Substance Use Disorders Treatment under Health Care Reform: Welcome to the Healthcare System

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Credits and Acknowledgements

During the past 10 months we have attempted to learn as much as possible about potential impact of HCR on the delivery of SUD treatment. We have borrowed (and credited, hopefully) all those individuals whose materials we have adapted for use in this presentation. However, if we have failed to credit we apologize. Special thanks to Mady Chalk, Tom Kirk, Ron Manderscheid, Tom McLellan, Rob Morrison, and Pam Waters.

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“In times of change, the learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

-- Eric Hoffer

Using the Audience Response System

• When a question appears, simply press your choice on your keypad
• Responses are anonymous
• Results will be shown immediately so that we can see what everyone said.
• Everyone please participate in every question
The remotes ONLY work with the ARS system

- They will not:
  - Open your garage door
  - Turn on your television
  - Work as a cell phone
- They do:
  - Cost a lot
  - Belong to someone else

Please return them before you leave!

What did you listen to in the car on the way to this training?

1. Nothing…I need my quiet time.
2. Rock and Roll, baby!
3. Other music that matches my style.
4. Talk, news, traffic or weather.
5. Other

How long did it take you to travel to this training?

1. <15 min
2. 15 – 30 min
3. 31 – 45 min
4. 45 – 60 min
5. > 1 hour

What percentage of your clients has a substance use disorder?

1. 0 - 25%
2. 26 – 50%
3. 51-75%
4. 76 – 100%
5. Don't know

What percentage of your clients has a co-occurring substance use and mental health disorder?

1. 0 - 25%
2. 26 – 50%
3. 51-75%
4. 76 – 100%
5. Don’t know

What percentage of your clients has diabetes?

1. 0 - 25%
2. 26 – 50%
3. 51-75%
4. 76 – 100%
5. Don’t know
Clinicians who address substance use disorders in primary care settings should become aware of approaches that use:

- Dynamic psychotherapy (32%)
- Confrontation of denial (65%)
- Positive reinforcement (15%)
- Psychoanalysis (8%)

When medical services are moved into substance use specialty care programs, we call this:

- Co-location (35%)
- Interference (5%)
- Medical Monitoring (48%)
- Reverse co-location (5%)

Of the 21 Million individuals in the US who currently need treatment, what percent are currently in treatment?

- 1. 10% (35%)
- 2. 1% (20%)
- 3. 50% (5%)
- 4. 20% (44%)

The major impact of healthcare reform will occur in what year?

- 1. 2010, it has already occurred (0%)
- 2. 2020 (0%)
- 3. 2011 (35%)
- 4. 2014 (65%)
Which states have already implemented a form of healthcare reform?

- 7% 1. Nevada, Arkansas, Ohio
- 49% 2. Maine, Massachusetts, Vermont
- 7% 3. Texas, Arizona, New Mexico
- 35% 4. None of the above

Vivitrol is the trade name for what addiction treatment medication

- 9% 1. Bupropion
- 47% 2. Naltrexone
- 19% 3. Methadone
- 26% 4. Buprenorphine

Buprenorphine is an opioid...

- 18% 1. Agonist
- 48% 2. Antagonist
- 21% 3. Partial Agonist
- 6% 4. Agony
- 13% 5. None of the above

Healthcare Reform Goals

President’s Principles:
- More stability & security for those who have insurance
- Affordable coverage options for those who do not
- Lower costs for families, businesses, and governments

Affordable Care Act

A consolidation of:
The Patient Protection and Affordable Care Act (PPACA)
and
The Health Care and Education Reconciliation Act of 2010

Changes in Place

- Pre-existing Conditions (2010-14): Eliminate exclusions, starting with children/adolescents.
- Adult Child Inclusion (2010): Permit adult dependent children to age 26 to remain on parents’ policy.
- Tax Credit (2010): Small businesses (25 employees or less & average salaries of $40K or less) can receive a 35% tax credit for insurance premiums.
### 2014 Changes

- New insurance for about 32 million more adults.
- Medicaid (2014): To 133% of poverty.

