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The Opioid Addiction Epidemic: An Interview with Andrew Kolodny, MD
National Expert on the Current Opioid Addiction Epidemic in the United States

By Ira Minot, LMSW
Executive Director
Behavioral Health News

Ira Minot (IM): We are honored to have this opportunity to speak with you Dr. Kolodny. Our readers are anxious to learn about the current opioid epidemic.

Andrew Kolodny (AK): I am very pleased that *Behavioral Health News* is devoting this issue to the current opioid epidemic. Opioid addiction is the most urgent public health crisis facing the country. The CDC would agree with that and are calling this the worst drug epidemic in our country's history, and have placed this issue on their *top five priority health challenges* for the country. The Obama administration has finally recognized the seriousness of this problem and the President is proposing $133 Million in the 2016 budget to target the opioid crisis. As you and your readers may know, governors around the country have been talking more about the opioid addiction epidemics in their states. Last year for instance, Governor Peter Shumlin of Vermont devoted his entire State of The State Address to the crisis they are dealing with (www.governor.vermont.gov/newsroom-state-of-state-speech-2013). Many other state's elected officials have come out to proclaim the opioid epidemic as a signature issue in their state. With that background I am again so glad you're publication is focusing on this because frankly, I am amazed by how little attention this problem gets considering how serious it is.

When we talk about the problem you'll hear it described in different ways. You will hear it described as a problem with prescription drug abuse, or Heroin abuse. However, I think that's the wrong way to describe the problem. It's the wrong language, and I believe the language we use to describe it is important. I don't believe we have an epidemic of people abusing opioids – which sort of makes you think of it as teenagers taking pills for fun and then overdosing on the pills, or people using Heroin because it feels so good. That's not the problem.

The problem we have in this country is an epidemic of opioid addiction. Some of the people who have this *disease* of opioid addiction develop the disease through abuse of painkillers, but many people develop this disease through *medical use* of painkillers. It's both medical and non-medical use of painkillers which lead to opioid addiction.

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Unintended Consequences:
Are We Inadvertently Increasing Heroin Overdose Deaths?

By Richard Juman, PsyD
Editor, Professional Voices
TheFix.com

Two years ago, The Fix spearheaded an effort to highlight the public health epidemic caused by the overprescribing of opioid pain medications which resulted in the tens of thousands of overdose deaths that were making front page news. The epidemic was iatrogenic- "caused by physicians"- in nature. Until quite recently, the vast majority of physicians understood that opioid pain medications—invaluable for short-term pain, for treating cancer and for easing suffering at the end of life—had no place for longer-term, chronic use. It was accepted that the opioids' side effects and the potential for tolerance, the risk of addiction and the eventual pain of opioid withdrawal made for a very poor risk-benefit analysis for their patients. Unfortunately, over a decade ago, a variety of forces changed all that, including a general movement in medicine to treat pain more adequately, a tendency for consumers to believe that every discomfort should have a medical cure and a devastatingly successful campaign by pharmaceutical companies to convince physicians that opioid pain medications, prescribed to patients with genuine pain, would not lead to addiction. These factors were the primary agents behind a sea change in physician behavior, where routinely and repeatedly, opioid pain medications were prescribed to patients suffering from chronic, non-terminal pain.

Obviously, as a nation we are still devastated by this paradigm shift. Into the calculus of addiction, which was already impacting around 15% of our population, prescribed opioid addiction was introduced. Vicodin and OxyContin led the charge, and opioid addiction quickly became the fastest-growing drug problem in the nation. Accidental drug overdose outstepped car accidents as the most common cause of accidental death, with most deaths resulting from prescribed opioids.

In a series of articles designed to bring a better understanding of these complex issues to primary care physicians, The Fix has endeavored to illuminate the problem of the opioid epidemic as well as to inspire change. And there have been important actions taken since these efforts began two years ago. Have they had the desired impact, or have efforts to decrease the overprescribing of prescription pain medications inadvertently created a boom in the misuse of heroin?

Federal and State Action

In the past two years, both federal and state governments have enacted changes designed to impact the epidemic of addiction and overdose from prescribed pain medications. The federal government has pushed for pain medications to become more difficult to misuse by requiring that they are more difficult to crush, break or dissolve. Additionally, it has reclassified Vicodin and other products containing hydrocodone from Schedule III to the more restrictive Schedule II, which imposes more restrictions on prescribers. At the same time, most state governments have created Prescription Monitoring Programs or Prescription Drug Monitoring Programs (PMPs or PDMPs). These are electronic databases that collect information

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#CombatHeroin: New York State's Campaign To Address Heroin and Prescription Opioid Abuse

By Arlene González-Sánchez, MS, LMSW, Commissioner, New York State Office of Alcoholism and Substance Abuse Services (OASAS)

Heroin and prescription opioid medication abuse are persistent national problems that are reaching deep into communities across New York State. The problem is increasingly affecting teenagers and young adults, though older New Yorkers are consistently affected.

More and more people are dying from poisonings involving these substances each year. More than 16,000 people in the U.S. died in 2013 using prescription painkillers, according to the latest National Center for Health Statistics data. Comparatively, in 2000, there were 4,400 deaths from prescription painkillers. Nationally, the annual number of deaths involving heroin has gone from 1,842 in 2000 to 8,257 in 2013. Data from the CDC just this month states that in New York State death rates involving opioid pain medications were highest among men, whites, people ages 45-64, those who reside outside of New York City, and Medicaid enrollees. In 2014, there were more than 118,000 admissions into New York State-certified treatment programs for heroin and prescription opioid abuse – a 17.8 percent increase over 2009. The largest increase in heroin and prescription opioid admissions during that time was for patients ages 18 to 34.

Young People at Risk of Addiction

According to the Center for Alcohol and Substance Abuse at Columbia University, 9 out of 10 people with addiction started using substances before they turned 18. According to the Youth Risk Behavior Survey, the percentage of New York State high school students who reported using heroin more than doubled between 2005 and 2011.

Fighting Back: New York State's #CombatHeroin and Prescription Drug Abuse Campaign

Under Governor Andrew M. Cuomo's leadership, New York has taken an aggressive approach to combating heroin. In June 2014, Governor Cuomo signed a package of historic bills to address the heroin and prescription opioid abuse epidemic using a collaborative approach, focusing on public health, safety, education and awareness.

The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) has spearheaded the educational and public awareness efforts by launching a multi-faceted #CombatHeroin campaign. To help shape the campaign, NYS OASAS conducted a series of listening forums which included young people in recovery, parents, students, treatment providers, and individuals impacted by substance use disorders, including those who were specifically impacted by heroin and opioids.

OASAS Commissioner Arlene González-Sánchez, MS, LMSW

The campaign evolved around individuals sharing their experiences and offering advice on how and where to reach the target audiences identified as young people ages 15-25 and adults/parents. Consistent with the campaign's theme that "addiction can happen to anyone, any family, at any time," 20 individuals who exemplified courage and strength were interviewed and shared their perspective. They shared personal stories about their or their loved ones' progression into addiction, challenges they faced in accessing treatment, peer pressure, trauma, helping a loved one or family member who was battling the disease of addiction, and even recounting the devastating loss of a child due to a heroin or prescription opioid overdose.

Using some of the most impactful sound bites from these interviews, four public service announcements were produced and were aired on network and cable T.V. in the fall of 2014 and again in the winter of 2015. A digital and social media campaign ran simultaneously which was followed up with an outdoor campaign which featured highway billboards, and large campaign posters on trains, in train stations, on the Staten Island Ferry, and in high-traffic areas in select malls.

Another key component of the campaign included the development of a new website focused on educating the public about heroin and opioids. The Combat Heroin website www.combatheroin.ny.gov has received nearly 350,000 page views and contains information on prevention, warning signs of opioid use, getting help, getting involved and accessing treatment. The ***Real Stories*** section of the website features interviews with the real people referenced above who talk about addiction, withdrawal, treatment and recovery. The availability of these stories has helped to open the door to a conversation on a topic that, for many, may be uncomfortable.

Other components of the campaign included the distribution of informational flyers to help explain the warning signs of addiction, and especially how addictive heroin and opioids can be. Campaign materials also included a fact sheet with tips on how to prevent prescription drug misuse, a listing of opioids, depressants and stimulants and facts meant to raise awareness about the risk these drugs can present when taken inappropriately. Other materials point parents and young people to action steps they can take to get help or to get involved in the state-wide campaign. All of the materials are downloadable or can be ordered in bulk free of charge within New York State. They can be found on the #Combat Heroin Resources webpage: www.combatheroin.ny.gov/resources and click on the order form link on that page.

Anti-overdose Medication Trainings: Naloxone Saves Lives

Governor Cuomo's multi-pronged approach to combating heroin also includes a commitment to train more community members to deliver the life-saving anti-overdose medication naloxone. This medication is important for reversing an overdose, but is also an important first step in ensuring that individuals who suffer from addiction have an opportunity to enter treatment and begin a road to recovery.

OASAS, through its 12 Addiction Treatment Centers, in partnership with other state agencies including the NYS Department of Health, the NYS Department of Criminal Justice Services, the State Police, the SUNY and CUNY systems, and the Division of Homeland Security and Emergency Services, has conducted hundreds of sessions to train the general public and law enforcement on the use of naloxone, a.k.a. Narcan, and has provided kits to those who have been trained so that they can deliver the medication in an emergency. To date, more than 44,000 people have been trained to administer the anti-overdose medicine and there have been over 1,250 lives saved.Additional trainings are being offered in communities throughout New York State each week. Trainings are FREE and OPEN TO THE PUBLIC. To organize or attend a training in your community, visit: www.oasas.ny.gov/atc/ATCherointraining.cfm for a listing of trainings in your area

Insurance Changes: Access to Treatment

Another critical component of the heroin and opioid epidemic legislation is to ensure that those with substance use disorders have access to treatment. To this end, one of the laws passed in June of 2014 addressed the issue of insurance coverage for substance use disorders. Those with substance use disorders and their families had reported facing struggles accessing appropriate levels of care for themselves or their loved ones. For example, individuals were told they need to "fail first" at outpatient treatment before they could be admitted for inpatient treatment, when they may have needed and qualified for a more-intensive inpatient treatment first.

To address this, and other concerns, NYS insurance laws were changed to:

- Enact a state level parity law;
- Require utilization review agents to have behavioral health experience;
- Require insurers to pay for inpatient care during the appeals process; and
- Require NYS OASAS Commissioner approval of the level of care/medical necessity tools used by insurers to make substance use disorder (SUD) decisions.

NYS OASAS has developed a new "level of care" tool (LOCATDR 3.0) for insurers and treatment providers to use to determine the most appropriate level of care for individuals, ensuring that "fail first" policies are no longer allowed.

There is HOPE: Opioid Dependence is a Treatable Illness

Though the problem of opioid dependence is widespread, and New York State has several aggressive efforts underway aimed at curbing the epidemic, it is important to remember that opioid dependence is a treatable illness. With appropriate treatment, many people can have lasting recovery sustained over many years. Addiction, including opioid dependence, should not be thought of as a moral disorder. It is a primary disorder of the brain.

The opioid epidemic across the nation has prompted a more general and frequent discussion of addiction than that which has occurred in many years. This recent uptick in discussions will hopefully allow society to have a greater understanding of addiction, relapse and recovery. Similar to other chronic illnesses, relapse can occur and not unlike heart disease and repeated cardiac events, addiction relapse should be treated and efforts should be aimed at preventing such a relapse.

Individualized Treatment: Medication Supported and Behavioral Therapies

Treating opioid dependence includes several modalities and it is important that the treatment modality is tailored to the individual.

One treatment option is medication assisted treatment or what we in New York State prefer to call medication supported recovery. In this modality people receive medication along with some sort of psycho-social spiritual treatment, such as cognitive behavioral therapy, contingency management, dialectical behavior therapy and/or a 12 step program facilitation. This sort of treatment can be very effective in not only helping the person affected with opioid dependence to stop using opioids or other intoxicants on a regular basis, but in facilitating the individual's reunion with her or his family. It can also help an individual gain emotional stability. Medications that are commonly used and which are quite effective include:

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Combat Heroin and Prescription Drug Abuse

Barriers to Medication Assisted Treatment for Opiate Use Disorders

By Christene Amabile, FNP-BC and Paige Prentice, MM, CASAC Horizon Health Services

Christene Amabile, FNP-BC

Paige Prentice, MM, CASAC

It has become an all too familiar (but no less disturbing) scenario for the nurse practitioner working in a large drug treatment center in upstate New York. Today she is leading an educational support group for individuals who are opiate dependent and awaiting medication assisted treatment with buprenorphine/naloxone (brand names: Suboxone or Zubsolv) or Buprenorphine (brand name: Subutex). The topic today is overdose prevention and group participants share their stories. Tom a 20-year-old well groomed, athletic, male tells the group that four months ago he had his fourth heroin overdose. "I'm not sure why I'm still alive. I was dead for 20 minutes during resuscitation attempts. I knew I was at risk after my first overdose but I was out of control and *could not* stop. I had to keep using heroin. I'm still shooting just enough to keep from getting sick until there is an opening for me to see the doctor who prescribes buprenorphine. I've been on the waiting list for a month."

Jamie spoke next. He is 19 years old and had been using prescription opiates since a motor vehicle accident three years ago. At first the "hydros" (street name for hydrocodone) were for pain. Eventually, his pain resolved but his use of opiates continued. Soon he was buying prescription opiates, "off the street" until they became too hard and too expensive to obtain. "A friend of mine introduced me to heroin which was much cheaper and much easier to get. I have overdosed three times in the past six months and I was admitted to an ICU two of those times. I still owe $30,000 in ambulance bills alone. While I wait for my buprenorphine appointment (he's on the waitlist too), I'm buying Subs (street term for Suboxone) off the street."

Perhaps most disturbing of all was Andrew, age 45, who has been using intravenous heroin since age 11. "Once I woke up on a gurney in a morgue surrounded by dead people on either side of me. Someone must have mistaken me for dead and brought me there. I pulled the sheet off of my face, wrapped it around me and got up and started running. I think I gave the coroner a heart attack!" The group laughed nervously at this unbelievable scenario. With a sense of frustration, the group facilitator wonders if/when she will be able to prescribe buprenorphine, which seems to her one viable option to improving access to treatment for individuals with opiate use disorders (OUD). She cannot help but wonder how these clients will fare while they await their appointments to receive buprenorphine. Some of them have already been waiting several weeks and are anxiously awaiting a call for an appointment. What if there was just such a waitlist for insulin? Because the individuals in this group are at high risk for yet another overdose, the NP introduces the topic of overdose prevention.

With consequences like overdosing, why don't they just stop? The answer is altered brain chemistry, genetics, and life circumstances, not moral failing. Extended opiate use causes changes in brain chemistry, structure and function. These changes result in relentless, intense cravings that override all other normal judgment and decision-making. Persons addicted to opiates need time for their brain and body to heal. What is known definitively is that the most effective treatment for OUD is counseling *with* medication assisted therapy.

Opioid dependence represents a serious public health problem affecting a growing number of individuals in the United States. It is estimated that there are 1 million heroin addicted individuals in need of treatment and nearly 2 million untreated prescription opiate dependent people in the United States (NSDUH, 2011). The opiate overdose statistics are just as staggering. Fatal overdose from opiate medications such as oxycodone, hydrocodone and Fentanyl have *quadrupled* since 1999 accounting for an estimated 16,651 deaths in 2010 (these are prescription opiate overdoses only and do not include overdoses caused by heroin). Interestingly, there has been a 5% decline in opiate analgesic death rates from 2011 to 2012. This represents the first decrease seen in more than a decade (Warner, Hedegaurd).

One explanation for this decline is in part due to much needed and essential legislation that makes obtaining prescription opiate analgesics more difficult. For example, the prescription drug monitoring program (PDMP) is a statewide electronic database of prescriptions dispensed by pharmacies for controlled substances. This information can be used to help identify or prevent drug abuse or diversion, facilitate the detection of patients who may have an addiction problem, and inform and educate public health agencies and health professionals about the use, abuse and diversion of prescription drugs (PDMP Training and Technical Assistance Center www.pdmpassist.org).

Unfortunately, there has been a ripple effect of stricter policies regarding prescription opiate analgesics. That is, a resurgence in the widespread use of heroin which is a cheaper and more readily available illicit and potentially lethal opiate. In 2013 there were 169,000 persons aged 12 or older who used heroin for the first time in the past 12 months compared to 90,000 individuals in 2006 (US Department of Health and Human Services, 2013). On January 12, 2015, The White House Office of National Drug Control Policy (ONDCP) announced the 2013 drug overdose mortality data from the Center for Disease Control and Prevention (CDC). The data shows that the mortality rate associated with heroin increased for the third year in a row representing a 39 % rise from 2012-2013 (Office of National Drug Control Policy, 2015).

Like diabetes and hypertension, chemical dependency is considered a chronic medical condition and often requires ongoing management with a combination of treatment modalities. Because of the complex changes that occur in the brain both structurally and chemically with substance use disorders, outcomes rely on a variety of factors including the individual's motivation for recovery and access to treatment (outpatient, inpatient, or residential treatment centers). Once in treatment for an OUD there are three options for medication assisted treatment (MAT); Methadone, Naltrexone/Vivitrol, and Buprenorphine.

1. Methadone is a full opiate agonist and is an effective, evidenced-based treatment for opiate dependence. However, it requires that individuals receiving methadone obtain their daily dose from a federally qualified methadone clinic.

2. Naltrexone (oral form) and Vivitrol (intramuscular injection form) is an opiate agonist and is designed to block the desired opiate response. An individual must be opiate-free for 7-10 days prior to starting

see Barriers on page 30

Homelessness and Addiction – Housing and Services

By Martin Teller, Executive Director Finger Lakes Addictions Counseling and Referral Agency, Inc. (FLACRA) NYASAP Board Member

The New York Association of Alcoholism and Substance Abuse Providers (*NYASAP*) recognizes that access to safe, affordable housing and stable living-wage employment are fundamental to long-term health, wellness, and recovery for individuals, families and communities.

The Office of Alcoholism and Substance Abuse Services (OASAS) residential treatment system alone admits over 4,000 homeless persons annually. Additionally, 50% of all single men seeking homeless shelter admissions, 25% of single women, and 25% of heads of household have addiction histories, with most also struggling with chronic psychiatric and medical conditions.

Our *NYASAP* member agencies have extensive experience in Outreach, motivational counseling, and successful referral to ongoing health and social services, especially with homeless people and individuals with histories of criminal justice involvement. Our agencies are uniquely situated to provide Transitional Housing and supports to homeless or at high risk of homelessness patients about to be discharged from hospital surgical or medical services as well as from acute psychiatric or chemical dependency detoxification services. Many of our Intensive Residential programs, especially in NYC, have on-site Article 28 Primary Care clinics and many of our Upstate Community Residential providers have existing partnerships with general hospital and community health center primary care and specialty service clinics.

There now are over fifty *NYASAP* member agencies who operate Treatment and Supportive Housing programs designed to serve homeless individuals and families. Our agencies have significant experience in "bundling" housing, daily living skills, care coordination, job development and post-employment support, and Recovery Support services and activities, because they have secured funding for all of these activities. Approximately 90% of all admissions remain in Permanent Supportive Housing (PSH) programs for at least one year, with less than 10% incidence of addiction-related hospitalizations during that time period.

