and the alleviation or amelioration of significant and debilitating symptoms impacting at least one area of the patient's life domains (e.g., family, social, occupational, educational).

The goals, frequency, intensity, and length of treatment vary according to the needs of the patient and the response to treatment. A clear treatment focus, measurable outcomes, and a discharge plan including the identification of realistic discharge criteria are developed as part of the initial assessment and treatment planning process and are evaluated and revised as needed.

OARS: Outpatient Addiction Recovery Services.

DIMOCK SERVICES FOR PATIENTS WITH SUD, cont.

Residential Treatment Program:

- John Flowers – men, 20 beds
- Askia – men, 22 beds
- My Sister's House – women, 20 beds
- Mary Eliza Mahoney Shelter – 26 families

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