### Health Care Reform Implementation Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Coverage of preventive services with no co-pays</th>
<th>Expanded Medicaid eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>health insurance exchanges</td>
<td></td>
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<tr>
<td>2011</td>
<td>Imposes smoking cessation and treatment</td>
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<tr>
<td>2012</td>
<td>Expands home and community-based services</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Health Insurance Exchanges</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Requires individuals to get insurance</td>
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### Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Interim Final Rule (IFR)

- Passed October 3, 2008
- Effective January 1, 2010. Implementing regulations issued February 2, 2010, requiring compliance of all new plans after July 2010
- Expected to affect more than 150 million people
- Adds SUD to MHP
- Impacts self insured (ERISA) plans for the first time
- Stronger State Laws Protected

### Mental Health Parity and Addiction Equity: Overview of the Law

- If employer plans includes MH/SUD benefits, mental health and addiction treatment benefits must have the same financial terms, conditions, requirements, and treatment limitations as they do for medical and surgical conditions
- Single Plan = Single Deductible
  - Cost-sharing, deductibles, co-pays, other forms of co-insurance, and annual limits and lifetime limits must be equal to “predominant” coverage for “substantially all” of the covered medical and surgical conditions

### Overview of the Law

- Expected to affect more than 150 million people
- Adds SUD to MHP
- Impacts self insured (ERISA) plans for the first time
- Stronger State Laws Protected
Wellstone-Domenici Mental Health Parity and Addictions Equity Act of 2008
• Does Address:
  – MH and SUD Tx
  – Employer health plans that cover 50 or more persons
  – Day and visit limits
  – Care management factors
  – MBHCOs combine data with MCOs for single deductible.
• Does Not Address:
  ▫ Small group (<50) or individual plans
  ▫ Medicare
  ▫ The uninsured
  ▫ A common definition of medical necessity
  ▫ Scope of services
  ▫ Quality or outcome.

How will Health Care Reform and Parity effect the treatment of substance use disorders?

Substance Use Disorders (SUD)
The language we use matters

Substance Misuse

Background
› 2006-2008 - 39 States enacted laws to expand access to health insurance
› Maine, Massachusetts and Vermont – the states that sought to achieve universal health coverage
› Need empirical studies of HCR effects on access to, as well as quality and outcomes of, substance abuse treatment (SAT) services

What happens when benefits for SUD are expanded? Hints from...

Vermont

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People Receiving Alcohol or Drug Treatment in Vermont 1998-2007

- Blueprint for Health designed, first mobile methadone clinic opened
- Catamount Health created, 1115a Medicaid waiver (more flexibility in Medicaid), Green Mountain Care (Medicaid) premiums decreased, funding for Blueprint Parity mandate, 1115 Medicaid waiver (first was in 1996) – non-categoricals Buprenorphine initiative, first methadone clinic opened

- Vermont: Health disorders, free or reduced cost, Medicaid, over 2000

- Massachusetts, Vermont, Maine

- Vermont: Health disorders, free or reduced cost, Medicaid, over 2000
Under HCR

ME, MA and VT:
- Saw the percent of uninsured drop
  - ME - 13% in 2002 to 10.3% in 2007
  - MA - 11.7% in 2004 to 2.6% in 2009
  - VT - 9.8% in 2006 to 7.6% in 2009
- SUD admissions rose; public funding increased
  - Medicaid expansions appear more significant than subsidized/private health plans (need to analyze claims)
- Opiate epidemic – big impact on type of care needed: Medication-Assisted Treatment (MAT)

Still Many Uninsured Seeking SUD Services

- Uninsured rate dropped, admissions rose, but many individuals with SUD clients still without health insurance
  - MA 2009 – 22% (down from 61% in 2005)
  - ME 2008 – 31% (steady since 2005)
  - VT 2007 – 30% (steady since 2005)
- Services paid for by safety net/SAPT funds
  - Without insurance or safety net funds, clients turned away/put on waitlist

NASADAD Study:
The Effects of Health Care Reform on Access to and Funding of Substance Abuse Services in Maine, Massachusetts and Vermont
http://www.nasadad.org

There will still be a large number of people who do not have healthcare coverage.

Estimates are that 10-25% of individuals with SUD will not have coverage even after 2014
Role of the SAPT Block Grant

- Remains critical to SSA, providers - funds services not covered by others, fills gaps in services
- Flexibility to address new challenges, services
  - Opiate epidemic (previously, cocaine)
  - Buprenorphine, methadone
- Safety net
  - Services for the uninsured
  - Services that “traditional” insurance will not cover
- Prevention – primary/only funder in these states
- Criminal Justice
- Workforce Development

How will the universe of SUD care change today through 2014?

Distribution of Alcohol (or Drug) Problems

- 2M people (0.8%) receiving treatment*
- 21M people (7%) have problems needing treatment, but not receiving it*
- ≈ 60-80M people (≈20-25%) using at risky levels

US Population:
307,006,550
US Census Bureau, Population Division
July 2009 estimate
*August, 2009

In treatment (2 Million)
Diagnosable problem with substance use referred to treatment by:
- Self/Family 37%
- Criminal Justice 25%
- Other SUD Program 8%
- County Assessment Center 19%
- Healthcare 3%
- Other 8%

*Los Angeles County Data

In need of treatment (21 Million)
- Reported problems associated with use
- Not in treatment currently
  - 1.1% Made an effort to get treatment
  - 3.7% Felt they needed treatment, but made no effort to get it.
  - 95.2% Did not feel that they needed treatment
Using at risky levels (60-80 Million)

- Do not meet diagnostic criteria
- Level of use indicates risk of developing a problems.
- Some examples…
  - Drinks 3-4 glasses of wine a few times per week
  - Pregnant woman occasionally has a shot of vodka to relieve stress
  - Adolescent smokes marijuana with his friends on weekends
  - Occasionally takes one or two extra vicodin to help with pain

These people need services, but will never enter the treatment system.