More than one-third of participants become employed within that first year, with another 15% enrolling as full-time students at Community Colleges or four-year colleges.

Over 90% of all families in PSH programs remain intact; one-half of families in OASAS Housing were re-united from Foster Care arrangements by the end of their first year.

The current *OASAS* Housing Portfolio is approximately 2,000 units statewide, with approximately one-third of the housing for families. OASAS PSH "brands" include approximately 1,000 units of HUD Shelter Plus Care programs for single adults and families (including 400 units in Upstate communities); 600 units of New York/New York III Housing (400 for Single Adults and 200 units for Families), in partnership with NYC government; 75 units of Upstate PSH units in partnership with seven Upstate counties; and 300 units of MRT Supportive Housing for single adults (100 units in NYC; 55 units in Long Island and the Lower Hudson Valley; and 145 units in Upstate New York).

A number of *NYASAP* member agencies have proudly developed housing for Veterans in recent years. Cadence Square in Canandaigua NY (photo below) includes 17 affordable housing units for Veterans.

NYASAP is convinced that Supportive Housing Builds Recovery --- for individuals, for families, and for communities that have been battered by substance use, homelessness, and lack of economic opportunities.

Prescription Drug and Heroin Epidemic A Central New York Perspective

By Monika Taylor, LCSW, CASAC, Director, Behavioral Health Services, Crouse Hospital; NYASAP Board Member and Women and Family Issues Committee Co-chair

Monika Taylor, LCSW, CASAC

Like much of the country, New York State is experiencing a public health crisis of a magnitude never before seen related to prescription opiate and heroin overdose and addiction. While efforts to address this crisis are multifaceted, many of those in need of treatment are unable to get the help they need and frequently lives are lost to overdose.

In August 2013, New York State launched a Prescription Monitoring Program (PMP) called I-Stop, requiring prescribers to consult the PMP registry when writing prescriptions for Schedule II, III and IV controlled substances. Prescribers are able to view patients' dispensed controlled substance prescription histories and determine whether there may be abuse or non-medical use and consequently they can better evaluate the appropriateness for these medications in the treatment of their patients.

Since its launch, the widespread abuse of narcotic medications like Oxycontin, Oxycodone, Hydrocodone, Hydromorphone, Fentanyl, Levorphanol, Codeine, Lorcet, Lortab, Norco, Oncet, Procet, Vicodin, Xodol and Zydone has declined due to decreased availability. Unfortunately, many individuals already addicted to opioids turned to heroin to support their addiction – especially if treatment was not readily available.

In June 2014 Governor Cuomo signed legislation to combat the heroin and opioid epidemic in New York State. The *Combat Heroin* campaign increased hope among the prevention, treatment and recovery community for additional support.

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Important Tool Reduces Overdose Deaths

By Sharon Stancliff, MD, Medical Director, Harm Reduction Coalition, New York Society Addiction Medicine (NYSAM) Executive Board, Secretary

Sharon Stancliff, MD

In 2012, there were 1,848 deaths due to drug overdose in New York State. Heroin was involved in 488 of these, and opioid analgesics in 879. Many, perhaps a majority of these deaths can be prevented through education and access to tools.

Drug treatment is a part of overdose prevention, however when patients with opioid use disorders leave or complete drug treatment they may be at higher risk of overdose than when they entered treatment due to loss of tolerance. Relapse is part of the path for many patients; drug treatment programs can offer help to prevent these deaths to all their patients.

Naloxone is a medication which reverses the effect of opioids, including respiratory depression which can lead to death. It is easily administered either intranasally or by injection; it's only effect is blocking opioids, thus is very safe. A New York State legislated initiative allows people at risk of witnessing an overdose to carry and use Naloxone on a person suspected of having an overdose. New York State Department of Health supplies free Naloxone to many agencies, including OASAS licensed clinics for the purpose of supplying it to patients. When patients receive training and a naloxone kit two messages are delivered. The first is that the treatment program cares about their safety even if he or she not successful in avoiding drug use. The other is that the program believes that the patient is capable of saving a life. Both can be powerful messages for individuals seeking help.

For information on how to register as an overdose prevention program to provide your program's patients with Naloxone go to www.nyhealth.gov/overdose or send an email to the Harm Reduction Coalition: stancliff@harmreduction.org.

Resources Are Needed To Address the Epidemic of Addiction and Overdose

By John Coppola, Executive Director New York Association of Alcoholism and Substance Abuse Providers (ASAP)

In spite of the fact that seemingly every media outlet in New York has raised awareness about the epidemic of addiction and overdose related to prescription opioids and heroin, the Office of National Drug Control Policy has identified it as a priority. Although the New York State legislature has taken some limited actions to address this public health crisis, the epidemic continues to ravage our State. Since the passage of I-STOP, a package of bills passed by our state legislators in June 2014 - including legislation to increase access to treatment for people with health insurance, and increased use of Naloxone that has saved hundreds of lives in NYC - have not been enough to reverse this epidemic. New Yorkers continue to die every day. Our continued failure to support a comprehensive continuum of prevention, treatment, and recovery support services has allowed the epidemic to continue causing more addiction, more death, and more pain for individuals, families, and communities throughout New York State and across our country. **New York State Must Address Its Prescription Drug and Heroin Addiction and Overdose Epidemic.**

The Combat Heroin Media Campaign and legislation signed into law by Governor Cuomo created hope that resources for prevention, treatment, and recovery support services would be increased in the 2015-16 state budget proposal to better address this epidemic. A flat budget proposed for the New York State Office of Alcoholism and Substance Abuse Services, (OASAS), surprised and disappointed family members and substance use disorders services providers who worked so hard to bring attention to the need for more resources.

A flat budget for OASAS fails to address unacceptable waiting lists for adults, a lack of available treatment services for youth and young adults, the need for more prevention professionals in school and community programs, the need for recovery support services, and the need for even more extensive availability of

John Coppola

naloxone and other harm reduction efforts. A flat budget for OASAS misses the opportunity for a much more concerted effort to combat the heroin and prescription epidemic AND the even greater consequences of addiction to alcohol that impact people of all ages throughout New York State.

What Must Be Done To Address This Epidemic?

New York State must take actions necessary to strengthen prevention, treatment, and recovery support. The New York Association of Alcoholism and Substance Abuse Providers, (ASAP) has asked our state legislators to:

1. Provide additional funding to OASAS to expand school and community-based prevention, treatment, and recovery support services.

- Make treatment available on demand.
- Expand the availability of services specifically designed for adolescents and young adults. An increasing number of 18-26 year olds (and younger) are being seen in emergency departments for opioid overdoses and need treatment. A full continuum of age appropriate treatment and recovery services must be made available on demand to meet the needs of this population.
- Strengthen prevention services with emphasis on specialized, targeted prevention focused on children, adolescents, young adults, adults, and older persons who are at risk for prescription misuse.
- Implement educational programs for physicians, pharmacists, and other health professionals focused on SBIRT training, assessing risk for addiction, availability of substance use disorders services in their community, and other related topics.
- Incorporate into existing public awareness campaigns information to increase public awareness about New York's Good Samaritan law and overdose prevention resources (Naloxone, etc.).
- Include OASAS prevention services providers in the implementation of the NYS Department of Health's prevention agenda
- Establish recovery centers in every New York State county.
- Support use of Certified Addiction Recovery Coaches and Peer Advocates in a variety of services and community settings. Continued emphasis on the importance of peers/ recovering persons as a vital part of the substance use disorders services delivery system is important.

2. Support increased and ongoing education efforts to ensure widespread access to and use of life saving Naloxone

3. Expand availability and access to medication assisted treatment in Opioid Treatment Programs, other treatment programs, and physician practices (Methadone, Suboxone, Vivitrol, etc.) with an emphasis on the vital role that individualized treatment services have in achieving positive health outcomes. Physicians who prescribe addiction medicines should be monitored and required to affiliate/collaborate with an OASAS licensed program to assure a connection with addiction counseling and recovery support services.

4. Support an aggressive campaign to expand use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in emergency departments, community health centers, and other primary care settings so that the 90% of persons with substance use disorders that are not currently accessing treatment are increasingly referred. SBIRT in primary care settings will help persons with problematic use of prescription medications to be identified earlier on and facilitate successful referral to treatment.

5. Insist that there be significant expansion of community-based detoxification services, particularly to address persons with a substance use disorder related to prescription opiates and heroin. This would help to increase access to detox, strengthen the connection between detox and engagement in treatment (because most community-based detox services providers will also be treatment services providers), help to reduce unnecessary hospitalizations, and address a major gap in substance use disorder services in NYS.

Resources for prevention, treatment, and recovery support services have not kept pace with the demand for services. Resources have failed to even keep up with inflation, creating a fiscal crisis for some programs, resulting in closure for some. This failure to adequately support the level of services needed to address the prescription opiate and heroin addiction and overdose epidemic is hard to understand given the increasing voice of families who have lost loved ones and the daily coverage of this crisis in the media**. It will take a significant advocacy effort to gain the resources and support needed to make prevention, treatment, and recovery support services available on demand.**

see Resources on page 26

Will The Effort to Prevent Overdose Deaths From Prescription Painkillers Work?

By Michael B. Friedman, LMSW
Behavioral Health Policy Advocate

Over 16,000 people per year die from overdoses of prescription painkillers (opiod analgesics) —more than triple the number of deaths two decades ago.[2,4,5,6,12] This vast increase has led to a major public health initiative to reduce the misuse and abuse of these drugs. Will it work? There are reasons for optimism, but there are also important questions to raise about whether these campaigns need to be recast to have greater impact on the behavior of people at high risk and of doctors who over-prescribe as well as to be sure that people who need pain relief get it.

Basic Facts

• Prescription painkillers include Oxycodone (OxyContin), Hydrocodone (Vicodin), Oxymorphone (Opana), and Methadone, which has been used to treat heroin addiction for over four decades but now is increasingly prescribed as a painkiller.[3,7]

• There are now more overdose deaths from prescription painkillers than from heroin and cocaine combined.[2]

• The increase in the number of deaths from prescription painkillers over the past two decades parallels the increase in the number of opiod analgesics prescribed, which has also more than tripled.[1]

• About 20% of doctors prescribe 80% of painkillers.[4] This may reflect the fact that some doctors are more likely to treat patients with severe pain. But in some cases doctors knowingly write prescriptions for drugs that will be resold illegally.

• Most people who die from overdoses of prescription painkillers did not have prescriptions. The drugs they use have usually been "diverted", either purposely or inadvertently, from the people for whom they were intended.[4] (There is some indication that in the case of methadone as many people with prescriptions die from overdoses as those using diverted drugs.[7])

• 30-40% of deaths from prescription painkillers involve the use of methadone. [3,7,12]

• About half of all deaths involve the use of more than one drug—frequently an anti-anxiety drug (a benzodiazepine) and/or alcohol.[4]

• Over 100 million Americans suffer from chronic pain.[8] Most can manage pain without recourse to opiod analgesics. But for some, opiods are the only painkillers that are effective.

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The Pubic Health Initiative

The public health initiative to reduce the number of overdose deaths from prescription painkillers focuses on (1) changing the prescribing practices of physicians who overprescribe opiod analgesics, (2) encouraging those who need and use prescription painkillers to use and store them cautiously, (3) persuading people who use opiod analgesics to get high not to do so and to get treatment if they are addicted, and (4) making an antidote to opiate overdoses available for emergency, lifesaving intervention.

Specifically, The Centers for Disease Control (CDC) recommends[4] that:

1. States should develop "prescription drug monitoring programs" (which 36 already have in place) to identify high risk patients and physicians who prescribe large quantities of opiod analgesics. (High risk patients include those who get prescriptions for both painkillers and benzodiazepines and who get prescriptions from multiple doctors.)

2. States should also develop "patient review and restriction programs" and restrict some high risk patients to one doctor and one pharmacy for their drugs. It might also be possible to provide education to them about the risks of their drugs and/or to engage them in treatment.

3. States should also develop "health care provider accountability" mechanisms, including education of doctors who are high prescribers of opiod analgesics, as well as removing licenses of some physicians for irresponsible practice and/or initiating criminal investigations for purposeful diversion of drugs for non-medical purposes.

4. States should develop laws to reduce diversion of drugs from those who need them to those who use them to get high.

5. There should be better access to drug treatment.

Notably missing from these CDC recommendations are efforts to reduce the demand for prescription painkillers and promote their safe use and storage through public education, including advertising. It appears, however, that a number of state and local health departments, NYC for example, have adopted this approach.

Also notably missing from the CDC recommendations is any concern about improving pain management. There are alternatives to opiod analgesics that are effective for some people with chronic severe pain. Many doctors need education about them. In addition, The National Institute of Drug Abuse (NIDA) notes a need for research to develop less dangerous treatments for people for whom opiod analgesics are currently the only effective form of pain treatment.[11]

Cautions About the Current Public Health Campaign

It is clear that misuse and abuse of prescription painkillers is a major public health problem in the United States and that there needs to be a major effort to reduce overdose deaths. And, the efforts now underway mostly fit the facts and may ultimately be as effective as anti-smoking campaigns have been.

But it seems to me that there is a moralistic tone to this public health campaign similar to the moralistic cast of most of American drug policy and quite dissimilar from the tone of anti-smoking campaigns. The CDC and others recommend monitoring doctors and their patients, putting patients on restrictions if they take multiple drugs or doctor shop, threatening the licenses of doctors who are high prescribers, and passing laws to stop the diversion of drugs (as if the failure of the effort to curb illegal drugs hasn't already raised enough questions about the use of that sort of approach).

It makes sense, of course, to identify high risk patients and reach out to them. And it makes sense to lift the licenses of doctors who violate professional ethics and to put them in prison if they are really drug dealers hiding behind a license. But to get people to say no to drugs takes a lot more than moralizing.

In addition, policies being put in place show a distinct lack of sympathy for those who suffer from severe chronic pain. Yes, NIDA has called for some additional research to find less dangerous treatments for pain management, but it is a minor part of its agenda. Most statements on the need to address addiction to, and deaths from, prescription drugs barely mention the suffering of people who have to live with severe, chronic pain.

So, it seems reasonable to ask whether the campaign against misuse of opiod analgesics will result in their becoming less available to people who desperately need them.

A recent article in *The Washington Post* highlights this concern.[13] "New federal rules that make it harder to get narcotic painkillers are taking an unexpected toll on thousands of veterans who depend on these prescription drugs to treat a wide variety of ailments, such as missing limbs and post-traumatic stress," the article begins. It focuses on bureaucratic obstacles emerging in the VA in an effort to avoid inappropriate prescribing practices. The VA, of course, is notorious for its bureaucracy. But isn't there reason to worry that physicians elsewhere will also become excessively cautious about prescribing painkillers as they come under greater scrutiny?

Government regulations and protective practices in health care organizations tend to be overly broad and to throw out at least some of the baby with the bathwater. Hopefully, the campaign to reduce the inordinate number of deaths from overdoses of prescription painkillers will be refined over time, dampening the possibly excessive enthusiasm for restricting access to these drugs and protecting those who need prescription painkillers so that they can have tolerable lives.

Michael Friedman is retired but continues to teach at Columbia University and to write about behavioral health and about aging. He is the founder and former director of the Center for Policy, Advocacy, and Education of the Mental Health Association of New York City. He can be reached at mf395@columbia.edu.

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Opiate Use Disorder: Management of Overdose, Intoxication, Withdrawal and Referral to Appropriate Level of Care

By Nabil Kotbi, MD
and Laura Kragt, PA-C
NewYork-Presbyterian Hospital

The Diagnostic and statistical Manual of Mental Health Disorders (DSM-V), combined two disorders from its previous edition (DSM-IV-TR), known as Opioid Dependence and Opioid abuse into one new diagnosis Opioid Use Disorder. This diagnosis includes a vast range of illicit as well as prescribed drugs of the Opioid class. In this article, we will attempt to give a brief overview of the management of this disorder, from an acute phase and a chronic perspective.

Definition of Opioid Use disorder (DSM- V)

Criteria from the American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC, American Psychiatric Association page 541:

Two criteria or more are required within a 12 month period from the list below:

- Opioids are often taken in larger amounts or over a longer period of time than intended.

- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.

- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.

- Craving, or a strong desire to use opioids.
Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.

- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

- Recurrent opioid use in situations in which it is physically hazardous.

- Important social, occupational or recreational activities are given up or reduced because of opioid use.

- Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.

The Next 2 criteria are not met for individuals taking opioids solely under appropriate medical supervision.

1. Tolerance, as defined by either of the following:

(i) A need for markedly increased amounts of opioids to achieve intoxication or desired effect.

Nabil Kotbi, MD

(ii) Markedly diminished effect with continued use of the same amount of an opioid

2. Withdrawal, as manifested by either of the following:

(i) The characteristic opioid withdrawal syndrome

(ii) The same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

DSM-V adds the following qualifiers: Severity: Mild: 2-3 symptoms, Moderate: 4-5 symptoms. Severe: 6 or more symptoms.

There are a variety of opioid drugs ranging from the natural, synthetic and semi synthetics. Heroin, a derivative of Morphine, is considered a semi synthetic opioid.

It worth noting that Heroin has received a lot of media attention in the past several years for several reasons, including the resurgence of a substance thought was a drug of the past, its potentially high potency, especially when laced with other substances and the shift in the socio economics of its users.

Our experience at NewYork–Presbyterian Hospital/Westchester Division's Addiction and Rehabilitation Service concurs with the findings of Cicero et al published in JAMA Psychiatry 2014, *The Changing face of Heroin Use in The United States: A retrospective Analysis of the Past 50 Years*.

Opioid Intoxication and Overdose

Mild to moderate opioid intoxication is evidenced by euphoria, relaxation and sedation and is usually dangerous. However, it can, in many instances (medical frailty, accidental, recent relapse, use with other substances…) lead to a life threatening medical emergency within a very short period of time.

The classical triad of opioid overdose is miosis, coma, and respiratory depression. In some instances when the brain has been hypoxic or anoxic for a significant period of time pupil dilation could be observed. A non-cardiogenic pulmonary edema and in rare cases seizures have been described.

Treatment of Opioid Intoxication and Overdose

In the unfortunate case of overdose, the management consists of maintaining adequate ventilation until normal and consistent level of alertness is reached, use of Narcan * (Naloxone hydrochloride) 0.4-0.8 mg initially and repeat preferably in appropriate medical setting where initial resuscitation medical interventions could be resumed.

If several trial of naloxone yield only partial response, polysubstance use overdose should be highly suspected after a thorough body check is performed removing analgesic patches, such as Fentanyl, that may have been overlooked.

The steady increase of opioid related overdose and mortality has prompted several public health officials, community leaders and family advocates to promote the ease of access to Naloxone not only for first medical responders, but also for police officers and families. There are several programs in the USA, promoting this harm reduction approach.

Opioid Withdrawal

The syndrome of opioid withdrawal is captured by the Clinical Opioid Withdrawal Scale (COWS), used in different clinical settings to assess the severity of symptoms. The intensity and onset of withdrawal symptoms depends of the opioid of choice, as well as the dose and duration of the addiction.