Implications

As long as the specialty care programs (AOD treatment programs) are the only places which address SUD:
- most people with severe problems will not receive treatment.
- virtually all with risky use will not receive professional attention.

“If Mohamed will not go to the mountain, the mountain must come to Mohamed”

What healthcare settings are good/important locations to identify individuals with SUD?

Healthcare Settings for locating individuals with SUD

- Primary care settings
- Emergency rooms/ Trauma centers
- Prenatal clinics/ OB/Gyn offices
- Medical specialty settings for diabetes, liver and kidney disease transplant programs
- Pediatrician offices
- College health centers
- Mental health settings
A key partner…

The Federally Qualified Health Centers (FQHCs)

Types of “Health Centers”

- Terminology used interchangeably but confusing: “federally qualified health centers (FQHCs),” “health centers,” “community-based health clinics,” “community health centers (CHCs)"
- Several types of FQHCs in the health center program:
  - Community Health Centers
  - Migrant Health Centers
  - Healthcare for the Homeless Program
  - Public Housing Program
- FQHC look-alikes
- Others- clinics operated by IHS or tribal authorities, school-based health clinics, nurse-led clinics

What are FQHCs?

- Federally Qualified Health Centers (FQHCs), designation provided to BPHC grantees (HRSA) under Section 330 Public Health Service Act
- Private non-profit or public free-standing clinics serving designated MUAs or MUPs
- One of few Federal programs for primary care to the non-institutionalized population
- Must meet additional requirements in order to participate in BPHC Health Center program
FQHCs
1,080 grantees nationwide with 8,176 sites

FQHCs in California
• 113 clinic corporations with 1,049 sites
• 3.7 million patients served
• 53% of state’s population below 100% of Federal Poverty Level (FPL) and 26% below 200%
• 15% of state’s uninsured residents served
• 46% of total revenues from Medi-Cal

Evidence shows that increases in funding to FQHCs result in an increase in the provision of behavioral health services.

• Federal government boosted financial support to FQHCs between 2002 and 2007
  – the number of FQHCs increased 43%
  – the number of FQHCs providing SUD services increased 58%.
  – newly funded FQHCs were no more likely than previously funded FQHCs to provide behavioral health care.

Interactive Table Discussions
• Visualize yourself working in the post ACA service system in 2014. What will it be like?
• At your tables, discuss the following issues:
  – What will be different about working in this new system?
  – What new skills will you need to develop in order to be successful?
  – What new systems (data, documentation, etc) will need to be developed in order to be successful?
  – What will the benefit be for your clients?

We’re planning on filling in the details later
What is “Primary Care Integration”?

- Primary care integration is the collaboration between SUD service providers and primary care providers (e.g., FQHC’s, CHC’s)
- Collaboration can take many forms along a continuum*


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**Minimal Coordination**

- BH and PC providers
  - work in separate facilities,
  - have separate systems, and
  - communicate sporadically.

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**Basic At a Distance**

- BH And PC providers
  - Engage in regular communication about shared patients leading to improved coordination

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**Basic On Site (co-location of services)**

- BH and PC providers
  - Still have separate systems
  - Some services are co-located (e.g., screening, groups, etc).

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**Basic On Site (reverse co-location)**

- BH and PC providers
  - Still have separate systems
  - Primary care services are integrated into BH Settings

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**Integrated**

- PC providers
  - Develop and provide their own services
BH and PC providers
- share the same facility
- have systems in common (e.g., financing, documentation
- regular face-to-face communication

The Primary Care System
SUD Care System
MH Care System

Specific services that are likely to be employed in integration activities

- SBI
- MAT in primary care
- Brief Treatments (what are they?)
- “Warm hand off” techniques (cold referrals don’t work)
- Behavioral enhancement techniques (MET, MI, NIATX)

How will the money change?

New People, New Settings

- Specialty treatment system will need to be able to bill for individual services
- Specialty treatment system will need to respond to patient choice
- A whole new group of patients will enter the system through the health care system
- The healthcare (primary care, mental health, specialty docs) system will be able to provide some of our services

We have lots to do and only a little time to prepare

2014 2010
What are the implications of HCR for the SUD Workforce?