The opiate withdrawal syndrome, while a difficult experience, is almost never fatal. It consists of wide range of symptoms and can include: Tachycardia, hypertension, GI discomfort, muscle and joint pain, mood dysregulation, insomnia, lacrimation, excessive sweating, gooseflesh, yawning, and sneezing.

Medical Management of Opiate Withdrawal

After an assessment of medical, psychiatric issues and psychosocial situation, an initial level of care is recommended for acute opioid withdrawal (inpatient versus detoxification). Pharmacological therapies involve opioids (Methadone and Buprenorphine) as well as non-opioids. At NewYork-Presbyterian Hospital/Westchester Division, two addiction trained psychiatrists (board certified and board eligible) meet with patients daily and the multidisciplinary comprehensive team. All staff, including nurses, social workers, and therapists, are trained in additions. This daily therapy provides close monitoring and treatment modifications as necessary.

Methadone is highly regulated for addiction. It can only be dispensed in a federally approved facility such as a Methadone clinic or in a hospital if the detoxification required hospitalization. Furthermore, there are restrictions on initial dosing and EKG is important to monitor for prolongation of the QT interval.

Buprenorphine or Buprenorphine/Naloxone is reported to be as efficacious and an appropriate effective alternative to Methadone. It has a relatively safer profile and its ceiling effect on agonist activity may reduce the danger of illicit abuse. It also can be prescribed under strict guidelines for clinicians who satisfied federal licensing requirements (DATA 2000). Both attending psychiatrists at NewYork-Presbyterian Hospital/Westchester Division are licensed to prescribe Buprenorphine.

Non opioids are primarily represented by Clonidine, an a 2 antagonist, which is thought to reduce the severity of opioid withdrawal by blocking the activation of the locus coreuleus and subsequently noradregenic nucleus that shows hyper activity during the opioid withdrawal phase. Clonidine helps in most of the commonly reported opioid withdrawal symptoms. Although, it is less effective than Methadone and Buprenorphine, it has the advantage of not having any potential for physical dependence or abuse. Its use for opioid detoxification remains "off label."

Other useful medications are Non Steroid Anti Inflammatory Drugs (NSAIDS) for pain, Imodium for diarrhea, Ondansetron, Metoclopramide for nausea. Once the acute phase is completed, it is important to think as a comprehensive multidisciplinary team as to what the next level of care should be.

FDA Approved Medication Assisted Treatment for Opioid Addictions

Methadone can be used in approved Methadone clinics where doses could be adjusted and medications dispensed accordingly. Bupreneorphine or Buprenorphine/Naloxone is available in some outpatient clinics. Naltrexone which is also FDA approved for alcohol use Disorder and can be given as an injection once a month.

Other treatment modalities involving addiction specialists from a cohesive multidisciplinary team (physicians, nurses, physician assistants, social workers, addiction counselors, pharmacists, mental health workers, advocates and volunteers) are fundamental to patients' sustained recovery.

Comorbid Medical and Psychiatric Conditions

As an acute psychiatric inpatient unit, NewYork-Presbyterian/Westchester Division is able to treat comorbid psychiatric conditions along with addictions. Opioid use disorder is often associated with other illicit substance use. "Speedball" or "powerballing" is a term use for combining cocaine and heroin in a same syringe for IV use. Anxiety, depression, and psychosis are seen more often in our clinical practice and we, in the trenches, suspect that the "new" drugs are either laced with other substances or are made more potent contributing to this new opioid endemic.

see Management on page 36

Seven Steps to Fix the Opioid Addiction Crisis Now: We Already Have Most of the Tools We Need

By Richard Juman, PsyD
Editor, Professional Voices
TheFix.com

Recently, Professional Voices revisited an issue that The Fix has been focused on since its inception: the public health debacle caused by the overprescribing of opioid pain medications, and the related increase in heroin use and overdose, which has contributed to the deaths of tens of thousands of U.S. citizens. By now, the underlying issues that developed the epidemic are well-known, which makes the fact that we are still deeply embedded in the crisis that much harder to stomach.

The response to this crisis has been tragically sluggish, because we actually already have the knowledge and the tools that we need to drastically improve matters. We know what needs to be done to keep those who are already addicted alive. We know how to help people who are struggling with addiction enter recovery. We know how to stop creating more problems with prescribed opioids. But we also know that we just haven't done a good job so far, and that now would be a good time to start. Here's how.

First, keep people who are already addicted to opioids alive by making all of

Richard Juman, PsyD

the effective tools available in this regard. Naloxone, a drug that reverses opioid overdose, should be made as widely available as possible. Just as those who are allergic to bees or other allergens carry around an EpiPen, those who use opioids should be able to have Naloxone on hand.

Good Samaritan laws, which protect people from criminal prosecution when they call 911 because somebody is overdosing, can save lives and should be the law of the land. Syringe exchange programs and safe injection sites should be widely available. All of these efforts keep people alive.

Second, make sure that all patients have access to the evidence-based, addiction medicine interventions that most opioid-dependent individuals are not receiving right now. Part of the reason for that is the stigma around addiction, which has placed restrictions on the mechanisms through which addiction medications are delivered. Methadone, for example, is doled out in clinics- what other medication can you think of that is delivered that way? Although patients can receive buprenorphine from private doctors, there are significant restrictions on the number of patients that physicians can prescribe buprenorphine to. Methadone, Suboxone, naltrexone and Vivitrol are all evidence-based treatments that are not being used by thousands of people who would benefit from them. According to Mark Willenbring, MD., "The main deficiency of current actions to address opioid addiction is the lack of access to prompt, professional opioid maintenance treatment with buprenorphine or methadone. Opioid maintenance therapy is the only proven effective treatment for established opioid addiction, but government and mainstream healthcare organizations have not mobilized to make this life-saving and cost-effective treatment widely accessible and affordable."

Third, provide enhanced training for physicians so that they become more adept at screening for, recognizing and treating addiction. We need to make sure that physicians have the kind of training in addiction medicine that will help interrupt the flow of newly-created prescribed opioid addictions. According to Kevin Kunz, M.D., M.P.H., the Executive Vice President of The American Board of Addiction Medicine, "We can no longer afford to focus only on treating advanced cases of addiction and its complications; we need to focus on prevention. In addition to the monitoring and control measures that many states have put in place, we believe the most effective long-term strategy is a shift in medical training and practice that builds a workforce of physician experts in addiction medicine who can both provide treatment for all addictive substances for those who need it and educate other physicians about the nature of addiction, how to prevent it, its appropriate treatment, the dangers of addiction involving prescribed drugs, how to screen for patients at risk and appropriately intervene, and how to secure quality specialty care for treatment and disease management."

see Seven Steps on page 24

Ensuring Evidence-Based Treatment for Substance Use Disorders

By Joseph Hullet, MD, National Medical Director of Behavioral Solutions, and Dona M. Dmitrovic, Director of Consumer Affairs, Substance Use Disorders, Optum

The use of heroin, other opiates, and inappropriate prescription drugs are currently a major public health problem in this country. According to the Centers for Disease Control and Prevention (CDC), national death rates from prescription opioid pain reliever overdoses quadrupled during 1999 to 2010, whereas rates from heroin overdoses increased by less than 50%.[1] Between 2010 and 2012, U.S. drug poisoning deaths involving heroin doubled, and although death rates from opiate pain medications had declined overall, they remained more than twice as high as heroin overdose death rates.[1] Although the highest overdose mortality rates remain in older age groups, the 15- to 24-year-old age cohort saw an 86% increase in deaths by heroin overdose from 2008 to 2010.[1]

In New York City specifically, heroin-related deaths increased 84% between 2010 and 2012.[2] And, according to the city's Department of Health and Mental Hygiene, heroin was involved in 52% of all overdose deaths in 2012.[2] This problem is not confined to inner cities, and involves people of all ages in small towns and rural settings.

The impact of opioid use has had a significant impact on increasing health care costs and adverse outcomes. Between 2004 and 2011, drug-related visits to emergency rooms have soared and resulted in a 423% increase in these costs.[3] Reasons cited for the increase in drug-related emergency room visits include illicit drug use (which increased 21%), misuse and abuse of pharmaceuticals (increased 56%), and to adverse reactions to medication (increased 46%).[4]

In order to address these rapidly evolving challenges, insurance plans are developing new programs and provider partnerships to improve the outcomes of care. Optum has established teams of clinical experts who are focused on identifying, evaluating, and refining clinical approaches to help this population. This includes anticipating and proactively responding to high-risk situations; identifying and helping to shape industry-leading best practices for the care of these conditions and actively working to break down barriers that fragment care. Partnering with local provider networks also support the expanded use of evidence-based treatments for substance use disorders. Another key is empowering consumers and their families through education and resources designed on the principles of recovery and resiliency.

Shaping Industry Best Practices

Optum has adopted an evidence-based, best practices approach to address the problems of heroin and opioid use, and prescription drug abuse for their covered populations. The primary goal is to engage members in treatment moving from acute interventions to long-term recovery solutions addressing each member's strengths, weaknesses and barriers to treatment. All substance use disorder benefit requests are reviewed based on medical necessity criteria set by Level of Care Guidelines and/or Coverage Determination Guidelines (and where applicable, criteria established by the American Society of Addiction Medicine [ASAM]). Similar to medical care, an individual's previous clinical and psychosocial experiences are considered in determining the best treatment choices and outcomes. All treatment plans and care are also individualized to each member's specific needs, and are overseen by a board-certified addictions provider.

Partnering With Local Provider Networks

Strategies that support person-centered care for the effective treatment of substance use disorders requires the development of networks of providers and

see Treatment on page 32

Creating Innovative Programs for Young Adults in Treatment

By Valerie Noel, MEd, Drug and Alcohol Counselor, Lori Pilosi, MS, CTRS, Lead Recreation Therapist, and Dominic Vangarelli, MA, CAC, Director of Counseling, Marworth

As more opioid-addicted young adults are entering treatment facilities, many addiction professionals are seeking alternative ways to guide this demographic into recovery. Marworth Alcohol and Chemical Dependency Treatment Center's young adult population (ages 18-25) doubled from 159 in 2009 to 319 in 2014. Today, young adults account for a quarter of all our inpatient admissions, and the majority claim opioids as their former drug of choice.

As our young adult population grew, we noticed a related increase in non-routine discharges from our facility. We convened a multi-disciplinary team of counseling, recreation therapy, medical, nursing, disease management, quality and support staff to investigate this trend and determine why this population was struggling to make a full commitment to the treatment process.

We discovered that young adults think and act differently than our older patients and haven't had the time to develop as many coping skills. When considering the perspective of Prochaska and DiClemente's Stages of Change model—pre-contemplation, contemplation, preparation, action, maintenance, termination—we found that most young adults enter treatment in the pre-contemplation or contemplation stage. However, our staff had grown accustomed to working with older adults who enter treatment in the preparation or action stages. Essentially, we were treating our young adult patients as though they were further along in the recovery process. Recognizing that each stage of change requires different types of interventions, our treatment team set out to adopt treatment approaches that will better meet the needs of our growing young adult population.

Several staff members expressed interest in working with the young adult population, and we encouraged them to trust their clinical intuition to tailor creative treatment interventions. We regularly evaluated new treatment modalities to see what worked and what didn't.

The treatment modalities that have proven to resonate most with young adults include acupuncture, sand tray therapy and recreation therapy. Over the course of a year we developed a successful program that resulted in an eight percent decrease in non-routine discharges of patients in the 18-25 age range.

Acupuncture

The detoxification phase of treatment is physically uncomfortable for those withdrawing from opiates. For young adults who often have low frustration tolerance, this process is especially painful and distressing despite medical interventions such as suboxone therapy.

To ease the discomforts of detox, an acupuncture protocol was implemented to complement the detoxification phase of treatment for those withdrawing from opioids. The National Acupuncture Detoxification Association (NADA) ear protocol was specifically developed to be used in addiction treatment settings. A licensed acupuncturist uses 10 needles placed in key spots on the patient's outer ear to correspond with organs that are negatively affected by substance abuse, such as the kidneys, liver and lungs. The procedure releases hormones, including endorphins and cortisol, which can aid in pain relief and stress reduction.

Eighty-nine percent of patients who experienced the acupuncture protocol reported that it improved their sense of well-being, improved the quality of sleep, improved their mood, and helped make their detoxification more comfortable.

Sand Tray Therapy

Sand tray therapy is one of the most recent techniques added at Marworth and it has been especially therapeutic for young adults. By manipulating sand and figurines in a tray to build miniature scenes, or "worlds," patients have the opportunity to visually portray feelings and experiences that are difficult to verbalize.

Sand tray sessions include four to five patients and two counselors. Patients spend about 25 minutes creating two worlds—one representing their life in addiction and one representing their aspirations for a life in recovery. The counselors offer directive guidance as needed and observe the patients to see how they are interacting with their worlds as well as the other group members. When the worlds are complete, the lead counselor uses Socratic questioning to help each patient process the experience. Describing their worlds helps the patients find the words to verbalize their history. The second counselor keeps detailed notes.

After patients leave a sand tray session, the counselors review the notes and pass along key observations to each patient's primary counselor. For example, a patient's world might depict himself or her - self standing on a bridge between the past and future worlds. This might indicate to the counselors that the patient is still in the contemplation stage of behavior change.

Sand tray therapy, which is also known as sand play or the world technique, has been shown to promote communication, anxiety reduction, emotional release, safety and containment, self-control, and therapeutic metaphors. Since introducing the technique at Marworth in 2014,

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Integrated Treatment Model For Medication Assisted Treatment of Opioid Use Disorders

By Abigail J. Herron, DO, Director of Psychiatry and Amy Dimun, MA, LMHC, CASAC, CRC, Mental Health Clinician, Institute for Family Health

Abigail J. Herron, DO

Amy Dimun, LMHC, CASAC

Individuals with substance use disorder have high rates of co-occurring medical disorders, and are many times more likely to experience serious conditions such as heart disease, cirrhosis of the liver, and pulmonary disease than individuals without substance use disorders. Additionally, individuals with substance use disorders have been shown to be less likely to adhere to medical treatment certain conditions such as HIV and diabetes. Despite the increased prevalence of medical illness in this population, substance abuse treatment is not readily available in coordination with medical treatment in most settings.

Integrated treatment, in which substance abuse treatment (and often behavioral health treatment) is provided in collaboration with primary care services at the same location, allow individuals to receive care from a team of treatment providers and increases access to care. Further, integrated treatment models may reduce the stigma that can be associated with seeking substance abuse treatment by providing treatment from clinicians with whom the patient has already developed a therapeutic relationship with, in a setting that is already familiar to the individual.

The provision of office-based opioid therapy (OBOT), in which an individual receives medication for the treatment of an opioid use disorder, is an ideal model for an integrated treatment team, consisting of primary care providers who are Buprenorphine prescribers, and behavioral health providers such as psychiatrists and social workers who function as experts in the diagnosis and treatment of substance abuse disorders. The team meets monthly to review cases, assess for treatment adherence to the Buprenorphine policy and develop guidance and training for staff and patients regarding opioid treatment.

In this model, all patients are screened by the behavioral health staff to assess appropriateness for Buprenorphine treatment. Ideal candidates are patients with opiate dependence who are interested in interested in office-based treatment, are able to understand the risks and benefits of Buprenorphine, are not taking medications that negatively interact with Buprenorphine, and are relatively stable psychiatrically and psychosocially such that they can be expected to be reasonably adherent to treatment. The goal is patient success, therefore if a patient is not a good match for this modality (i.e. dependent on high doses of benzodiazepines, alcohol, or other central nervous system depressants), they are referred to a different level of care and cases are reviewed by the larger team as needed. Once a patient is assessed as appropriate, an appointment is made for a medical consultation, where a primary care doctor reviews the induction or maintenance protocol.

After the consultation phase, the patient is seen for Buprenorphine induction (if they are being prescribed for the first time) or maintenance (if they are transferring care but already taking the medication). Patients continue to see the prescribing physician for ongoing medication management, and also engage in ongoing assessments with behavioral health providers at least quarterly for counseling,

see Model on page 37

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— The NYSPA Report —
A Multifaceted Approach to the Opioid Epidemic

By Frank G. Dowling, MD
Clinical Associate Professor of Psychiatry, SUNY at Stony Brook, NYSPA Representative Greater Long Island Psychiatric Association

There has been much discussion around NY State and the country about a surge in heroin usage and overdose deaths. Although the perception is that a drop in "doc shopping" caused the increase in heroin usage, the picture is complex and the history goes back further than some may realize. Heroin usage started to rise significantly in the US in the early 1990's when dealers started to sell a more purified form which allowed one to achieve a significant high by snorting instead of using intravenously (80-90% pure vs. 10-20%). In addition, the cultural norm for teens and young adults had shifted where experimentation with multiple drugs in addition to alcohol and marijuana became the norm. Ultimately, if these patients did not stop snorting heroin, the disease process would progress and they would end up on IV heroin, with all the associated risks including HIV, Hepatitis C, or overdose deaths.

After the rise of heroin, Oxycodone was approved by the FDA in 1996 and with it came the rise in opioid pain medication abuse. Over the last 15 years, we have seen a steady rise in both opioid pain medication and heroin abuse. Since 2011, with publicity and discussion about the proposed ISTOP Law, there was a small decrease in "doc shopping" in 2012 and 2013. Since the mandatory lookup in the PDMP (Prescription Drug Monitoring Program) started in August 2013, resulting in more than 40,000 look ups per day, NY State DOH reports that "doc shopping" has been reduced by 75% and opioid prescriptions have been reduced by 5-10% statewide. With increased usage of the PDMP and law enforcement actions, it appears that supplies of opioid pain medications on the streets have been reduced. However, the drug dealing industry is adapting to these changes. Drug dealers have increased the supply and distribution of heroin and prices have dropped. As a result it appears that heroin usage continues to increase and may be surging in some areas of NY State and the country.

While opposing the mandatory PDMP lookup of each and every patient every time a controlled medication prescription is written, MSSNY, NYSPA and other physician groups supported the recent upgrades to the PDMP that have greatly improved accessibility and utility of information available. Trying to address the opioid epidemic and rising overdose deaths, physician leaders from MSSNY and NYSPA called for such improvements to the PDMP over 3 years before the ISTOP law was introduced. The PDMP Database has become a useful tool to combat "doc shopping" and prescription drug abuse. However-there is more work to be done.

Frank G. Dowling, MD

When addressing substance use disorders, psychiatrists find that there are systemic obstacles that need to be addressed including: stigma; lack of awareness and understanding of substance use disorders among patients, the public and medical community; lack of access to treatment; and discriminatory practices by insurance plans that may violate Federal or State parity laws. One egregious example includes the sudden denial of Suboxone brand of Buprenorphine for stabilized patients with opioid use disorders -with plans going further to deny the substitute brand Zubsolv which they actually recommended as preferred, forcing patients into withdrawal while time consuming appeals take place.

It's time for all of us to acknowledge that substance abuse is a medical problem, not a character flaw. We have to offer treatment, without judgment of persons with substance use disorders. A multi-faceted societal solution is needed including:

• Increased access to screening and treatment in primary care and psychiatric offices and clinics

• Increased substance abuse training during medical school and residency training

• Increased CME for practicing physicians in family medicine, internal medicine, pediatrics, obstetrics and gynecology, emergency medicine and psychiatric medicine regarding screening, diagnosis, treatment and referral for specialized addiction treatment - with each physician choosing CME based on their individual practice and patients' needs

• Increased access to specialized addiction treatment services including detoxification programs, intensive outpatient residential and inpatient rehabilitation programs

• Expanded access to medication assisted treatment for alcohol and substance used disorders including Buprenorphine for opioid use disorders

• Increased CME for office based primary care physicians and psychiatrists to become certified to prescribe Buprenorphine, a unique opioid agonist/antagonist that has a substantial evidence base for improving outcomes and reducing overdose deaths in persons with opioid use disorders

• Increased public education regarding: safe storage and disposal of medications and strategies to limit diversion; the importance of sharing information with medical professionals regarding all prescribed medications

• Increased education of youth regarding the dangers of substance abuse, signs they or a friend may need help for substance abuse, and 911 laws that prevent prosecution of someone for substance possession who calls 911 in the event someone with them may have overdosed on alcohol or other drugs

• Changes in the criminal justice system including usage of drug and mental health courts and focus on diversion into treatment for non-violent drug related crimes

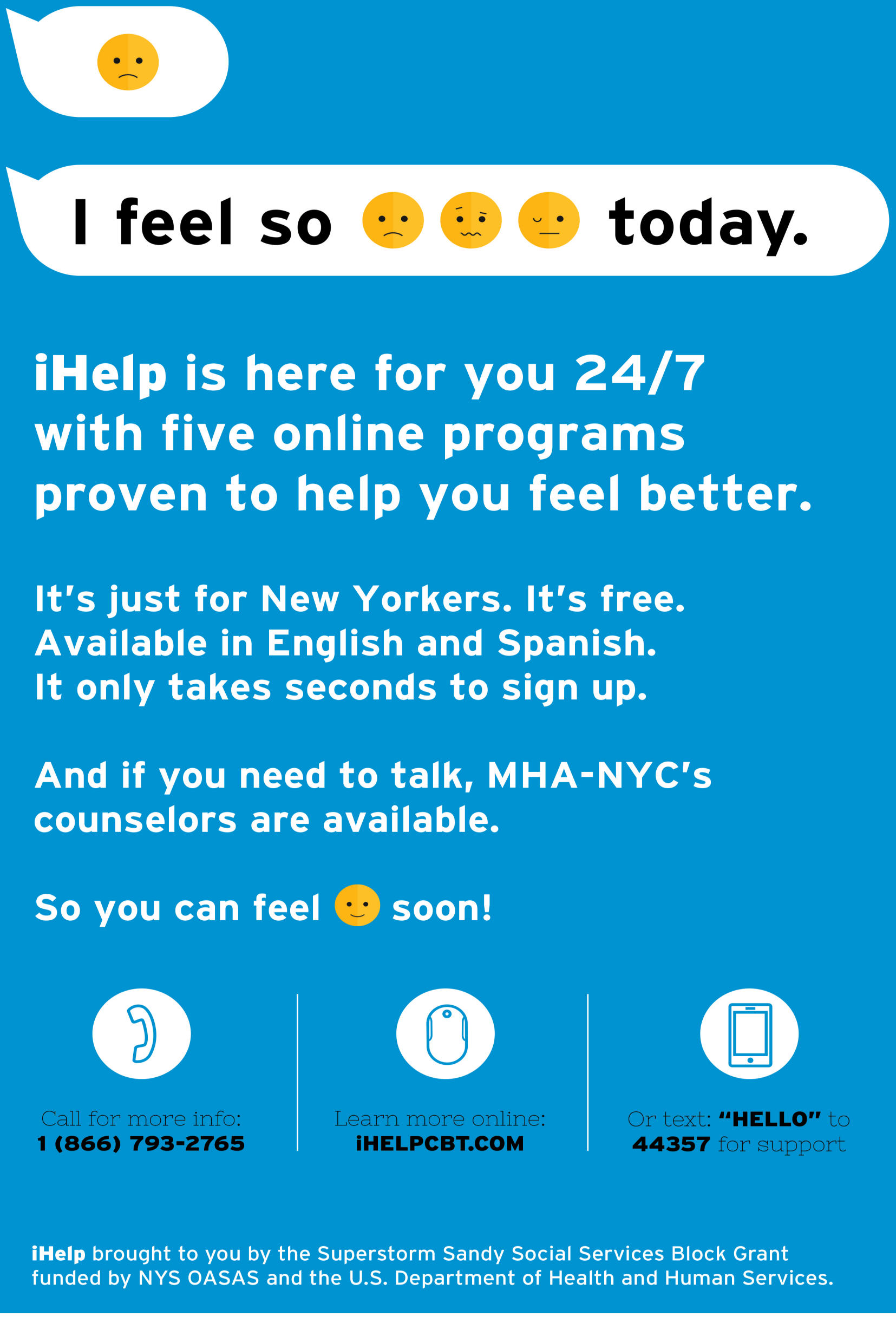
• Expanded awareness, education and access to Emergency Naloxone Kits that now can be used by basic level EMT's, law enforcement, or friends and family of someone with an opioid use disorder in the event of a relapse and accidental overdose

• Increased public and private funding for initiatives listed above

Psychiatrists and Addiction Medicine physicians find that there are several obstacles that limit access to care and timeliness of care for persons with substance

see NYSPA Report on page 34

If You are Feeling Hopeless, Alone and in Despair, Never Give Up.
There are Many Behavioral Health Organizations in The Community That Can Help,
Several of Whom are Listed in This Issue. It is NOT a Sign of Weakness to Ask For Help.
— A Message From the Board and Staff of Behavioral Health News —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Implementing a Buprenorphine Program in an Opioid Treatment Program

By Debbie Pantin, LCSW
Doreen Thomann-Howe, LCSW
Ernst Jean, MD
and Debbi Witham, LMSW, Esq
VIP Community Services

A critical element to successfully treating opioid addiction and addressing the epidemic is offering a wide range of therapies. Due to the extreme dependence created by opioid use, Medication Supported Recovery is often necessary. For decades, Methadone; dispensed in an Outpatient Treatment Program (OTP) was the only option available for maintenance. While this remains an important and well-researched treatment, new trends in addiction show that multiple treatments are needed. As such, other medications are becoming available. One such medication, Buprenorphine, has become a well known and effective treatment for opioid dependence.

Buprenorphine is an effective means of treatment and is known to be prescribed in primary care settings. However, the DEA limit on physicians' patient case load size restrict wide spread use of Buprenorphine, also the absence of substance abuse counseling in this setting can be an ineffective model. OTPs were waived from the above limits; therefore dispensing Buprenorphine in an OTP setting is very much needed as we continue to expand the use of this medication treatment to address the current opioid epidemic.

Debbie Pantin, LCSW

Prior to implementing any new modality of treatment, it is necessary to conduct the appropriate "pre-work." This includes analyzing your current population as well as target populations that may be able to enter treatment if this modality was offered. VIP Community Services tracked incoming requests for Buprenorphine maintenance from self-referrals as well as referents to assess that there was a population in our community in need of this form of treatment.

Cost is another major driver as Buprenorphine is significantly more expensive than methadone. Medicaid reimburses the cost of the purchase in the New York State blended rate; however a significant cost is required up front. It is important to assess your target population as this will help you determine the appropriate dosage amounts to purchase, as well as how quickly you will be enrolling clients and billing for services provided.

Space and client flow are other important aspects to be reviewed in the pre-implementation phase. Buprenorphine requires a separate inventory and space to house the medication. It also requires additional dispensing time as compared to dispensing methadone. Preparing for this different client flow is important to ensuring the ongoing operations of the clinic. VIP has designated areas for individuals who may be in withdrawal to rest comfortably through the induction process and encourage clients to adhere to a time for dispensing when client flow is less heavy.

Staff resources and staff training are additional factors to consider. Only Physicians are allowed to induce Buprenorphine, and the regular administration of Buprenorphine requires the nursing staff to watch a client while the film is placed under the tongue to be dissolved. Training and educating staff about the administration of Buprenorphine was another significant undertaking, which required repeated group and individual training session. It was important to help staff to understand which clients are well-matched for Buprenorphine treatment and the difference in service provision. Much of the individual services provided by staff are not reimbursed at an individual reimbursement rate. Having a written protocol in place definitely assisted with the orientation of staff.

The billing system for Buprenorphine is also different from methadone. Buprenorphine billing is a blended rate, individual services are not billed. Increasing the frequency of entitlement reviews is also of great importance. Due to the cost of purchasing Buprenorphine, prolonged lapses in a client's Medicaid could have an immediate negative financial impact. It is recommended that Medicaid status be reviewed a minimum of weekly. In addition, VIP reviews revenue on a weekly basis to ensure that all billings are being collected and that all claims have been accepted. Finally, this allows us to review the costs associated with providing the service and ensure that the revenue is meeting the resources that have been expended.

see Implementing on page 34

Seven Steps from page 14

Fourth, make sure that all prescribers have access to Prescription Monitoring Programs and that they use them. Although almost all states now have some type of electronic database that physicians can consult prior to prescribing opioid pain medications, not all states make it a requirement that they do so. Given what we know about the lethality of prescription pain medications, it seems both wise and inevitable that more and more states will make it a requirement—why not now? Given what we also know about how laws of this type frequently come to pass, because of the heartfelt, intense, grassroots efforts of people who have lost loved ones, why not make the use of these databases a requirement now, and save those lives and the agony of those who will be left behind? We should make the conditions for putting newly prescribed opioids into the system very stringent, and make sure that prescribers who knowingly circumvent the safeguards are taken out of the system.

At the same time, we need to make sure that the people for whom these medications were intended continue to have access to them. As noted by Michael Friedman, Adjunct Associate Professor at Columbia University School of Social Work, "there are people who cannot work, socialize, or be responsible family members because the pain they experience is intolerable. A complete campaign to prevent opioid addiction needs to address this fact as well as the fact of overprescription of a dangerous drug."

Fifth, make it as difficult as possible for opioid pain medications to be used in ways other than the ways they were intended or prescribed. As examples, we could stop approval of any new opioid painkillers that are not clearly safer than existing ones and remove from the market all high dose opioid analgesics that are easily crushed.

Sixth, educate the public about the risks of prescription pain medications. The path to addiction to opiates often comes from friends and family- often directly from the medicine cabinet. We all know people whose kid came back from the oral surgeon with an unreasonably large supply of Vicodin. So it is imperative that the public be aware of the dangers of prescription pain medications and especially the need to properly dispose of any unused opioids that remain after an episode of acute pain management. We know that "over 70% of people who abused prescription pain relievers got them from friends or relatives."

Last, but certainly, in my view, not least: we need to make sure that people suffering from opioid addiction, as with other forms of addiction, have access to the kind of evidence-based psychotherapy that is so conducive to ongoing recovery. Unfortunately, we know that all of our efforts to reduce or even eliminate the overprescribing and misuse of prescription pain medications can only go so far, because people will always have access to heroin.

There are so many opioids out there now, in both prescribed form and heroin, that there are limits as to how effective our efforts focused on the prescription side can be. As journalist Maia Szalavitz

see Seven Steps on page 32

From Collaboration to Collective Impact: A Community Approach to Tackle Youth Opioid Abuse on Staten Island

By Adrienne Abbate
Executive Director, Staten Island
Partnership for Community Wellness

No single organization, however *innovative* or *powerful*, alone can address youth substance abuse in a community. A dedicated group of community members, philanthropists, behavioral health providers, law enforcement, government partners, and parents, understood this and came together to collectively take ownership of the disturbing rates of opioid abuse on Staten Island.

Formed in 2011, with generous support from The Staten Island Foundation, Tackling Youth Substance Abuse (TYSA) is a community based coalition aimed at driving major improvements in youth substance use and youth health on Staten Island. TYSA uses collective impact as the driver to successfully align resources to address the local causes of opioid abuse. Today, more than 50 organizations are participating in the TYSA effort. Moving beyond traditional partnerships and engaging all sectors of the community to test new models of collaboration, this coalition is serving as a national model for addressing youth substance abuse efforts grounded in data, strong community engagement, stakeholder collaboration, and coordinated activity across the prevention and treatment continuum.

Adrienne Abbate

Why Collective Impact*?*

Collective impact is defined as the commitment of a group of cross-sector actors to a common agenda for solving a complex social problem through alignment and differentiation of efforts. Collective impact efforts grow out of the recognition that key stakeholders across the community have a deep, vested interest in improving outcomes, and that these outcomes depend on a complex range of challenges that can only be improved through a systematic and coordinated approach owned by the many relevant players. The five necessary conditions of collective impact are:

Common Agenda: At its inception, TYSA established a common agenda that examined a shared understanding of the issue of youth substance abuse and a shared vision of a collective solution. Shared understanding focused on prioritizing substances, identifying the root causes and local conditions (easy access to opioids, barriers to treatment, social attitudes that promote drug use), and research on effective substance abuse collaboratives. The shared vision approach used evidence based strategies, data to refine strategies, and buy-in from critical stakeholders who can affect organizational changes.

Shared Measurement: With stakeholders at the table including behavioral health providers, NYS OASAS and the NYC Department of Health and Mental Hygiene, TYSA was able to identify and gather outcome data to use as our guiding star. Identifying outcomes and agreeing to share data also provided a level of accountability for the many stakeholders. It was evident from sharing data that there were both indirect and direct outcome measures that are tied to youth substance abuse. TYSA uses clear metrics at the youth, organization, and system-levels. Some examples of data collected and shared by partners include: prevalence rates, hospitalizations, treatment admissions, overdose rates, drug-related crime statistics and age of onset.

Continuous Communication: In any organization communication plays an instrumental role in day-to-day operations. From monthly steering committee and workgroup meetings, regular check-ins from funders, to constantly being a presence on social media and in local news outlets, TYSA maintains communication among partners, the public, and funders.

Mutually Reinforcing Activities: TYSA looks to achieve major gains, not minor improvements, support the success of partner implementers, and ultimately avoid reinventing the wheel or duplicating

see Community on page 35

Living With Addiction: The Role of the Family

By Phyllis Elliott, LCSW
Parent Advocate

As you can see by the letters after my name I am a Social Worker by profession but one of the most significant roles in my life has been as a mother. For the last 6 years I have been the mom of a 28 year old son who is suffering from the disease of addiction. Prior to my knowing about his drug use I was pretty sure that this would never be an issue I would have to deal with. When I was told that he was at a prominent drug treatment facility I asked if he had gotten a job there. I was clueless to the fact that he was using drugs and that he had such a serious problem. I spoke to him often and I never saw the signs. My naive assumption could have cost me my son's life. I feel strongly about telling people about my own situation because I don't want parents to think that it can't happen to them. My son is smart, funny and loved by his family but he still used heroin. It is a common misconception that if our kids come from a happy home they won't use but that isn't the reality. Despite my professional knowledge I had no idea how to get him help and what my role as a parent should be. I read books and articles, talked to people, but everyone had a different answer and I felt hopeless and isolated. The words "heroin" and "addict" became my first and last thoughts each day and my fear for my son and for our family was always present.

My first sense of hope came when I saw a flyer about an informational forum about opiate addiction being run by a group called, "Drug Crisis in Our Backyard." I knew that I wanted to go to this forum because I was desperate to learn how to help my son. When I got there that

Phyllis Elliott, LCSW

night the room was full. I learned that, "Drug Crisis In Our Backyard" is a grassroots community action organization whose purpose is to raise awareness and provide education and support to families who are struggling with this disease. It was started in 2012 by Susan and Steven Salomone and Carol and Lou Christiansen after they lost their sons both of whom suffered from the disease of addiction. These two families are bravely trying to bring understanding and awareness to a public that doesn't always want to know. Their stories touched my heart and I felt that I needed to be involved not only to help my own son but to fight this terrible and life threatening disease. They were running a support group twice a month called, *Spotlight on Recovery,* and I decided to go there for help and to be more involved. As a parent in pain, it has helped me tremendously to feel connected to others who understand what I am going through. As parents together we can offer each other support without judgment.

As I speak to parents and listen to their stories, I realize how many major issues need to be addressed. One of my primary roles as a parent is to join others who advocate for these changes. Some of these issues are systemic, such as the need for insurance to cover longer and more comprehensive treatment. The penal system also needs to change. Incarcerating someone for being addicted to a drug is not an answer to the basic problem. If a crime is committed, the person should get the consequence, but if they have the disease of addiction they should also get treatment. Criminals with chronic illnesses get treatment in jail all the time. Why are people with addiction different? Doctors and pharmacists need to examine their prescribing practices. Big pharmaceutical companies also need to work to help in the battle against addiction. If we work together we can help our children get better treatment and a fair chance at recovery. I know that, historically, system improvement has come from the advocacy of those who have the need for the change. I have seen improvement in the mental health and developmentally disabled population because of the courage and persistence of the families. I believe one of the biggest and most important role family members can have is to be advocates for their loved ones by staying involved in the systems and finding solutions. No company or government official has a bigger stake in this issue. It is our children's lives that we are fighting for.

The stigma of drug addiction is part of our culture. Just the words and phrases we use to describe them, such as, *junky* or *clean versus dirty*, to name a few, has only served to marginalize them. The connotation of those words and phrases convey all that is negative about the disease. Society has interpreted them as the negatives of the person. Addiction is only part of a person's life. They may be artists, musicians, kind, funny and caring but none of that is part of the negative stereotype we picture when we hear the word addict. In my work, as a therapist, I try to be strength based. I want to see what is behind the façade of the person so that I can bring out their talents while helping them recover from whatever it is that I am treating them for. It is as if every person who is addicted to drugs is the same. My son has done similar things to others who are addicted, but he is an individual. Every one of us has talents that can contribute to society. I know that a person in active addiction does not display their best characteristics but those good parts of them are still there. All I am saying is that if words define us and add to an already existing stigma, maybe we should rethink the words we use. Is addiction the last place we can be politically incorrect?

Personally, I have learned so much in these last few years about living with addiction as part of my family's dynamic. I have learned ways to talk to my son. I know more about being supportive instead of enabling. I have learned to acknowledge how hard he tries and to celebrate his successes. I also know that I have a right to all my feelings concerning the effect his disease has on my life. I learned to use the support offered by others to help me through the tough times. I have always been there for others through my work and in life but I have never been good about asking for help for myself. I have met so many wonderful people who are there for me and my family. I have accepted the fact that there is always going to be worries about relapse and fear of

see Family on page 32

see Resources from page 9

Our concern and support go out to families that have lost sons and daughters, mothers and fathers, good neighbors and friends to overdose and other tragic consequences related to an addiction to prescription medications, heroin, alcohol and other drugs. With those impacted by addiction and overdose ASAP asks for your voice in the advocacy for services on demand.

We encourage the many dedicated *Behavioral Health News* readers to join ASAP advocacy efforts. If you are interested in working with us to make services more available and accessible, please contact Kathleen Campbell, ASAP Director of Public Policy at: KCampbell@asapnys.org. If you are interested in becoming a member of ASAP contact Janet Braga, Associate Director, at: JBraga@asapnys.org.