As the treatment of substance use disorders (SUDs) moves to the world of healthcare services.................................
A wide range of SUDs will be addressed, not just the most severe.
Patients will be viewed as respected healthcare consumers.
Treatments will need evidence of effectiveness
Treatment will be accountable.
Patients will have choice about treatment types and goals.

Workforce considerations

- Regulatory issues including credentialing and licensing
  - State laws/rules regarding licensure of mental health and substance abuse facilities – each with workforce requirements to deliver care
  - State laws/regulations about scope of practice – govern types of services that can provided and the extent to which clinicians can practice independently in different settings
- Levels of risk and responsibility depend upon the level of integration
- The use of paraprofessionals—common in the behavioral health setting—can be difficult to reimburse in a primary care site.

Consumer Improvement Strategies

- Increase the focus on consumer satisfaction and consumer perception of care
- Increase the use of behavioral enhancement techniques (use of positive reinforcement techniques).
- Increase the use to strategies to increase consumer access to care and appreciation of care (e.g. NIATx)
- Increase measurement of service effectiveness and greater provider accountability

Two New team members

Care Manager/BHC
- Educates the individual about depression/other conditions
- Supports medication therapy prescribed by the PCP
- Coaches individuals in behavioral activation
- Offers a brief counseling
- Monitors symptoms for treatment response
- Completes a relapse prevention plan with each individual

Consulting Mental Health Expert
- Caseload consultation for care manager and PCP (population-based)
- Diagnostic consultation on difficult cases
- Recommendations for additional treatment and referral according to evidence-based guidelines

Provider/practice barriers

- Differing practice styles
- Differing practice cultures and language
- Difficulty in matching provider skills with patient needs
- Heavy reliance on physician services
- Tension between direct patient care services (reimbursable) and integrative (non-reimbursable) services
Provider/practice barriers

- Lack of recognition of provider limitations
- Lack of MH knowledge in PC providers and lack of health knowledge in BH providers
- Lack of clinical competence in integrated service models (MH/SU and BH/PC) and selection of proper integration model based on practice context
- Differing coding and billing systems
- Provider resistance

FINANCIAL BARRIERS

- Payors have strict requirements of who can bill for what service
- Increase in Medicaid necessitates provider and workforce capability to bill this payor
- Payment for health/recovery coaches and use of peers is slow to emerge
- Allowances for payment for services in new job classifications areas, such as Care Managers

Behavioral Enhancement Skills for Attracting New Patients/ Clients under Health Care Reform

Using more carrots to change behavior

It is important in addiction treatment to:

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
It is important in addiction treatment to:
Confront negative behaviors
1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

It is important in addiction treatment to:
Use incentives
1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

It is important in addiction treatment to:
Understand why the person uses
1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

It is important in addiction treatment to:
Self disclose
1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

It is important in addiction treatment to:
Give advice
1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

It is important in addiction treatment to:
Offer the client a cup of coffee
1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
It is important in addiction treatment to: Search the clients for drug paraphernalia

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

14% 16% 10% 23% 3% 2%

It is important in addiction treatment to: Educate the client about the impact of substance use

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

0% 0% 0% 0% 0% 0%

It is important in addiction treatment to: Reflect understanding of the client’s experiences

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

0% 0% 0% 0% 0% 0%

Two Specific Strategies for Engaging Patients:

Medication Assisted Treatment (MAT)

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Medication Assisted Treatment (MAT)

Myth #1: Medication is not a part of treatment.
- Medication can be an effective part of treatment.
- Medication is used in the treatment of many diseases, including addiction.
- Medical decisions must be made by trained and certified medical providers.
- Decisions about using medications are based on an objective assessment of the individual client’s needs.

Myth #2: Medications are drugs, and you cannot be “clean” if you are taking anything.

- Misuse of Language:
  - “Drugs” are used to get high.
  - “Medications” are used to get better.
- Example: Millions use medication to quit smoking.
- Physical dependence versus addiction

MAT Myth Busters

Medicine is an innovation of the human species which has given us a competitive advantage for thousands of years; innovations in science & medicine have historically been helpful and progressive.
### MAT Myth Busters

**Myth #3**: Alcoholics Anonymous (AA) & Narcotics Anonymous (NA) do not support the use of medications.

- AA/NA literature and founding members did not speak or write against using medications.
- In fact, AA/NA endorses participants to use medicines as prescribed for the treatment of medical conditions.

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**Myth #4**: MAT is not effective.