Balanced Access: Opioids Benefit the Chronic Disease Patient

By Seth D. Ginsberg
Co-Founder and President
Global Healthy Living Foundation

Our interest in all things celebrity shines a spotlight on both the professional accomplishments as well as the more human failures, including addiction. Rockers (Steven Tyler), actors (Heath Ledger) and political commentators (Rush Limbaugh) all publicly battled opioid addiction. There doesn't seem to be a "type" who is more susceptible to abusing these powerful, yet often necessary, medications. Clearly, susceptibility to prescription drug abuse is bi-partisan, and not means tested, impacting all walks of life.

The National Institute for Drug Abuse (Drug Facts: Prescription and Over-the-Counter Medications) highlights that prescription medications, like opioids for pain, stimulants for Attention Deficit Hyperactivity Disorder (ADHD), and over-the-counter drugs are, after cannabis and alcohol, the most commonly abused substances by Americans 14 and older. A step further, the Centers for Disease Control and Prevention (CDC) (Prescription Drug Overdose in the United States: Fact Sheet) reports that in 2013 more than half of drug related deaths were related to pharmaceuticals and of those, 71.3% involved opioid analgesics (although some deaths include more than one type of drug).

Given that opioid misuse and abuse is particularly rampant, the Obama Administration called opioid dependency a "major public health and safety crisis" (White House press release, April 19, 2011). Major media outlets also reported the U.S. Drug Enforcement Agency

Seth D. Ginsberg

(aligned with FDA recommendations) has taken a stand by recommending that prescription medications containing hydrocodone be reclassified as Schedule II medications (HealthDay, Aug. 22, 2011) to reduce access to these highly prescribed and highly addictive medications.

Clearly, there is a real need to ensure the safe and warranted use of prescription pain medications. Yet while regulators debate access restrictions, a part of the conversation warranting more dialogue is what access limitations mean for patients very much in need of appropriately prescribed medications. Specifically, patients living with chronic diseases such as multiple sclerosis, systemic, autoimmune forms of arthritis such as Rheumatoid Arthritis, and cancer often benefit from the cautious and monitored use of these medications to manage pain associated with the disease (s). And these are just the people whose chronic conditions necessitate pain relief. Studies show an estimated 100 million Americans, about a third of the country, are on prescribed medication to control pain that is associated with other chronic conditions or acute injury. This might be on account of a root canal, a car accident, or recovery from other surgery.

To allow for the continued use of prescription pain medications while balancing a need for controlled access, a positive next step would be the required use of abuse-deterrent properties in all opioids on the market. Already integrated into some medications, abuse-deterrent properties prevent pills from being crushed and inhaled or melted and injected. This is important because much of the abuse of opioids is a direct result of alterations. For example, by crushing or melting pills, the abuser can remove the extended release properties of the medicine, resulting in an elevated high.

It's worth noting that while the standard terminology in discussing this issue is "abuse-deterrent", what we are really talking about is making them tamper-deterrent. Regardless of how pills are made, it is impossible to prevent the form of abuse caused by a person who deliberately takes too much medication by simply swallowing more pills.

Studies show that medications with abuse-deterrent properties work. In one study reported in the Journal of Pain, abuse of oxycodone fell 41 percent when the drug was reformulated with abuse-deterrent properties (Journal of Pain, April 2013, Volume 14, Issue 4, Pages 351–358). Another study reported by the International Society for Pharmacoepidemiology showed that deaths fell 82 percent after the reformulation of oxycodone.

Aligned with an American Academy of Pain Management Op-Ed (Tamper-Deterrent Opioid Formulations: Who Needs Them, and at What Cost? Jan. 29, 2014), it seems reasonable to expect that reformulating existing medications to be abuse-deterrent may cause the price of these drugs to go up. This is reasonable, when we consider that the inclusion of safety equipment – such as anti-lock brakes – increase the cost of a car. But the benefit is that these drugs could save as much as $430 million in medical costs due to fewer hospitalizations and visits to emergency rooms (J Med Econ. 2014 Apr;17 (4):279-87). Admittedly, this means that non-abusing patients shoulder a portion of the economic burden, but when viewed at a macro level and in the context of the potential harm that could be caused by those who could abuse these medicines, it's a small price to pay.

The Global Healthy Living Foundation (www.ghlf.org) is committed to ensuring that people living with chronic illnesses such as arthritis, cancer and central nervous system conditions have access to treatments that allow them to live with less or no pain. In many cases, opioid use can be a key tool, provided their use can be managed to help prevent their abuse. Patients (and non-patients misusing these medications) will benefit from a solution that prohibits the alternation of these drugs into forms that encourage abuse.

We are not alone in our quest to see that all opioids are formulated with abuse-deterrent properties. Most recently, during his 'State of the State' address to the National Governor's Association, Colorado Gov. John Hickenlooper cited his state's 20 percent reduction in prescription drug

see Balanced on page 32

Constance Brown-Bellamy Honored at Commerce and Industry Event

Staff Writer
Behavioral Health News

The Caribbean American Chamber of Commerce and Industry (CACCI), recently Honored 2015 Women History Makers: Dr. Evelyn Castro, Vice President for student affairs, Medgar Evers College, CUNY; Jennifer Jackson, President, T&T Cleaning and Janitorial Services, Inc.; Constance Brown-Bellamy, Vice President, ICL; Nadi Ghaness, Senior Partner, H&N Insurance Agency; Kaye Chong, Executive, Caribbean Airlines; Beth Goldberg, District Director, United States Small Business Administration (SBA); Marlie Hall, CBS News Correspondent and Beth Goldberg, NY District Director, US Small Business Administration. Special Guest, Sheimyrah Mighty, Vocalist.

The CACCI Business Networking Meeting was held on Thursday, March 26th., At the Historic Brooklyn Borough Hall and hosted by Brooklyn Borough President Eric Adams and Deputy Borough President Diana Reyna. It was billed as a "Special Business Membership Net-

Dr. Evelyn Castro, Jennifer Jackson, Constance Y. Brown-Bellamy, Dr. Roy Hastick, Nadi Ghaness, Sheimyrah Mighty, and Kaye Chong, photo by Seitu Oronde

working Reception" with a marked focus on doing business with the United States, the Caribbean, Puerto Rico, US Virgin Islands, the Dominican Republic, Haiti and the Netherland Antilles.

According to Dr. Roy Hastick, Sr. President/CEO, CACCI, "this was a networking session with a difference. As we continue to embrace the Caribbean-American, African-American, Women and Minority Business Enterprises, and the entire business community, we are also continuing to explore ways and means for us to network and do business with each other. At CACCI we believe that creating and fostering relationships between the English, Spanish, Dutch and French/Creole speaking members of the business, and linking them to the United States small business community is one of the ways of creating opportunities for all." "One of the ways to remain in business and be profitable and sustainable is to seek out new markets for goods and services and also develop new relationships." In the room was presidents and CEOs, decision makers and professionals. By bringing all of this talent and expertise together and putting them in one room, CACCI hopes to create a synergy that will motivate people to do business with each other. "By reaching out to our overseas partners, CACCI is moving aggressively to help our local business community develop new markets and think outside of the box," Hastick said.

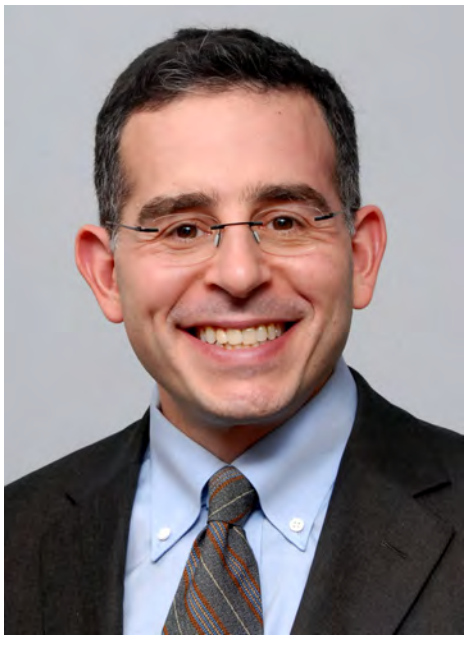
For more information call (718) 834-4544 or email: info@caccitradecenter. com.

Interview from page 1

What we've seen over the past 15 years is a very sharp increase in the prevalence of opioid addiction. The number of Americans who are now struggling with opioid addiction has skyrocketed since the late 1990's. The reason we're seeing overdose deaths at historically high levels, and why it has become the leading cause of accidental death in the United States, even surpassing deaths from motor vehicle accidents, is because we have so many people who are opioid addicted. The incredibly high amount of overdose deaths we now see is due to the fact that the prevalence of opioid addiction has increased dramatically and overdose death is a common outcome for people with the disease of opioid addiction.

When we talk about people who are using Heroin one of the things that we know is that those who have become users over the past 15 years (to separate them from those who have been using Heroin since the 1970's) is that at least 4 out of 5 of them (or more than 90%) began their opioid addiction using painkillers. When you look at the population of people struggling with the disease of opioid addiction there are roughly three different groups:

(1) Those who developed opioid addiction in the mid 1960's and 70's and have struggled with their addiction for the past 40-50 years. From that cohort, many people died from overdoses and many people also died of AIDS as the use of needles increased the spread of that disease. So we have a cohort of survivors from that



Andrew Kolodny, MD

epidemic who are aging. These are mostly men (as we see at Phoenix House) who are now in their sixties and who are disproportionately African American and Latino from inner-city communities.

Then we have the group I was speaking about that developed opioid addiction during the past fifteen years. Among these people who have become more recently addicted we have two different groups:

(2) One group of people who are young – perhaps in the range of 18 to 34 years of age who developed opioid addiction from medical or non-medical (recreational) use of painkillers. Some of them may have had a medical exposure (wisdom teeth or a sports injury) and they kind of liked the effect of the drug. So they were using the drug recreationally and probably didn't realize that they were essentially using Heroin pills – because Hydrocodone which is in Vicodin and Oxycodone which is in OxyContin and Percocet are opioids derived from Opium, the same as Heroin is. The effects they produce are indistinguishable from Heroin. For many, they probably thought they were playing around with a "soft drug" that was safe because it was prescribed by a doctor and not "cut" with anything – and it wasn't until they got addicted that they may ultimately figure out that this is basically the same thing as Heroin. Because they are young and typically do not have serious medical problems they have a hard time getting a large enough supply of pills from doctors so many of them have been switching to Heroin.

There is a common media narrative that our current Heroin problem is brand new was caused by government efforts to crack down on painkillers. But that's not true. There hasn't really been a government crackdown on pills and young people who became addicted to opioids from painkiller use have been switching to Heroin since the early 2000's, especially if they were in areas where Heroin was readily available. That's because when you compare a pill that cost $30 to a $10 bag of Heroin that would do pretty much the same thing, it boils down to a matter of cost.

The other people who are opioid addicted right now are individuals in their 40's, 50's, 60's, 70's and 80's. These are people who have mostly become addicted though medical use of opioids – in particular opioids prescribed to them for chronic non-cancer pain. This is a group that doesn't need to turn to Heroin because they generally don't have any problem finding doctors who will prescribe them all the pills that they need. One of the interesting things that observers and the media do not really capture is this older group that is addicted to legitimately prescribed medication. One of the more interesting findings is that the overdose death rates are much higher in that older group getting pills from doctors than the younger group that's been switching over to Heroin. The age group with the highest rate of drug overdose death in the United States is 45 to 54 years old. A recent Utah study where they looked at everybody that had died of painkiller overdoses found that 92% were having them prescribed to them by legitimate doctors for documented chronic pain.

I began by saying that there has been a very sharp increase in opioid addiction and overdose deaths are at an all-time high. But we are also seeing skyrocketing rates of infants born with *neo-natal abstinence syndrome* who are born dependent on opioids. We are also seeing a significant rise in Hepatitis C and a rise in Heroin flooding into communities where Heroin has never really been seen before.

The question you might ask is *what caused this increase in the disease of opioid addiction? Why are so many Americans addicted to opioids today, than there were 20 years ago?* The CDC has

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Governor Cuomo Announces Next Phase of Statewide Combat Heroin and Prescription Drug Abuse Awareness Campaign

By The Office of New York State Governor Andrew M. Cuomo

Governor Andrew M. Cuomo today announced the next phase of the statewide Combat Heroin and Prescription Drug Abuse awareness campaign to address the opioid epidemic in New York. The campaign includes messages on billboards, posters, online advertisements, social media and commercials that will be aired across the state for four weeks. The messaging warns that alcohol overuse and abuse of prescription opioid medications are often a gateway to heroin use, and refers those who need help to New York State's 24-hour addiction HOPEline.

"Our efforts to fight heroin and prescription drug abuse are raising awareness and helping to save lives in communities across New York," Governor Cuomo said. "Heroin addiction can often start with other forms of drug use – and with this next phase of the Combat Heroin campaign, we are working to break this cycle of abuse before it starts."

The Combat Heroin and Prescription Drug Abuse campaign is launching online advertisements that will appear on social media and select websites, and includes commercials underscoring the message, "addiction can happen to anyone, at any time – however, there is help available" to run on network and cable television stations.

Awareness posters will appear on the Staten Island Ferry, Staten Island subway lines, Long Island Rail Road trains, and

Governor Andrew M. Cuomo

at select Amtrak stations and malls in Poughkeepsie and Rockland County. The campaign's billboards will appear on highways in Albany, Binghamton, Buffalo, Rochester, Syracuse and Westchester County.

New York State Office of Alcoholism and Substance Abuse Services Commissioner Arlene González-Sánchez said, "Studies have shown that alcohol use can be a gateway to use of prescription drugs, heroin and other illicit drugs, especially in young people. Many of the young people that appear in the campaign PSAs and the website's 'Real Story' videos shared that their progression to heroin often started with alcohol and pain pills. This campaign helps get the message out that underage drinking, alcohol abuse, and illicit drug use can quickly spiral out of control resulting in serious addiction and devastating consequences."

The Combat Heroin website hosts 22 videos of New Yorkers describing first-hand how they or their loved ones progressed from alcohol to marijuana to heroin or prescription opioids and the devastation the addiction caused. Four of these videos will be used in television commercials.

Cortney, a young woman in recovery from heroin addiction who is featured in a campaign PSA, said, "I was 15 when I first tried alcohol. That didn't last long until it progressed to marijuana. Within a matter of months I was using pills all day long and by the time I was 17 I had tried heroin for the first time." Today, after Cortney received treatment and support, she is a national program officer for Young People in Recovery and a living example that recovery is real.

Heroin addiction and prescription opioid abuse are persistent national problems that reach deep into communities across New York and most heavily affect young adults. According to the Centers for Disease Control, nearly 15,000 people die every year of overdoses involving prescription painkillers nationwide, and nearly 4,400 died last year from heroin use – double that of 2011. In 2014, there were more than 118,000 admissions into New York State-certified treatment programs for heroin and prescription opioid abuse – a 17.8% increase over 2009. The largest increase in opioid admissions during that time was patients ages 18 to 34.

Governor Cuomo has made this issue a priority and implemented aggressive measures to help New Yorkers address heroin addiction and prescription opioid abuse. The Governor launched the Combat Heroin campaign in September 2014 to inform and educate New Yorkers about the risks of heroin and prescription opioid use, the warning signs of addiction, and the resources available to help. Additionally, the Governor launched the expanded first responder training program that in part requires every SUNY and CUNY police officer to be trained to respond to an opioid overdose by using Narcan. More than 40,000 New Yorkers are now trained – including nearly 3,800 law enforcement officers – and more than 1,100 lives have been saved.

New Yorkers seeking help can access prevention, treatment and recovery information on the Combat Heroin website or by calling the State's HOPEline at 1-877-846-7369. A list of treatment providers in New York State is available at www.oasas.ny.gov/accesshelp/.

New Yorkers who want to help are encouraged to share posters, billboards and PSAs in their local communities or become trained in anti-opioid overdose response. Combat Heroin campaign materials, including fact sheets and informational flyers, are available in English, Spanish and Russian on the Combat Heroin website (www.combatheroin.ny.gov). Information about anti-opioid overdose training is available at www.oasas.ny.gov/atc/ATCherointraining.cfm.

Addressing the Opioid Crisis in New York City

Hillary Kunins, MD, MPH, MS
Assistant Commissioner, Bureau of Alcohol and Drug Use – Prevention Care and Treatment, New York City Department of Health and Mental Hygiene

Like communities and cities across the country, New York City (NYC) has experienced increasing deaths from overdoses due to opioids, which include both opioid analgesics (prescription painkillers) heroin. In NYC, opioid overdoses are the leading cause of deaths from accidental injuries and a leading cause of premature mortality. From 2000 to 2013, rates of overdose death from opioid analgesics increased 256% in New York City. In 2013, about 1 New Yorker died every other day from an opioid analgesic overdose. Rates of heroin overdose deaths doubled in the City between 2010 and 2013, after four successive years of declining rates between 2006 and 2010. In 2013, 420 New Yorkers died from unintentional heroin overdose deaths. These unintentional overdoses are preventable with the right combination of prevention and care strategies.

Nationally, the opioid epidemic is of high priority. In March, 2015, the United

States Department of Health and Human Services (HHS), called for a three-part approach to reduce opioid overdose and the prevalence of opioid use disorders (or addiction), including promotion of safer opioid prescribing practices, and increased access to naloxone and medication-assisted treatment.[1] In NYC, the Department of Health and Mental Hygiene has included these key strategies in its response to the opioid epidemic, as well as several other key public health strategies, including the use of data to understand the extent and distribution of the problem, providing access to harm reduction services, and raising public awareness and reducing stigma.

Public Health Data to Monitor The Magnitude of the Opioid Epidemic

Public health data allows us to identify trends in drug-related deaths (or mortality) and other health-related consequences of drug use, such as hospitalizations, and emergency department visits. For example, our mortality data enabled us to identify that rates of overdose deaths involving opioid analgesics (prescription painkillers) were four times higher in Staten Island than any other New York City borough in 2011. In addition, prescribing patterns of opioid analgesics also varied across boroughs, with Staten Island residents filling prescriptions for these medications at more than double the rate of residents in all other boroughs. The Department also found that heroin-involved overdose deaths increased for three consecutive years, from 3.1 per 100,000 New Yorkers in 2010 to 6.2 per 100,000 New Yorkers in 2013. Using data such as these, the Department partners with communities, providers, and other stakeholders to develop and implement interventions to reduce the adverse health consequences of opioid misuse and overdose.

Judicious Prescription Painkiller (Opioid Analgesic) Prescribing

A key departmental initiative is the development and dissemination of guidelines for health care providers that promote judicious opioid analgesic prescribing. Although opioid analgesics are a very important medication to control certain types of pain, their role in treating chronic pain and for use over long period of time is not well-proven in scientific studies. Moreover, the risks of long-term opioid analgesic use may well outweigh the benefits, particularly increasing the risk of addiction and of overdose deaths. NYC is similar to communities around the country

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The campaign has raised awareness of the epidemic in communities across the state.

The combatheroin.ny.gov website has a wealth of information and assists in reducing stigma. One of the resources on the website is a link to treatment providers; unfortunately many of these providers are not able to meet the increased demand, in particular for medication-assisted treatment.

For more than 30 years, Crouse Hospital in Syracuse has provided safe, quality methadone treatment in our community. Our Opioid Treatment Program (OTP) provides a critically important service and has saved many lives by supporting individuals on their road to recovery.

Crouse presently operates the only methadone program in the Central New York region and our patients come from a radius covering close to 20 counties. The demand for opioid treatment services is so great that other centers could open in our surrounding counties and be filled to capacity in short order.

In December 2013, our opioid clinic was approved to expand from 500 to 800 patients. In 2014 we admitted 215 patients, offset by 152 discharges, and the program is presently at a census of 570 patients and has a wait list of 550 individuals.

Our efforts to expand quickly and safely have been hampered by lack of available physical space, finding qualified RNs and limited outside funding to help offset losses incurred in providing this essential service to the community.

Current Medicaid rates for Opioid treatment services do not adequately cover the cost to deliver the care. In 2013, the unfunded operating loss of the program was $1 million. In 2014 the loss was $1.8 million.

Over the last decade other forms of medication-assisted treatment have gained market share. Buprenorphine and the combination of Buprenorphine/naloxone and naltrexone can be viable alternatives to methadone for many patients. Unfortunately the availability of physicians prescribing Buprenorphine is extremely limited. Physicians must obtain a waiver to dispense or prescribe buprenorphine for maintenance treatment or detoxification treatment. After obtaining the waiver physicians are limited to 30 patients during the first year and 100 patients after that. There are presently not enough physicians who have the waiver and some of those who have it will not take Medicaid as a form of payment, providing this service on a cash-only basis.

Legislation is needed to make this treatment available to more patients. One way to accomplish this would be by allowing physician assistants and nurse practitioners to prescribe narcotics for maintenance treatment (they are already allowed to prescribe narcotics for the purpose of pain management).

Organizations like the NYS Association of Alcoholism and Substance Abuse Providers (ASAP) and the Coalition of Medication-Assisted Treatment Providers and Advocates (COMPA) continue to advocate for the specific needs of individuals struggling with opioid use disorders and the allocation of additional state and federal funds being made available to the New York State Office of Alcoholism and Substance Abuse Disorders (OASAS) to support providers of this life-saving treatment.

This growing epidemic leaves no age group or socio-economic class unscathed. In Onondaga County, the rate of infants born with drug-related problems passed on in utero is significantly higher than New York State and national averages.

According to New York State Health Department Statistics for 2007-2009 the number of newborns with drug related problems per 1,000 hospital discharges was 26. Women who use substances during pregnancy are more likely to seek prenatal care late and less likely to deliver a full-term, healthy baby.

As the area's largest provider of obstetrical and neonatal intensive care services, Crouse cares for the majority of these mothers and infants, which results in additional clinical and financial burdens on the healthcare system.

Concerted efforts across systems need to be based on a three pronged approach. Prevention of new cases of opioid addiction, on demand treatment for individuals who are already addicted and supply control through medical boards and law enforcement to reduce overprescribing and black-market availability.

Parallel to this approach we need to continue to remove the stigma associated not only with addiction, but specifically with medication-managed treatment and recovery. Individuals on maintenance therapy live productive lives and return to a level of functioning where they can be successful in their roles within their family, place of employment and society as a whole.

Barriers from page 6

this medication, making it very difficult for someone in active addiction to abstain from using an opiate for that length of time. If a patient is able to abstain, or if s/he has already had a period of abstinence from opiates, this is a safe, effective, non-narcotic, MAT. It is utilized for both opiate and alcohol dependence.

3. Buprenorphine is a partial opiate agonist and antagonist has been used for opiate use disorders since 2000. It can be prescribed and monitored in an outpatient office setting. Buprenorphine is a safe, effective alternative to methadone and has been associated with increased treatment retention and survival as well as fewer adverse side effects (Wally et al., 2008). Unlike methadone, buprenorphine has a ceiling effect that enhances patient safety by reducing the risk of overdose (SAMHSA, 2010). Buprenorphine is prescribed as part of an outpatient office visit and also unlike methadone, does not require daily visits to a specialized clinic.

One of the barriers for better access to treatment with Buprenorphine is that only "qualifying *physicians*" (those that complete minimally an eight hour course in opiate dependence) may prescribe buprenorphine for the purpose of treating individuals with OUD. Prior to the year 2000, buprenorphine was not yet utilized for the treatment of opiate addiction. The Drug Abuse Treatment Act of 2000 (DATA 2000) was passed and allowed "qualifying physicians" to treat a maximum of 30 patients with OUD at any given time with Buprenorphine (House Resolution 4365.2000). In 2006, this law was amended to allow the maximum to be increased to 100 patients after one year. Interestingly, Buprenorphine is the only Schedule III medication that existing laws permit *only physicians* to prescribe (House Resolution 4365, 2000). For reasons not clearly identified, nurse practitioners (and Physician Assistants) were excluded from DATA 2000.

More specifically, under DATA 2000, Nurse Practitioners (NP's) are not permitted to prescribe Buprenorphine for the treatment of opioid dependence, as the term "qualifying physician" is specifically defined to include *only physicians* licensed under state law (House Resolution 4365, 2000). NPs can prescribe all other medications, including all controlled substances. Ironically, NPs can prescribe Butrans (a transdermal patch which contains buprenorphine) for pain management and sublingual buprenorphine (if used off label) for pain - but not buprenorphine to treat addiction (NP's cannot prescribe methadone to treat OUD's either, but this article is specifically about prescribing Buprenorphine).

DATA 2000 was a step in the right direction, but it has left a shortage of health care providers who can legally prescribe buprenorphine for opiate use disorders. This, in turn, results in people waiting several weeks to months before obtaining this often lifesaving treatment. While awaiting an appointment to receive buprenorphine, individuals are exposed to multiple risks, not the least of which is overdose and death.

There are ways to manage this ongoing and ever increasing opiate epidemic which affects the lives of many. In July of 2014, Senator Ed Markey of Massachusetts proposed a legislative Bill (S. 2645) which called for the expansion of buprenorphine treatment by allowing NPs and Physician Assistants (PAs) to prescribe buprenorphine for opiate dependence and to permit physicians to have more than 100 clients on buprenorphine at any one time. Apparently the bill "died in committee" and will need to be redesigned and submitted to The Senate with a compatible bill to The House of Representatives for reconsideration. As concerned citizens, medical providers, parents, siblings and neighbors, we can write, email and/or call local congressional representatives to express our concerns and to suggest viable alternatives for the treatment of OUDs. Again, this would include better access to treatment by allowing NPs and PAs to prescribe buprenorphine which is a safe, evidenced based often lifesaving treatment for patients with opiate use disorders and by lifting the 100 patient limits for physicians.

Controlled substances are used to treat a plethora of medical issues, including pain, epilepsy, and mental health disorders such as anxiety and ADHD. In the acute phase of a chronic medical condition, patients should not have to wait for treatment. What if you, a family member or someone you knew could not get care because treatment slots were limited. The answer to immediate access is as simple as amending a Federal law. The resources are already in place. Now, we need legislation in order to use those resources!

Christene Amabile, FNP-BC is a nurse practitioner working in the field of addiction medicine at Horizon Health Services, the largest behavioral health organization in the Western New York area. Paige Prentice is Vice President of Operations for Horizon Health Services and serves on the board of NYASAP (New York Alcoholism and Substances Abuse Providers).

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HHS Leaders Call for Expanded Use Of Medications to Combat Opioid Overdose Epidemic

By The National Institute on Drug Abuse (NIDA)

A national response to the epidemic of prescription opioid overdose deaths was outlined in the New England Journal of Medicine by leaders of agencies in the U.S. Department of Health and Human Services. The commentary calls upon health care providers to expand their use of medications to treat opioid addiction and reduce overdose deaths, and describes a number of misperceptions that have limited access to these potentially life-saving medications. The commentary also discusses how medications can be used in combination with behavior therapies to help drug users recover and remain drug-free, and use of data-driven tracking to monitor program progress.

The commentary was authored by leaders of the National Institute on Drug Abuse (NIDA) within the National Institutes of Health, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Medicare and Medicaid Services (CMS).

"When prescribed and monitored properly, medications such as methadone, buprenorphine, or naltrexone are safe and cost-effective components of opioid addiction treatment," said lead author and NIDA Director Nora D. Volkow, M.D. "These medications can improve lives and reduce the risk of overdose, yet medication-assisted therapies are markedly underutilized."

Research has led to several medications that can be used to help treat opioid addiction, including methadone, usually administered in clinics; buprenorphine, which can be given by qualifying doctors <http://buprenorphine.samhsa.gov/data.html>; and naltrexone, now available in a once-a-month injectable, long-acting form. The authors stress the value of these medications and describe reasons why treatment services have been slow to utilize them. The reasons include inadequate provider education and misunderstandings about addiction medications by the public, health care providers, insurers, and patients. For example, one common, long-held misperception is that medication-assisted therapies merely replace one addiction for another -- an attitude that is not backed by the science. The authors also discuss the importance of naloxone, a potentially life-saving medication that blocks the effects of opioids as a person first shows symptoms of an overdose.

The article describes how HHS agencies are collaborating with public and private stakeholders to expand access to and improve utilization of medication-assisted therapies, in tandem with other targeted approaches to reducing opioid overdoses. For example, NIDA is funding research to improve access to medication-assisted therapies, develop new medications for opioid addiction, and expand access to naloxone by exploring more user-friendly delivery systems (for example, nasal sprays). CDC is working with states to implement comprehensive strategies for overdose prevention that include medication-assisted therapies, as well as enhanced surveillance of prescriptions and clinical practices. CDC is also establishing statewide norms to provide better tools for the medical community in making prescription decisions.

"Prescription drug overdoses in the United States are skyrocketing. The good news is we can prevent this problem by stopping the source and treating the troubled," said co-author and CDC director Tom Frieden, M.D., M.P.H. "It is critical that states use effective prescription drug tracking programs so we can improve prescribing practices and help get those who are abusing drugs into treatment."

Charged with providing access to treatment programs, SAMHSA is encouraging medication-assisted therapy through the Substance Abuse Prevention and Treatment Block Grant as well as regulatory oversight of medications used to treat opioid addiction. SAMHSA has also developed an Opioid Overdose Toolkit <http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742> to educate first responders in the use of naloxone to prevent overdose deaths. The toolkit includes easy-to-understand information about recognizing and responding appropriately to overdose, specific drug-use behaviors to avoid, and the role of naloxone in preventing fatal overdose.

"SAMHSA's Opioid Overdose Toolkit is the first federal resource to provide safety and prevention information for those at risk for overdose and for their loved ones," said co-author and SAMHSA Administrator Pamela S. Hyde, J.D. "It also gives local governments the information they need to develop policies and practices to help prevent and respond appropriately to opioid-related overdose."

CMS is working to enhance access to medication-assisted therapies through a more comprehensive benefit design, as well as a more robust application of the Mental Health Parity and Addiction Equity Act.

"Appropriate access to medication-assisted therapies under Medicaid is a key piece of the strategy to address the rising rate of death from overdoses of prescription opioids," said co-author Stephen Cha, M.D., M.H.S., chief medical officer for the Center for Medicaid and CHIP [Children's Health Insurance Program] Services at CMS. "CMS is collaborating closely with partners across the country, inside and outside government, to improve care to address this widespread problem."

However, the authors point out that success of these strategies requires engagement and participation of the medical community.

The growing availability of prescription opioids has increased risks for people undergoing treatment for pain and created an environment and marketplace of diversion, where people who are not seeking these medications for medical reasons abuse and sell the drugs because they can produce a high.

More than 16,000 people die every year in this country from prescription opioid overdoses, more than heroin and cocaine combined. According to SAMHSA's 2012 National Survey on Drug Use and Health www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#fig7.2, almost 2.1 million people in the United States were dependent upon or abusing opioid pain relievers. More information on prescription opioid abuse can be found at: www.drugabuse.gov/publications/research-reports/prescription-drugs.

#CombatHeroin from page 4

- Methadone, which is given in an outpatient clinic that dispenses methadone called an Opioid Treatment Program.

- Buprenorphine, which is given in clinics (OTPs) or in private physician practices in which the physician is specifically certified to prescribe buprenorphine.

- Naltrexone, which can be administered by mouth once a day or through a monthly injection called Vivitrol.

A common misconception is that people who are taking one of these medications are impaired. However, according to medical professionals who utilize these medications to treat opioid dependence, these medications when they are administered properly, do not result in impairment of the individual.

Another modality is treating opioid dependence without medication. This modality is also available in New York State. There are people in the recovery community who have years of sobriety using this modality.

Recovery Is Real

Recovery from addiction is possible. Those who relapse or return to opioid use should understand that they can re-enter recovery, and once in recovery can return to their work, interact in a healthy way with family members, and make valuable contributions to their communities. Individuals and families who have been affected by the disease of addiction should recognize that they are not alone. A listing of NYS OASAS-certified treatment providers can be found on the Combat Heroin website and the NYS OASAS website www.oasas.ny.gov/providerDirectory/index.cfm?search_type=2 or by using the NYS OASAS HOPEline, 1-877-846-7369, a 24/7 confidential telephone hotline to assist individuals with help and accessing treatment.

Getting Involved:
Combating Heroin in Communities

New York State has taken a national leadership position in recognizing the serious nature of the heroin and prescription drug abuse epidemic and has taken decisive action to raise public awareness about this deadly epidemic and ensure that those with substance use disorders have access to treatment. NYS OASAS continues to work to implement all aspects of the historic legislation enacted in 2014 and will continue to increase public awareness through additional phases of the Combat Heroin campaign and other public education efforts.

In fact, New York State was awarded $8 million in federal funds to help 10 local communities, through community coalitions, implement environmental strategies targeting heroin and prescription abuse and overdose prevention in the 12- to 25-year-old age group. More information about these federal funds can be found on the Governor's website at this link: http://www.governor.ny.gov/news/governor-cuomo-announces-8-million-combat-heroin-and-prescription-drug-abuse-among-young-adults.

To get involved in these and other efforts, visit the "Get Involved" section of the Combat Heroin website www.combatheroin.ny.gov/ for ideas on how you can help raise awareness in your community. Together, we can push back against this epidemic and give more New Yorkers a chance at recovery from addiction.

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facilities that offer the full continuum of evidence-based care, including Medication-Assisted Treatment (MAT). Withdrawal management and recovery-based treatments integrate MAT with an overall long-term treatment plan that includes individual, group and family therapies, treatment for co-occurring psychiatric and medical disorders, and interventions that target psychosocial barriers to recovery. Recovery coaches and peer support services help promote individual well-being and foster resiliency. Care coordination is also provided to help integrate care between multiple providers and facilities.

Optum supports contracting with local certified substance use treatment facilities that offer the full range of evidence-based treatments and alternatives, including all FDA-approved MAT options. Effective networks of providers and facilities that offer this comprehensive spectrum of services reduce or eliminate the need for people to travel to other destinations for care, as well as support the critical role of community integration in the process of care. Other strategies that promote improved outcomes of care include: access to intake and screening within 24 hours of referral or member outreach; coordinated services between treatment providers, facilities, and care managers who are accustomed to developing person-centered recovery plans; Medication-Assisted Treatment which is used as a tool to address cravings, and support program engagement and retention; and expedited transitions across levels of care that support established treatment plans and individual progress towards recovery goals.

Empowering Consumers and Families

Care coordination is also provided to help educate and engage consumers and their families regarding what treatment options are available and how to access treatment. Person-centered treatment planning is essential to promote consumer safety and goal-directed outcomes. This treatment planning involves establishing measurable and achievable goals, multidisciplinary treatment strategies, and a phased approach to care that fosters recovery, resiliency, and community engagement. Comprehensive assessments include medical, psychosocial, and motivational evaluations. Evidence-based services should include counseling, self-help and peer support, and Medication-Assisted Treatment, as indicated.

Person-centered care is respectful and responsive to the needs of those served and their families. This includes education that supports improved engagement in care and activation for the changes necessary to achieve individual recovery goals. Peer support and other locally based resources foster improved long-term health outcomes and sustained community-based recovery and resiliency.

Ensuring Evidence-Based Outcomes

Heroin and opioid use and prescription drug misuse are significant public health challenges and require integrated strategies that must include a full range of evidence-based services, including Medication-Assisted Treatment. Care must also be coordinated across all health providers and services to promote whole-health goals and outcomes. Equally important, treatment must have a person-centered approach that is locally based to effectively promote community integration and ongoing recovery supports.

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A Brief Overview of
Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) incorporates the use of medication in addition to a comprehensive range of services that include counseling, cognitive behavioral therapies, and recovery support from peer coaches and other community services. Some of the FDA-approved medications used in MAT include: Buprenorphine to treat opioid addiction, which is provided by a certified prescriber; Methadone which is provided at a licensed clinic and not always covered by commercial insurance benefit plans; Naltrexone Injection and Extended-release Naltrexone to treat opioid and alcohol addiction; and Acamprosate to treat alcohol addiction. Providing increased MAT services offers access to a range of treatment options that have been shown to control cravings, reduce relapse, and improve treatment outcomes. MAT is an evidence-based approach recognized by the Substance Abuse and Mental Health Services Administration (SAMSHA) and supported by ASAM.

Optum does not recommend or endorse any treatment or medications, specific or otherwise. The information provided is for educational purposes only and is not meant to provide medical advice or otherwise replace professional advice. Consult with your clinician, physician or mental health care provider for specific health care needs, treatment or medications. Certain treatments may not be included in your insurance benefits. Check your health plan regarding your coverage of services.

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abuse due to such measures. He and Utah Gov. Gary Hebert said “the federal government should work in close coordination with governors to develop policies that complement state efforts” to encourage “the development and use of abuse-deterrent formulations.” Further, physicians and law enforcement as well as groups such as The Partnership at Drugfree.org and the Center for Lawful Access and Abuse Deterrence have joined this cause. It’s time to make sure that patients who benefit from opioids get them while working to prevent their misuse.

Seth Ginsberg began his 20-year career as a health advocate at age 13 when he was diagnosed with a form of arthritis called Spondyloarthritis. Since then, Seth has evolved into a passionate thought leader and social entrepreneur in the global healthcare conversation. He believes that all patients with chronic disease deserve the best access to care, and that it is everyone’s responsibility to participate in patient-centered research to unlock the clues needed for better health outcomes in the fututre. Seth spends his energy engineering that future.

At 18, Seth helped pioneer the online patient community for others like himself who were suffering with arthritis, co-founding CreakyJoints. The CreakyJoints platform today is a highly customized, interactive delivery channel of relevant patient education, emotional and personal support services, advocacy initiatives and patient-centered research efforts. The Global Healthy Living Foundation is the non-profit parent organization of CreakyJoints, which Seth and CreakyJoints co-founder social entrepreneur Louis Tharp, created in 2004.