- MAT had to demonstrate the same level of effectiveness as all other types of medications for other diseases to get FDA approval.
- We tend to have a biased perception:
  - Patients who improve leave and are forgotten.
  - Patients who do not improve return frequently and are remembered.
- Leads us to think that most patients do not improve… contrary to scientific data.

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**Effect of MAT**

- Increases retention and effectiveness of community addiction treatment
- Decreases recurrent drug use
- Decreases drug-related crime
- Decreases addicted persons being arrested/re-arrested
- Increases time between relapses
- Decreases incarceration costs

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**Extended Release Naltrexone – Vivitrol™**

**Extended-Release Naltrexone General Facts**

- **Generic Name**: naltrexone for extended-release injectable suspension
- **Marketed As**: Vivitrol®
- **Purpose**: To discourage drinking by decreasing the pleasurable effects from consuming alcohol.
- **Indication**: For the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment.
- **Year of FDA-Approval**: 2006

**Extended-Release Naltrexone Administration**

- **Amount**: one 380mg injection
- **Method**: deep muscle in the buttock
- **Frequency**: every 4 weeks
- Must be administered by a healthcare professional and should alternate buttocks each month.
- Abstinence requirements: must be taken at least 7-10 days after last consumption of opioids; must not be actively drinking at time of administration.
- Should not be administered intravenously.
How Does Naltrexone Work?

Antagonist

1) It blocks opioid receptors,
2) the reinforcing “reward” effects from dopamine are reduced,
3) drug consumption is thus reduced.

What does the research say?

• Naltrexone was well tolerated and associated with a significant abstinence rate.
• In a five-year follow up study, naltrexone with behavioral therapy saw improvements in number of days of use, legal status, and psychiatric functioning.

Scientific Research about Extended-Release Naltrexone for alcohol

Results: Participants treated with extended-release naltrexone did not maintain complete abstinence more frequently than those treated with placebo.

Scientific Research about Extended-Release Naltrexone for alcohol (cont.)

Results: Participants treated with extended-release naltrexone had a greater reduction in the number of heavy drinking days during the entire study than those treated with placebo.

Scientific Research about Extended-Release Naltrexone for alcohol (cont.)

Participants treated with extended-release naltrexone who had a seven-day abstinence period prior to treatment initiation had a greater reduction in the number of heavy drinking days during the entire study than those treated with placebo.
Scientific Research about Extended-Release Naltrexone for Opioids

Remained in Treatment after 2 months

Krupitsky, Zvartau, and Woody (2010). Current Psychiatry Reports, 12, 448–453

Mean Time to Dropout

Placebo 192mg 384mg

How Does Naltrexone Work?

Antagonist

Opiate Effect

Dose of Opiate

How Does Naltrexone Work?

Full Agonist (e.g., methadone)

Partial Agonist (e.g. buprenorphine)

Antagonist (e.g. Naloxone)

Buprenorphine

Development of Tablet Formulations of Buprenorphine

• Buprenorphine is currently marketed for opioid treatment under the trade names:

  Subutex® (buprenorphine)

  Suboxone® (buprenorphine/naloxone)

  Over 25 years of research

  Over 5,000 patients exposed during clinical trials

  Proven safe and effective for the treatment of opioid addiction

Buprenorphine: A Science-Based Treatment

Clinical trials with opioid dependent adults have established the effectiveness of buprenorphine for the treatment of opioid addiction. Effectiveness of buprenorphine has been compared to:

• Placebo (Johnson et al., 1995; Kallos et al., 2003; Ling et al., 1998)

• Methadone (Fischer et al. 1999; Johnson, Jaffee, & Fudula, 1992; Schottenfeld et al., 1997; Strain et al. 1994)

• Methadone and LAAM (leva-alpha-acetylmethadol) (Johnson et al., 2000)
**Buprenorphine Research Outcomes**

- Buprenorphine is as effective as moderate doses of methadone (Fischer et al., 1999; Johnson, Jaffee, Fudala, 1992; Ling et al., 1996; Schottenfeld et al., 1997; Strain et al., 1994).
- Buprenorphine is as effective as moderate doses of LAAM (Johnson et al., 2000).
- Buprenorphine’s partial agonist effects make it mildly reinforcing, encouraging medication compliance (Ling et al., 1998).
- After a year of buprenorphine plus counseling, 75% of patients retained in treatment compared to 0% in a placebo-plus-counseling condition (Kakko et al., 2003).

**Buprenorphine as a Treatment for Opioid Addiction**

- A synthetic opioid
- Described as a mixed opioid agonist-antagonist (or partial agonist)
- Available for use by certified physicians outside traditionally licensed opioid treatment programs

**The Role of Buprenorphine in Opioid Treatment**

- Partial Opioid Agonist
  - Produces a ceiling effect at higher doses
  - Has effects of typical opioid agonists—these effects are dose dependent up to a limit
  - Binds strongly to opiate receptor and is long-acting
- Safe and effective therapy for opioid maintenance and detoxification

**Advantages of Buprenorphine in the Treatment of Opioid Addiction**

1. Patient can participate fully in treatment activities and other activities of daily living easing their transition into the treatment environment
2. Limited potential for overdose (Johnson et al., 2003)
3. Minimal subjective effects (e.g., sedation) following a dose
4. Available for use in an office setting
5. Lower level of physical dependence

**Advantages of Buprenorphine/Naloxone**

- Discourages IV use
- Diminishes diversion

**Disadvantages of Buprenorphine in the Treatment of Opioid Addiction**

1. Greater medication cost
2. Lower level of physical dependence (i.e., patients can discontinue treatment)
3. Detectable only in specific urine toxicology screenings
Why was Buprenorphine/Naloxone Combination Developed?

- Developed in response to increased reports of buprenorphine abuse outside of the U.S.
- The combination tablet is specifically designed to decrease buprenorphine abuse by injection, especially by out of treatment opioid users.

What is the Ratio of Buprenorphine to Naloxone in the Combination Tablet?

- Each tablet contains buprenorphine and naloxone in a 4:1 ratio
  - Each 8 mg tablet contains 2 mg of naloxone
  - Each 2 mg tablet contains 0.5 mg of naloxone
- Ratio was deemed optimal in clinical studies
  - Preserves buprenorphine’s therapeutic effects when taken as intended sublingually
  - Sufficient dysphoric effects occur if injected by some physically dependent persons to discourage abuse

Why Combining Buprenorphine and Naloxone Sublingually Works

- Buprenorphine and naloxone have different sublingual (SL) to injection potency profiles that are optimal for use in a combination product.

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<th>SL Bioavailability</th>
<th>Potency</th>
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<tr>
<td>Buprenorphine 40-60%</td>
<td>Buprenorphine ≈ 2:1</td>
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<tr>
<td>Naloxone 10% or less</td>
<td>Naloxone ≈ 15:1</td>
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Buprenorphine/Naloxone: What You Need to Know

- Basic pharmacology, pharmacokinetics, and efficacy is the same as buprenorphine alone
- Partial opioid agonist; ceiling effect at higher doses
- Blocks effects of other agonists

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services
- For persons with substance use disorders
- Those who are at risk of developing these disorders
Primary care centers, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users
Before more severe consequences occur
SBIRT: Core Clinical Components

- **Screening:** Very brief screening that identifies substance-related problems
- **Brief Intervention:** Raises awareness of risks and motivates clients toward acknowledgement of problem
- **Brief Treatment:** Cognitive behavioral work with clients who acknowledge risks and are seeking help
- **Referral:** Referral of those with more serious addictions

SBIRT Goals

- Increase **access to care** for persons with substance use disorders and those at risk of substance use disorders
- Foster a **continuum of care** by integrating prevention, intervention, and treatment services
- Improve linkages between health care services and alcohol/drug treatment services

Rationale for screening and brief intervention

Benefits of Screening and Brief Interventions

$1 Spent

**Saves**

$2-4
Benefits of Screening and Brief Interventions

- Work Performance
- Neonatal Outcomes

Screening, Brief Interventions for Alcohol: Major Impact of SBI on Morbidity and Mortality

<table>
<thead>
<tr>
<th>Study</th>
<th>Results - Conclusions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma patients</td>
<td>48% fewer re-injury (18 months) 50% less likely to re-hospitalize</td>
<td>Gentilello et al, 1999</td>
</tr>
<tr>
<td>Hospital ER screening</td>
<td>Reduced DUI arrests E DUI arrest prevented for 9 screens</td>
<td>Scheer et al, 2008</td>
</tr>
<tr>
<td>Physician offices</td>
<td>25% fewer motor vehicle crashes over 48 month follow-up</td>
<td>Fleming et al, 2002</td>
</tr>
<tr>
<td>Meta-analysis</td>
<td>Interventions reduced mortality</td>
<td>Cuijpers et al, 2004</td>
</tr>
<tr>
<td>Meta-analysis</td>
<td>Positive social outcomes: substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence)</td>
<td>Burke et al, 2003</td>
</tr>
<tr>
<td>Meta-analysis</td>
<td>Interventions can provide effective public health approach to reducing risky use.</td>
<td>Whitlock et al, 2004</td>
</tr>
</tbody>
</table>