Seth continues to innovate ways to accelerate access to care, incorporating evidence-based advocacy, and patient reported outcomes measurement for improved care delivery and comparative effectiveness research. This unique combination of government-funded research initiatives (as a principal investigator of a PCORI-funded research network Arthritis Power), along with public and private partnerships, yield better patient insights and better health outcomes.

Seth works closely with Congress (aiding the efforts of the Congressional Arthritis Caucus), as well as health-related Congressional and Senate Committees, the U.S. Department of Health and Human Services (HHS) and its regulatory agency the Food and Drug Administration (FDA) and Centers for Disease Control (CDC), as both a representative of the patient community, and convener of other healthcare stakeholders. Seth and GHLF engage Governors and legislature leadership in states throughout the country to ensure better implementation of healthcare reform through “Seth’s 50 State Network.” This unique network of patient Super Advocates is in all 50 states and Puerto Rico, allowing patients to actively participate in the policy and regulatory conversations, and speak with media, as the voice for other patients.

Seth is a frequent guest on local and national news programs, a regular op-ed contributor, talk radio show guest host, and a keynote speaker at professional conferences and patient meetings.

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notes, "You can't solve this problem on an enforcement level, even if you put a tracking device on every chronic pain patient in the U.S." We need to do a better job treating addiction as the complex and devastating clinical issue that it is. And, word to the wise, improving our approach to addiction will also “cut state and local spending, lower crime, traffic accidents, suicides, domestic violence, homelessness, birth defects and a host of other devastating and costly health and social ills.” Most people struggling with an addiction aren’t receiving any treatment at all.

As in all cases of addiction, “the object of study should be the individual, rather than the substance,” according to psychologist/psychoanalyst Debra Rothschild, PhD. We need to treat the real problem instead of simply dealing with its inevitable consequences.

Every patient brings to treatment a unique history, biology and relationship to their drug use. A thorough treatment for opioid addiction should afford a stable, ongoing, non-stigmatizing treatment alliance with a primary therapist that patients work with on a regular basis. I believe that this type of therapeutic relationship, with a licensed mental health provider who has a sense of overall responsibility for their care, and who is able to help the patient come to an understanding of their addiction in the context of a variety of other factors, is essential. We know that addiction is often found along with other mental health issues such as trauma, depression and anxiety, not to mention the patient’s underlying personality. So our patients “require professionals trained in mental health, skilled in psychotherapy, knowledgeable about the full range of psychological treatments, and fluent in the use of both addiction and psychiatric medications."

We can have a transformative impact, in the very near future, on the epidemic of opioid addiction and on addiction more generally. Let’s do everything in our power to make it a reality.

Dr. Juman is a licensed clinical psychologist who has worked in the integrated health care arena for over 25 years providing direct clinical care, supervision, program development and administration across multiple settings—is the editor of Professional Voices on TheFix.com and is also a former President of the New York State Psychological Association. You may write to Dr. Juman at: dr.richard.juman@gmail.com, and you can find him on twitter: @richardjuman

This article appeared originally on 01/20/15 on TheFix.com and can be read there with full embedded internet links to important references at: http://www.thefix.com/content/let%E2%80%99s-fix-opioid-addiction-crisis-now.

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death. I have also seen that I have to allow myself and my family to have fun and not let addiction be the center of our lives. I have seen myself grow stronger and more determined to fight this battle alongside my son. The Serenity Prayer has become a way of life for me. For all those who suffer and their families, I pray for strength, hope and recovery.

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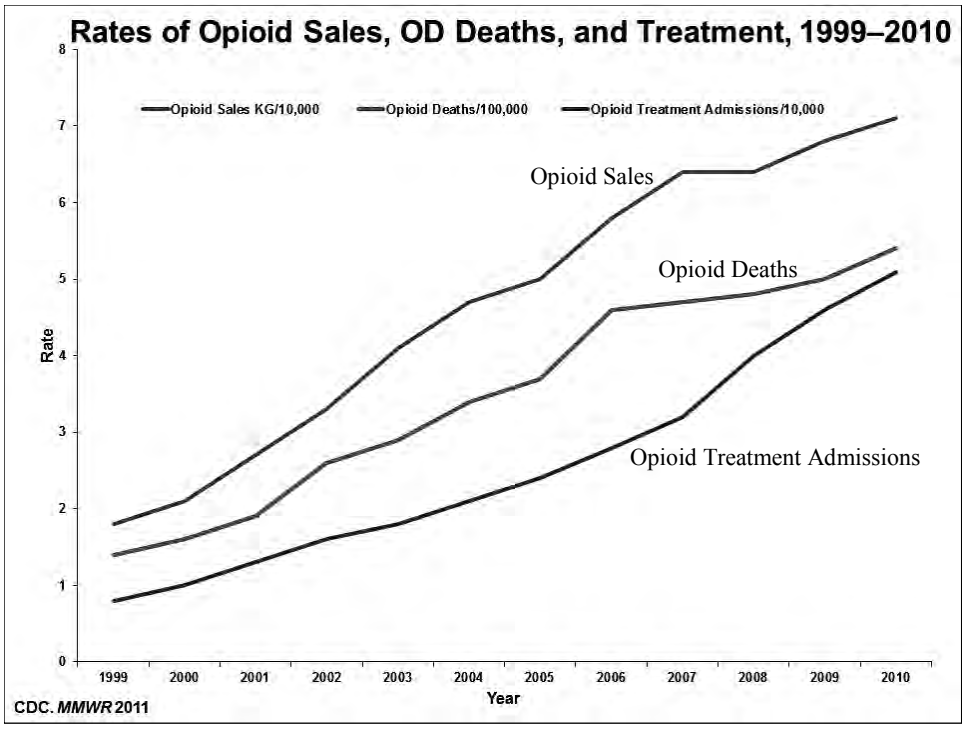
done a pretty good job of answering these questions. (see graph)

What the CDC is saying is that this epidemic has essentially been caused by the medical community. Doctors began prescribing opioids in the 1990's more aggressively than they had ever done before (other than the 1800's another era when opioids were overprescribed). As prescriptions soared it led to parallel increases in opioid addiction and overdose deaths.

There are situations when opioids are essential medicines such as in end-of-life care and they are also very important for easing suffering of someone who has just come out of surgery or had a very serious accident.

What's so disturbing about the vast over-consumption of opioids in the United States is that it is not for these conditions where opioid use is appropriate or essential. On the contrary, the vast over-prescribing of opioids are for conditions where opioids are much more likely to hurt patients then help them. I am talking about conditions like lower-back pain in a patient with a normal spine, fibromyalgia, and chronic headache. These are conditions where the experts that study them have made clear that opioids are not safe or effective.

IM: How do addictions actually begin? Are there bodily thresholds that must be met, or certain parts of the brain that differ in each person that are involved?



AK: That's a very good question. Addiction doesn't happen from a single exposure and is very different depending on the drug. For example some drugs like alcohol are inherently less addictive. About 90% of the people who drink alcohol do not become addicted to it. When you look at who becomes addicted to alcohol you will often see a very strong genetic component suggesting that alcohol addiction runs in families.

When it comes to highly addictive drugs such as nicotine, opioids (both Heroin and painkillers), and meth-amphetamine, genetics play much less a role, and the inherent addictive property of the drug plays a much more important role.

Environmental factors or the person's psycho-social state can also play an important role. If you are depressed for example and you are taking opioids and they not only relieve your pain but improve your mood, that's going to put you at greater risk of becoming addicted. For the most part it's mostly repeated exposure to the addictive drug that leads to addiction.

One exposure to an addictive drug is unlikely enough to cause an addiction. Let's say I offered you one cigarette, you would not develop a nicotine addiction. However, if I gave you a few packs and told you to smoke 5 cigarettes a day for an entire month, it's very possible that you would develop a nicotine addiction. Generally if you begin taking an opioid over and over again regardless if it's a recreational user who starts off doing it on week-ends or at parties because it's fun, it can easily lead to an addiction. Similarly when someone is prescribed long-term opioids, taking them every day, they can easily become addicted.

We now know a fair amount about the neuro-biology of opioid addiction as well and we understand that with repeated exposure to an opioid there are structural changes that occur in the brain that may even be irreversible.

IM: In your opinion, is there a solution to the current opioid epidemic in this country?

AK: I think the way out of this is to first think of this as a disease epidemic not an epidemic of people using drugs. We need to face this epidemic as you would any other disease epidemic such as an HIV epidemic, Measles, or Ebola epidemic, by which I mean we need to contain the disease by preventing new cases and we have to treat people with the disease so that it doesn't kill them. The first thing we have to do is prevent new cases of opioid addiction from occurring and the second

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on prescribed substances, allowing physicians and other prescribers to see what medications their patients have been prescribed, and by whom. These programs are designed to avoid "doctor shopping" by making a patient's medication history transparent to all providers. Among other things, PMPs are designed to "facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs." But, in addition to these goals, are PMPs and the other efforts that have been implemented in the last two years to address the prescription opioid epidemic also driving people to heroin?

The answer is cloudy, and for a number of reasons.

The Heroin Epidemic

There is no question that there has been an enormous increase in the number of heroin-related overdoses over the last decade, and that there has been a very dramatic increase in the last couple of years. The real question is whether well-intended efforts to combat the prescribed opioid problem are responsible.

A recent article in the Economist that made a splash in the treatment community asserts that "the face of heroin use in America has changed utterly", that the old stereotype of heroin users as young, poor, black and male has been replaced by a new reality in which users are overwhelmingly white, increasingly older, middle-classed and female. The shift is connected to prescribed opiates. In profiling a woman who was given OxyContin following an injury, the article connected the patient's heroin habit to the prescribed opiates, in a scenario that has become all too familiar: "On the black market OxyContin pills cost $80 each, more than she could afford to cover her six-a-day habit; so she began selling her pills and using the proceeds to buy cheaper heroin. As if from nowhere [she] had become a heroin addict."

Figures from the Centers for Disease Control support the idea that the prescription opioid crisis continues in full force. Over 100 people a day die in this country because of drug overdose, a figure that has been rising steadily for over two decades. In 2012, of the 41,502 drug overdose deaths in the US, 16,007 or about 38%, involved prescription painkillers.

There is also ongoing evidence that many of the millions who were initially introduced to opioids by their doctors have turned to heroin, and in fact that most of the people that use heroin now started out with a prescription opioid. While most hospital ED admissions for opioid overdose are still caused by prescribed painkillers, both government authorities and local media around the country continue to report an ongoing dramatic rise in heroin overdose deaths.

Many addiction treatment providers say that this has become a familiar paradigm among the patients that they treat. "A troubling comment pops up more and more during my discussions with people actively addicted to opioids," writes Jeffrey T. Junig, MD, a physician and PhD neuroscientist who practices in Wisconsin. They say, "Now that O-C's (OxyContins) are abuse-proof, we gotta' use heroin." Adds Dr. Junig who is open about being in recovery himself: "There are many addicts out there, each subject to severe withdrawal in the absence of their daily dose of oxycodone. What would a reasonable person expect them to do, knowing the intensity of their desire for opioids and their fear of withdrawal? Are they just going to stop?"

Arnold Washton, PhD, the Executive Director of Compass Health Group, a multi-specialty team of addiction providers in New York, reports that the same phenomenon Junig describes in Northern Wisconsin can be found among the C-suite executives that he sees in his high-end practice in Manhattan. He notes that "increasing numbers of clients are coming in reporting that they are physically dependent on heroin, having switched from OxyContin and other prescribed painkillers as they've become harder to get from their physicians. I've had two of these patients enter treatment just in the last week." In Manhattan, adds Washton, "these guys don't have to buy it on the street, there are heroin delivery services that will bring it to them in their doorman buildings."

Percy Menzies, the President of the Assisted Recovery Centers of America in St. Louis, a treatment center based in St Louis, confirms that many of his patients come to use heroin as a result of changes in their ability to access prescribed opioids. He notes that:

"The restrictions that have been placed on prescription opioids have resulted in a decreased availability of these drugs on the street. Some of our patients initially were started on prescription opioids for chronic pain, but after a period of time the patients were 'fired' by their doctors for abusing the drugs. Some of these patients tried switching doctors and when nothing worked, came to us for treatment. Other patients obtained prescription opioids illegally from friends, stole them, etc., and then switched to the cheaper opioid – heroin- and got addicted to the heroin." Adds Menzies, "We were caught unprepared for the 'man-made' addiction to prescription pain medications. Heroin quickly became the 'generic' version for the prescription opioids."

But other addiction medicine providers are not seeing a lot of this pattern in their practices. Mark Willenbring, MD, the former Director of the Treatment and Recovery Research Division at NIAAA/NIH and the CEO of Alltyr: Addiction Treatment for the 21st Century, says "I am unsure of the prevalence of prescription opioid users switching to heroin but I suspect it is very small. Most people have no idea how to procure it and are too afraid of the consequences. I've seen this a few times, but only in people with a history of serious non-medical opioid or other drug use." Adds Anna Lembke, MD, the Director of Stanford's Addiction Medicine Program, "I find that the switching from prescription opioids to heroin is more common among the younger generation, who seem to be generally more open to experimentation with all types of drugs, and are not deterred by legal status. Whereas with middle-aged and older folks, heroin represents crossing a line for them, and they'd rather get help before going there."

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Young Adults from page 17

96 percent of patients cited that they had a positive experience with it in their discharge evaluation. The majority found it helpful in improving their abilities to talk about their addictions; improving their insights into the impact of the disease on their lives; uncovering ideas for what life in recovery can look like; expressing themselves in a creative manner; and relating to others through discussion of the meanings of the sand trays.

Recreation Therapy

Our investigation into how to better work with young adults revealed challenges that results from interactions with older adults. The age gap creates significant personality differences that can be disruptive to everyone. For example, young adults often have lower self-motivation levels and less coping skills to manage stress, so they require supplemental guidance and encouragement that takes focus away from other group members. Also, transference between patients is common. Specifically, many young adult patients regard the older patients as parental or authority figures, and the older adults consider the younger patients as children. While these roles may be beneficial in some situations, it is important for all patients to be equal when in treatment.

To address these issues, we now offer some recreation therapy sessions for young adults only. By grouping peers together in treatment, we create social settings that are similar to what they'll experience after discharge from the inpatient program. This also reduces disruptions to patients in other age groups.

Young adults usually have higher energy levels and different interests than their older counterparts. We provide them with additional physical activities in the form of fitness center groups and team sports, like disc golf, flag football, or ultimate Frisbee. Aside from burning energy, these activities promote support, trust and asking for help.

Also, boredom is a top relapse trigger for most young adults. By learning to fill their free time with positive leisure choices, they can avoid filling it with using or other destructive activities. Indeed, these are important coping skills that will be useful in their daily lives.

Another successful recreation therapy activity is music and film appreciation, in which young adults listen to songs or watch movies together. Afterward, the group members analyze the lyrics or scenes and discuss themes that relate to addiction and recovery.

Other recreation therapy activities include facilitating a "circle of identities" project that promotes self-awareness and self-acceptance. We also ask patients to create their own coat of arms to express special memories, achievements, and dreams to aid in values clarification.

To culminate the recreation therapy experience, we created a yearbook for young adult patients to help illustrate they are not alone in the journey of recovery. At the last recreation therapy session, each patient has the opportunity to leave a message or draw a picture in the yearbook for future young adults to view.

Naloxone Initiative

Another important part of our treatment program for opiate-addicted patients, including young adults, is relapse prevention. As with any addiction, relapse is always a possibility. In the case of opiates, a relapse that results in an overdose can be fatal. To this end, we provide a prescription for Naloxone (Narcan®), an overdose reversal agent, to patients before discharge to be kept on hand in the event of an overdose. As part of their participation in the family program, family members learn how to identify an overdose and how to use the injection on their loved one.

The emphasis of our relapse prevention program continues to be on education and coping skills to help prevent patients from returning to drugs. However, the naloxone can be used as a life-saving tool in an emergency situation.

Marworth Alcohol and Chemical Dependency Treatment Center is located in Waverly, Penn. Valerie Noel, MEd, is a Drug and Alcohol Counselor, Lori Pilosi, MS, CTRS, is the Lead Recreation Therapist, and Dominic Vangarelli, MA, CAC, is Director of Counseling. Visit us online at www.marworth.org.

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Finally, evaluating your effectiveness is critical to program success. Programs should determine indicators early in the process that will measure how effective the program is. Retention, reduction in illicit substance use, and attendance are some initial factors. As the program develops we will continue to measure other indicators of a holistic recovery, such as vocational engagement, family involvement, and other community engagement.

Implementing multiple treatment modalities to address the diverse populations entering care for opioid abuse is becoming increasingly important. It is critical that new treatment options are implemented in a manner that ensures their sustainability and success to continue opening access to treatment.

Debbie Pantin, LCSW, is Associate Executive Director; Doreen Thomann-Howe, LCSW, is Chief Program Officer; Ernst Jean, MD, is Medical Director; and Debbi Witham, LMSW Esq, is SVP Compliance, Policy, and Planning at VIP Community Services.

Correction Notice: In our Spring Issue article entitled *Patriot Housing and Employment: Helping Veterans in Westchester County*, the opening sentence should have read: "In 2010 there were 76,329 homeless Veterans on the streets of America."

The Effort from page 10

Overdoses: Use and Abuse of Methadone As A Painkiller." CDC Vital Signs. July 2012

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6. Centers for Disease Control and Prevention. "Prescription Drug Overdose in the United States: Fact Sheet". March 2, 2015.

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9. Substance Abuse and Mental Health Services Administration. *Opiod Overdose TOOLKIT*. HHS Publication No. (SMA) 14-4742. 2014.

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11. Volkow, Nora. "America's Addiction to Opioids: Heroin and Prescription Drug Abuse: National Institute of Drug Abuse (NIDA) Presentation to the Senate Caucus on International Narcotics Control". May 14, 2014.

12. Warner, Margaret, et al. "Increase in Fatal Poisonings Involving Opiod Analgesics in the United States, 1999-2006". National Center for Health Statistics of the Centers for Disease Control. September 2009.

13. Wax-Thibodeaux, Emily. "New Rules on Narcotic Painkillers Cause Grief for Veterans and VA". *The Washington Post*. February 18, 2015.

NYSPA Report from page 22

use disorders. Since relapses are common and motivation for treatment often fluctuates with Substance Use Disorders (particularly when a patient is in withdrawal), obstacles to access or delays in treatment too often contribute to or prolong setbacks with substance use disorders. Timely, if not immediate, access to care during windows of motivation can be the difference between success or failure or even sometimes life and death for someone with a substance use disorder. Too often, insurance plans

• Don't adequately cover substance abuse assessments or treatments by non-psychiatrist physicians

• Carry out a "fail first" policy whereby a patient must first "fail" or relapse in a lower level of treatment before a higher level of care is covered

• Require time consuming and treatment delaying prior approval processes for medications needed to manage withdrawal or to assist substance abuse treatment to reduce risk of relapse

• Deny continued treatment, citing a relapse as the reason for no longer covering treatment stating arbitrarily that the plan is not working, or citing a lack of relapse as the reason treatment has succeeded and is no longer needed.