Screening, Brief Interventions for Alcohol: Saves Healthcare Costs

<table>
<thead>
<tr>
<th>Study</th>
<th>Cost Savings</th>
<th>Authors</th>
</tr>
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<tr>
<td>Randomized trial of brief treatment in the UK</td>
<td>Reductions in one-year healthcare costs: £2.30 cost savings for each £1.00 spent in intervention</td>
<td>UKATT, 2005</td>
</tr>
<tr>
<td>Project TREAT (Trial for Early Alcohol Treatment) randomized clinical trial</td>
<td>Reductions in future healthcare costs: £4.30 cost savings for each £1.00 spent in intervention (48-month follow-up)</td>
<td>Fleming et al, 2003</td>
</tr>
<tr>
<td>Randomized control trial of SBI in a Level I trauma center</td>
<td>Reductions in medical costs: £1.07 cost savings for each £1.00 spent in intervention.</td>
<td>Gentilello et al, 2005</td>
</tr>
</tbody>
</table>

What did you learn?

Clinicians who address substance use disorders in primary care settings should become aware of approaches that use:

- 11% Dynamic psychotherapy
- 20% Confrontation of denial
- 60% Positive reinforcement
- 16% Psychoanalysis

When medical services are moved into substance use specialty care programs, we call this:

- 50% Co-location
- 0% Interference
- 13% Medical Monitoring
- 38% Reverse co-location
Of the 21 Million individuals in the US who currently need treatment, what percent are currently in treatment?

- 11% 1. 10%
- 37% 2. 1%
- 0% 3. 50%
- 11% 4. 20%

The major impact of healthcare reform will occur in what year?

- 0% 1. 2010, it has already occurred
- 0% 2. 2020
- 0% 3. 2011
- 98% 4. 2014

Which states have already implemented a form of healthcare reform?

- 0% 1. Nevada, Arkansas, Ohio
- 96% 2. Maine, Massachusetts, Vermont
- 3% 3. California, Arizona, New Mexico
- 3% 4. None of the above

Vivitrol is the trade name for what addiction treatment medication

- 0% 1. Bupropion
- 92% 2. Naltrexone
- 0% 3. Methadone
- 12% 4. Buprenorphine

Buprenorphine is an opioid...

- 7% 1. Agonist
- 18% 2. Antagonist
- 75% 3. Partial Agonist
- 0% 4. Agony
- 0% 5. None of the above

Recovery Support Services in California
**What is Recovery?**

Recovery is a voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship.

Betty Ford Consensus Panel, 2007

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**Paradigm Shift**

- **Chronic Care Model**: When treated as a chronic illness, relapse rates are as good or better than other chronic illnesses (-McLellan et al. 2005)
- **Recovery Oriented System of Care (ROSC)**: Support person centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems (CSAT).

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**Recovery Oriented System of Care (ROSC)**

- ROSCs are founded on a chronic care model of substance use treatment and recovery services that use recovery management approaches to engage and treat, and provide recovery support services that help individuals/families sustain their recovery.

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**Recovery Oriented Approach to Tx**

- **Severe**
- **Remission**
- **Time**

---

**Recovery Support Services (RSS)**

- RSS are services that assist individuals & families working toward recovery.
- Incorporate a full range of social, legal, and other services that facilitate recovery and wellness.
- Include social supports, linkage to and coordination among allied service providers, and other services that improve Quality of Life of people seeking recovery.
Recovery Support Services (RSS)

• RSS may be provided before, during, or after formal clinical treatment or to those individuals who are not in treatment but need and seek support services.
• RSS are provided by professionals and peers
• Services are delivered through a variety of community and faith-based groups, treatment providers, and RSS providers.

Models of Recovery Support Services

• Self/Mutual-Help Programs
• Traditional Counseling
• Telephone-based
  – Monitoring, feedback and counseling
• Recovery “Check-ups”
  – Specialty & Primary care-based
• Assertive Continuing Care
• Recovery Centers
• Recovery Schools
• Faith-Based/Recovery Ministries
• Home Visits
• Medications
• Sober Living

Recovery Management Checkups

Study Overview (Dennis, Scott et al, 2003)

• An early re-intervention experiment evaluated the impact of a Recovery Management Checkup (RMC) protocol.
• Included quarterly recovery management checkups (assessments, motivational interviewing, and linkage to treatment re-entry).
• Data compiled from 448 adults who were randomly assigned to either RMC or an attention (assessment only) control group.