Insurance plans don't stop covering treatment of diabetes or other medical problems because the treatment is succeeding, and they don't stop covering treatment of medical conditions because there is a setback such as an elevation of blood sugars, myocardial infarction or CVA-such discriminatory practices with substance use disorders must end. Such practices may well be a violation of the Federal Mental Health Parity and Addiction Equity Act which requires plans to cover care for mental illnesses and substance use disorders the same as they cover other medical conditions. Enforcing the Federal Parity Laws, the NY State Attorney General's Office recently investigated and achieved settlements against 5 insurance plans or mental health/addictions benefit management companies for such discriminatory practices against persons with mental health and addiction disorders. Patients, families and physicians need to keep the pressure on insurance plans and pharmacy benefit managers by appealing each and every unreasonable denial, and by filing complaints with the NY State Division of Insurance and the NY State Attorney General's Healthcare Bureau.

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thing is that we must see that people with opioid addiction receive effective treatment. That's really it.

Number 1: Preventing new cases of opioid addiction boils down to getting doctors and dentists to prescribe more cautiously. By doing so they won't directly addict their patients or indirectly cause addiction by stocking medicine cabinets with pills that become an attractive hazard for their teenagers.
Number 2: We have to get better at improving access to treatment for people who already have this disease. If it's easier to get pills or Heroin than it is to access treatment, we're going to have no chance of reducing overdose deaths.

IM: What's the first line of defense in terms of treatment options available today?

AK: Buprenorphine therapy, also called Suboxone, when administered and monitored properly is one of the more effective treatments.

IM: Is Buprenorphine similar to Methadone?

AK: It's similar to Methadone. Methadone is a full opioid which is potentially dangerous when taken outside of Methadone clinics. Buprenorphine is a safer medicine that has fewer side effects, but the main advantage is that doctors can prescribe if from their offices, but it still must be done responsibly. By that I mean urine test should be done to verify that the patient is taking it, and you would want patients to receive psycho-social support. When it's done well, patients can have excellent outcomes. This is a very treatable condition.

IM: Is Buprenorphine used to wean the patient off opioids or is it used as a lifelong substitute for opioid addiction.

AK: That depends on the patient, but many people do need to stay on Buprenorphine long-term. Just like diabetes or high blood pressure, patients can be able to get off pills or insulin if they lose enough weight, eat right and exercise regularly- but if they can't do these things, we still give them the medicines they need.

IM: Does the Buprenorphine give the patient a euphoric effect when taken?

AK: Patients who take it regularly do not feel high from it. Some patients describe it feeling similar to having a cup of coffee. Patients look and feel alert on it.

IM: Is there a down side to taking it?

AK: The down side is that Buprenorphine is an opioid which means that if a patient runs out of it or loses their prescription while on vacation they are going to feel ill. It's not fun to be dependent on a medicine and need to worry about running out. But unfortunately, not many opioid addicted patients are able to do well without Buprenorphine or Methadone.

IM: What are current attitudes towards using Buprenorphine by the treatment community?

AK: That's a good question. Unfortunately, Buprenorphine isn't as widely accessible as it could be. This may be due to ideological differences at treatment facilities where some centers feel they do not believe in mediated assisted treatment. What we end up with is people dying of overdoses who might have lived had they been prescribed Buprenorphine.

IM: We are deeply grateful for this opportunity to speak with you. Do you have a message you'd like to leave with our readers.

AK: Yes, first I would like to thank *Behavioral Health News* for providing a much needed forum for information and collaboration among professionals in the field of chemical dependency and for providing a roadmap to resources in the community for individuals struggling with substance use disorders and their families.

My second message is to tell everyone that there is hope for people with serious chemical dependency issues.

Andrew Kolodny, M.D., Phoenix House's chief medical officer, started his career with a keen interest in public health and a passion for helping those who are suffering from addiction.

Prior to joining Phoenix House, Andrew served as Chair of Psychiatry at Maimonides Medical Center in Brooklyn, New York. In that role, he provided clinical and administrative oversight of psychiatric services and a residency-training program for one of the largest community teaching hospitals in the country. During his tenure, Andrew demonstrated a hands-on approach to improving quality of care, integrating health and mental health services, and developing new services and programs to meet changing community needs.

Andrew received his medical degree from Temple University School of Medicine. After completing his residency in psychiatry at Mount Sinai School of Medicine, he pursued his interest in public health with a public psychiatry fellowship at Columbia University and a Congressional Health Policy fellowship in the United States Senate.

Andrew then worked as Medical Director for Special Projects in the Office of the Executive Deputy Commissioner for the New York City Department of Health and Mental Hygiene. Tasked with decreasing overdose deaths, Andrew helped expand access to opioid addiction treatment. He also developed and implemented citywide programs to improve New Yorkers' health and save lives, including naloxone overdose prevention programs and emergency room-based screening, brief intervention, and referral to treatment (SBIRT) programs for drug and alcohol misuse.

When Andrew began a clinical practice, he encountered the type of patient who has become the new face of the worst drug crisis in U.S. history—young adults and middle-aged pain patients from suburbs who were addicted to prescription opioids. Andrew realized a new drug epidemic was emerging. People were dying in greater numbers every day, and no one seemed to be paying attention.

To combat this crisis, Andrew co-founded "Physicians for Responsible Opioid Prescribing" (www.supportprop.org), now a program of Phoenix House. Through his advocacy, he met and worked with people who have lost loved ones to prescription opioids—people he considers heroes because they have the courage to speak out despite stigma and work to make something meaningful come from their loss. Their advocacy with FDA led the rescheduling of Hydrocodone products such as Vicodin, correcting a mistake in federal law that had led to inappropriate availability and hundreds of thousands of cases of addiction.

When it comes to his role at Phoenix House, Andrew is most excited about the opportunity to close the treatment gap in addiction, and states, "There are millions of people in this country suffering from this disease of addiction who are unable to access effective and affordable care."

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Andrew Kolodny, MD, the Chief Medical Officer of Phoenix House and the President of Physicians for Responsible Opioid Prescribing (PROP), is a long-time crusader against the "epidemic of opioid addiction caused by overexposure of our population to prescription opioids." He argues for a balanced perspective on the challenges we're confronted by. He points out that "there is strong evidence that heroin use was increasing before any significant federal or state interventions on prescription opioids were implemented. The idea that efforts to curb prescription drug misuse have led to a spike in heroin use or overdose has become a common media narrative, but the facts don't support it. It is the overprescribing of opioids itself that has caused increases in opioid addiction of all kinds, not the efforts to control the prescribing. The transition from prescribed opioids to heroin has been happening since the beginning of the epidemic, and there is no evidence that the interventions brought forth to reduce the overprescribing have been fueling the increase in heroin use or overdoses. Because of the epidemic of opioid addiction, you now have markets for heroin that you didn't have in the past. So there has been an increase in heroin overdose deaths, but that increase was prior to states' implementation of Prescription Monitoring Programs or any of the changes from the FDA."

Obviously, there are regional differences in both the severity of opioid addiction and the tendencies for users of prescribed opioids to switch to heroin. Other factors are also at play, such as the fact that most opioid overdose deaths actually involve a variety of substances, particularly, alcohol and benzodiazapines. Beyond that, since we know that the supply of heroin in the US is high and the cost low, it's difficult to accurately assess the impact of any particular element or trend on the rate of heroin use and overdose. What is clear is that our problems with opioids, both prescribed pain medications and heroin, continue at full throttle, and more needs to be done. We'll look at our options in Part II of this series.

Dr. Juman is a licensed clinical psychologist who has worked in the integrated health care arena for over 25 years providing direct clinical care, supervision, program development and administration across multiple settings—is the editor of Professional Voices on TheFix.com and is also a former President of the New York State Psychological Association. You may write to Dr. Juman at: dr.richard.juman@gmail.com, and you can find him on twitter: @richardjuman

Credits: This article appeared originally on 1/15/15 on TheFix.com and can be read there with full embedded internet links to important references at: http://www.thefix.com/content/unintended-consequences%C2%A0are-we-inadvertently-increasing-heroin-overdose-deaths.

Community from page 25

existing programs. A strong strategic framework that identifies and improves upon already existing evidence-based programs and innovations by expanding their success, strengthening, and broadening them. These activities work to build upon existing efforts while discouraging duplication.

Backbone Support: All too often successful collaborative efforts are not sustained due to competing priorities of members. The Staten Island Partnership for Community Wellness serves as the backbone for TYSA by providing dedicated staff to align, coordinate, and support the work of member stakeholders. Qualities of a successful backbone are the flexibility to adapt, ability to influence, and passion about the work.

Starting to See Outcomes!

Because so much of the work of collective impact is about systems change, outcome level results are not typically seen in fewer than 5 years. What we can point to are the short-term wins that contribute to community change. In response to the success of a Staten Island based pilot program where NYPD Officers were equipped with naloxone, an effective medication that counteracts the effects of an opioid overdose, all NYC Police Officers are now equipped with this life saving medication. TYSA was also the first to organize a naloxone training for community members that has since been expanded across the Island. In 2011, overdose deaths were the highest out of the five boroughs of NYC at 11 per 100, 000 residents. In 2013, Staten Island dropped to 7 per 100, 000 OD deaths. We firmly believe that this decline was a result of the increased alignment and collaboration of many of TYSA's partners including – law enforcement, treatment providers, government agencies, and the media. While we are encouraged by this early success, we know the importance of continued vigilance and efforts until our rates are below citywide averages. The effort put forth by TYSA proves that a community aligned can move forward farther and faster.

Management from page 12

Medical conditions associated with Opioid use disorder affect almost every organ system and are summarized in the table below by Gordon, Physical Illness and Drugs of Abuse (2010).

Infectious	Abscess, cellulitis, endocarditis, sepsis
Musculoskeletal	Rhabdomyolysis, Osteopenia
Respiratory	Asthma, pulmonary edema, respiratory depression
Nervous	Seizures, cerebral dysfunction
Ocular	Strabismus, fungal infection
Urological	Renal disease
Ob/Gyn	Fetal growth restriction, neonatal abstinence syndrome, placental changes, congenital disease
Cardivascular	CAD, endocarditis, arrhythmias
Nutrition	Calcium deficiency, hypercholesterolemia, hypo/hyperthermia
Endocrine	Pituitary enlargement, local changes

Conclusion

In summary, this article is by no mean comprehensive but to emphasize that we are facing an epidemic endemic opioid use disorder and there are several effective treatments. Additionally there are merits to making Noloxone available to all first responders, but training is a must. The treatment of Opioid Use Disorder has different stages. Detoxification is only one aspect of treatment and without proper after care, the relapse is extremely high, hence our obligation to educate patients, families, significant others and continue to advocate for our patients.

Multidisciplinary teams that are cohesive, up to date and respectful to each other are crucial to making a difference in a population, often than not, with poor resources, becoming older and more medically compromise.

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in that rising rates of opioid analgesic prescribing have accompanied the increases in opioid analgesic overdose deaths.

To reduce the risk of addiction and overdose, the Department's guidance for prescribers recommends judicious use of opioid analgesics, only when other medications are ineffective and for only as long as needed to control pain. Our guidelines, first published in 2011, are available on-line at the Department's website.[2] In 2013, we conducted a public health detailing campaign in Staten Island to disseminate these guidelines, through one-to-one educational visits with over 1,000 prescribers, and we will be conducting a similar campaign in the Bronx this spring.

The Department has also tailored opioid prescribing guidelines for emergency departments, in collaboration with local clinicians. To date, these prescribing guidelines for emergency department clinicians have been adopted by 39 emergency departments across New York City.

Opioid Overdose Prevention
And Access to Naloxone

Since 2009, the Department has supported opioid overdose prevention training and access to naloxone, a medication that can reverse an overdose from both opioid analgesics and heroin. Naloxone is a safe and easy-to-use medication that can be used by laypeople who have been trained to recognize an overdose and administer naloxone to the person experiencing an overdose. New York State's Opioid Overdose Prevention Act, passed in 2006), makes it legal for laypeople to use naloxone to reverse an overdose, and for clinicians to prescribe it for this use in communities. The Department has distributed over 30,000 intranasal naloxone kits to New Yorkers through registered opioid overdose prevention programs. These registered programs are located in a diverse array of community-based and other organizations, such as syringe exchange programs, addiction treatment programs, housing programs, and organizations serving veterans. Additional kits are also being distributed by the New York State Department of Health. Over 550 overdose reversals have been reported in New York City — a number which is considerably under-reported.

In 2013, the Department began a collaboration with the New York Police Department to pilot a naloxone program through which police officers are trained as overdose responders. Increased access to naloxone for those at high risk of witnessing an overdose is a key part of preventing fatal overdoses from opioids including prescription painkillers and heroin.

Access to Services for
New Yorkers Who Use Opioids:
Treatment And Harm Reduction

Effective treatment for opioid use disorders (or addiction) can save lives and help individuals recover, regaining physical, mental, and social health. Scientific studies of the treatment for opioid addiction show that treatment is particularly effective with medication-assisted treatment. The most extensive scientific evidence demonstrates that use of one of two medications, methadone or buprenorphine (also known as Suboxone®) can reduce deaths from opioids, reduce drug use, and, most importantly, help individuals regain their ability to participate in their communities, families, and workplaces.

One advantage of buprenorphine is that it is available through prescriptions in primary care as well as in specialized drug treatment settings. Having buprenorphine available in primary care settings can help attract people in need of treatment for their addiction who might not choose to seek care in specialized settings. The Department is working in various ways to increase access to and awareness of medication-assisted treatment, supporting buprenorphine practice change for primary care practices and trainings for physicians, and will provide funding for several primary care and addiction treatment programs to incorporate buprenorphine into their practices. In April, 2015, the Department released an updated guidance for buprenorphine treatment in primary care settings.[3]

Harm reduction services are also a critical part of care and treatment for New Yorkers who use heroin and/or prescription painkillers. Arising out of the HIV/AIDS epidemic, harm reduction is an approach that seeks to reduce the consequences of drug use, originally through the provision of sterile injection equipment to individuals who inject drugs, but now refers to a larger array of services and counseling approaches that help people take steps to reduce risks from drug use, even if entering addiction treatment is not their immediate goal. The Department supports NCY's syringe access programs, which have led the development of harm reduction practices, including distribution of naloxone to people at risk for overdose. The City's syringe access programs provide numerous health-related services, including health and mental health care, and linkage to treatment for HIV, hepatitis C and other health conditions; overdose prevention; access to housing and food, and many other services.

Raising Awareness and Reducing Stigma

By raising awareness of opioid misuse and overdose, the Department seeks to educate New Yorkers about the risks of prescription painkillers, and availability of effective services for individuals in need of help. We recently developed and aired two testimonial-style TV ads focused on the risks associated with opioid analgesics, featuring Staten Islanders; one shared the experience of an individual in recovery from opioid analgesic dependence, and the other showed a parent who lost a child to opioid analgesic overdose.[4] Following our departmental multi-prong approach, as well as other state efforts, opioid analgesic overdose deaths decreased by 29% in Staten Island in 2013.

Underlying the Department's efforts is the overall goal to reduce the stigma associated with drug use and addiction. Stigma impedes our ability to reduce the risks from opioid addiction, causing individuals to be reluctant to disclose their drug use and seek help, and providers to identify and offer services. Together with the behavioral health and entire health community – including providers and individuals receiving services – we can lessen stigma by speaking about addiction and overdose, and supporting access to effective prevention and treatment strategies. Using evidence-based treatment service and policy strategies along with efforts to raise awareness and reduce stigma, the Department will continue to champion efforts to reduce overdose and other consequences of opioid use disorders and addiction in New York City.

1. United States Department of Health and Human Services. ASPE Issue Brief: Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Death, March 26, 2015. Available at: http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/ib_OpioidInitiative.pdf, accessed, April 13, 2015.

2. Paone D, Dowell D, Heller D. Preventing misuse of prescription opioid drugs. City Health Information, 2011; 30(4): 23-30. Available at: http://www.nyc.gov/html/doh/downloads/pdf/chi/chi30-4.pdf, accessed April 13, 2015.

3. Kattan J, Fox AD, Cunningham CO, Paone D, Harrison M, Kunins HV. Buprenorphine – An Office-Based Treatment for Opioid Use Disorder. City Health Information, 2015; 34(1): 1-8. Available at: http://www.nyc.gov/html/doh/downloads/pdf/chi/chi-34-1.pdf, accessed April 13, 2015.

4. New York City Department of Health and Mental Hygiene Opioid Awareness Public Service Announcements. Available at: http://www.nyc.gov/html/doh/html/mental/prescription-tv-ads.shtml, accessed April 13, 2015.

Behavioral Health News Theme and Deadline Calendar

Fall 2015 Issue:

"Caring for Depression in Integrated Settings"

Deadline: July 14, 2015

Winter 2016 Issue:

"Wellness in The Workplace"

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relapse prevention and monitoring of treatment status.

One case example of the effectiveness of the collaborative team approach involves a patient who initially met with his primary care physician for an annual physical. At the time, the doctor reviewed his treatment plan, saw that he was on long term Methadone maintenance on a low dose, and discussed the option of switching to Buprenorphine treatment. The patient was excited at the idea of making the transition to Buprenorphine as he is a single father and was looking for work. He was tired of making the trip to the methadone clinic every day. He found the clinic to be depressing and a relapse trigger as other clients were using drugs. He was often offered pills or heroin while waiting in the dispensing line. After completing the assessment and medical visit, the patient was started on Buprenorphine. When asked about his experience, patient state he was comforted by the team approach. He received a phone call from his primary care doctor and social worker after he began taking the medication as well as the next day to see how he was feeling. He felt he was informed about the process including symptoms he would experience and how to manage them. When the patient returned a week later for follow up, the social worker met him at his PCP appointment and encouraged him to continue with weekly therapy.

It's been a year since the patient made the change from methadone to Buprenorphine. He still attends bi-weekly therapy. He attends AA. He is still a single father and active in his daughter's life, and he now works fulltime. He reports being very happy that he made the change to office based treatment.

Providing comprehensive medical and substance abuse services to these individuals also enhances their recovery. Research has shown that individuals with substance abuse related medical conditions who access primary care services, are three times more likely to achieve remission over 5 years and also decreased hospitalizations by up to 30% (Weisner, C, Mertens, J, Parthasarathy, S, Moore, C, and Lu, Y. (2001). Integrating Primary Medical Care With Addiction Treatment. JAMA: The Journal of the American Medical Association, 286(14):1715-1723. doi:10.1001/jama.286.14.1715). Integrated treatment is ideal for meeting the comprehensive needs of individuals with substance use disorders.

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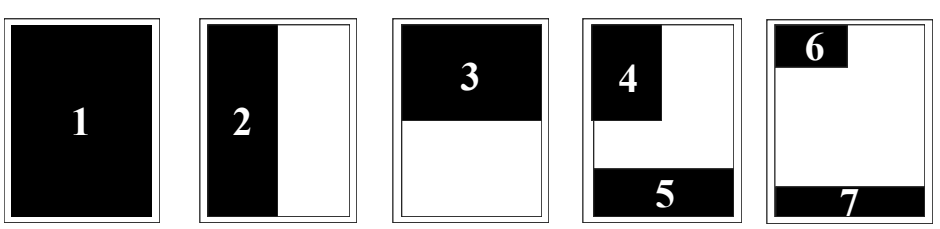

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