An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. Dennis, M., Scott, C., and Funk, R. Evaluation and Program Planning 26, 2003, 339-352

Recovery Management Checkups

Intervention

• If patient reports any of the following……
  – Use of alcohol or drugs on ≥ 2 weeks
  – Being drunk or high all day on any days
  – Alcohol/drug use led to not meeting responsibilities
  – Alcohol/drug use caused other problems
  – Withdrawal symptoms

  …Patient transferred to linkage manager

Recovery Management Checkups

Results

• Participants assigned to RMC were significantly more likely to:
  – Return to Treatment
  – Return to treatment sooner;
  – Spend more subsequent days in treatment; and
  – They were significantly less likely to be in need of additional treatment at 24 months

An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. Dennis, M., Scott, C., and Funk, R. Evaluation and Program Planning 26, 2003, 339-352
Recovery Management Checkups

Conclusions

- These findings clearly support the wide spread belief that addiction is a chronic condition as well as demonstrating the need and effectiveness of post-discharge monitoring and checkups.

Telephone-Based Continuing Care

Overview of Model

- Potential to promote better long-term engagement and participation because:
  - Convenient for client
  - Promotes "self-management"
  - Reduces stigma of weekly trips to the treatment program
  - Individualized attention
  - Can be automated (Helzer, Searles et al.)
  - Lower costs of ongoing care (face-to-face care)

Telephone-Based Continuing Care

Study Overview (McKay et al, 2005)

- Study sought to compare telephone-based continuing care with 2 more intensive face-to-face continuing care interventions.
- Alcohol- and/or cocaine-dependent patients (N = 359) who completed a 4-week intensive outpatient program.
- A randomized 3-group clinical trial with a 2-year follow-up was conducted at 1 community-based and 1 Veterans Affairs medical center facility and 2 outpatient substance abuse treatment programs.

Data on 12-Steps

Summary of Findings (Humphreys, 2004)

- Longitudinal studies associate AA and NA participation with increased abstinence, improved social functioning, and greater self-efficacy.
- Participation seems more helpful when members engage in other group activities in addition to attending meetings.
- 12-step self-help groups significantly reduce health care utilization and costs, removing a significant burden from the health care system.

Data on 12-Steps

Conclusions (Humphreys, 2004)

- Self-help groups are best viewed as a form of continuing care rather than as a substitute for acute treatment services

Data on 12-Steps

Summary of Findings (Donovan, 2008)

- Longitudinal studies usually find that 12-Step involvement after treatment is associated with higher rates of abstinence regardless of the kind of treatment received;
- Consistent and early attendance/involvement leads to better substance use outcomes;
- Small amounts of participation may be helpful in increasing abstinence, whereas higher doses may be needed to reduce relapse intensity;
Data on 12-Steps

Summary of Findings (Donovan, 2008)

• Attendance is not involvement; when AA attendance and AA involvement (e.g., reading 12-step literature, getting a sponsor, “working” the steps, or helping set up meetings) are both measured, involvement is a stronger predictor of outcome; and
• Reductions in substance use associated with 12-Step involvement are not attributable to...influences such as motivation, psychopathology, or severity.

Funding RSS

According to SAMHSA’s survey of 22 states, RSS funding mechanisms include:
- Medicaid
- The Substance Abuse Prevention and Treatment (SAPT)
- Block Grant
- Access to Recovery (ATR) program,
- Recovery Community Services Program (RCSP),
- State and local funding,
- Other funding streams such as Temporary Assistance for Needy Families (TANF), drug courts, and private funding.

The Cost of Recovery

• A study of drug treatment programs published in the journal Health Policy Research found that every dollar spent on treatment saves $7 in costs ranging from health care and mental health services, to criminal activities and resulting incarceration, to lost earnings.

Treatment of SUDs: Changes Ahead

SUD Treatment will increasingly become a part of the healthcare system and less an extension of the criminal justice system. Treatments will be required to “attract” patients based on their effectiveness, convenience and patient acceptability, rather than relying on patient coercion. Scientific evidence and treatment accountability will play increasingly important roles.

Current SAMHSA initiatives

- Preparing field (states, providers, consumers, families)
  Capacity to provide mental health and substance use services (workforce)
  Accessing and developing strategies to improve infrastructure (data, HIT)
  Facilitating linkage with primary care and other providers
  Providing enrollment information
- Reviewing current block grant spending to focus on recovery and support services not paid for through Medicaid or commercial insurance

- Providing workforce development to addiction service providers through the ATTC Network www.attcnetwork.org
- Grants for screening and brief interventions (SBIRT) for primary care
- National Technical Assistance Center for Primary Care and Behavioral Health Integration (SAMHSA/HRSA). Awarded to the National Council for Community Behavioral Health Care
ROSC Resources

- Technical Assistance
  - ATTC/ROSC Website: www.ATTCnetwork.org/recovery

- Recovery Community Service Programs
  - www.rcsp.samhsa.gov

- State Analysis of Funding Recovery Support Services

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  www.uclaisap.org

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- Wednesday, December 1,
  2010 Merced County

- Tuesday December 7, 2010
  Alameda County