Current Trends in Substance Use Prevention, Intervention and Treatment

Ken Martz, Psy.D. CAS
Special Assistant to the Secretary
Pennsylvania Department of Drug and Alcohol Programs

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Overview

- Introduction
- Warning Signs
- Disease Model
- Components of effective treatment
- Components of recovery
- Case examples
- Recommendations/Discussion

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- Background

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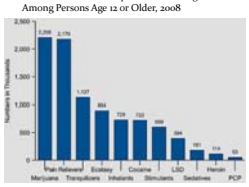
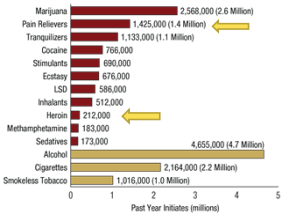
Overview of Substance and Drug Use

Past-Year Initiates for Specific Illicit Drugs Among Persons Age 12 or Older, 2008



Past-Year Initiates for Specific Illicit Drugs Among Persons Age 12 or Older, 2014



Source: Substance Abuse and Mental Health Services Administration. (2009). *Results From the 2008 National Survey on Drug Use and Health: National Findings* Rockville, Maryland.

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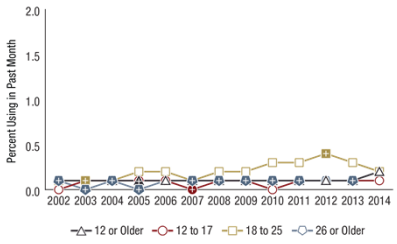
Past Month Heroin Use among People Aged 12 or Older, by Age Group: 2002-2014



Source: Substance Abuse and Mental Health Services Administration. (2014). *Results From the 2015 National Survey on Drug Use and Health: National Findings* Rockville, Maryland.

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Drug Related Overdose Deaths in Pennsylvania

Figure 7: Ranking of Frequency of Drugs of Interest Present, and Rate of Change (Δ), In Drug-Related Overdose Decedents, Pennsylvania, 2014-2015

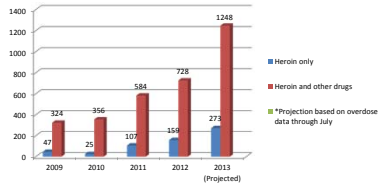
Rank	Drug	% Reported Among 2015 Decedents	Δ From 2014
1	Heroin	**54.6%**	5.4%
2	Fentanyl	27.0%	**92.9%**
3	Cocaine	23.9%	**40.6%**
4	Alprazolam	20.5%	5.7%
5	Oxycodone	18.6%	3.9%
6	Clonazepam	9.9%	3.1%
7	Diazepam	7.5%	-9.6%
8	Marijuana	7.1%	7.6%
9	Methadone	6.7%	-11.8%
10	Hydrocodone	5.8%	7.4%
11	Tramadol	3.8%	-17.4%
12	Acetyl Fentanyl	3.6%	*
13	Methamphetamine	3.1%	95.0%
14	PCP	1.7%	-16.5%

*No Acetyl Fentanyl Reported in 2014

Source: Pennsylvania Coroner Data

Heroin Related Overdose Deaths in Pennsylvania

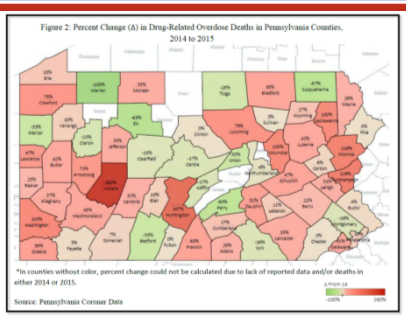
Heroin Only and Multidrug Toxicity Deaths



- Based on Pennsylvania Corners Association (PCA) reports in 43 counties, heroin and heroin related deaths have been on the rise for the past 5 years (PCA, 2013)
- Between 2009 and 2013 there 2,929 heroin related overdose deaths identified by county coroners. Of these, 490 (17%) were heroin only, while 2,439 (83%) involved multiple drugs.

- Other drugs commonly found along with heroin overdose include
  - Other opiates: Methadone, Oxycodone, Fentanyl, Morphine, Codeine, Tramadol
  - Other Illegal drugs: Marijuana, cocaine
  - Other sedating drugs: Alcohol, benzodiazapines
  - Antidepressant medications: Prozac, Celexa, Remeron, Trazadone, Zoloft

Overdose Deaths in Pennsylvania



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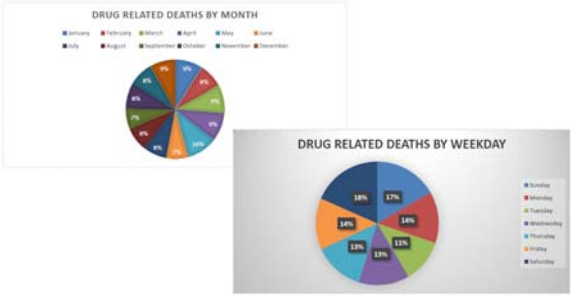
Heroin Related Overdose Deaths in Pennsylvania



Source: Pennsylvania Coroner's Association, 2014

History

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients' who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind V, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

NEJM, 1980

History

NEJM, 1980

A 1989 monograph for the National Institutes of Health, which asked readers to "consider the work" of Porter and Jick.
A 1990 article in Scientific American, where it was called "an extensive study"
A 1995 article in Canadian Family Physician, where it was called "persuasive"
A 2001 Time magazine feature, which said that it was a "landmark study" demonstrating that the " exaggerated fear that patients would become addicted" to opiates was "basically unwarranted"
A 2007 textbook, "Complications in Regional Anesthesia and Pain Medicine," which said that it was "a landmark report" that "did much to counteract" fears that pain patients treated with opioids would become addicted.

(Jacobs, 2016)

Warning Signs

Intervention- Identify Warning Signs

- **Physical warning signs of drug abuse**
  - Bloodshot eyes, pupils larger or smaller than usual
  - Sudden weight loss or weight gain
  - Deterioration of physical appearance, personal grooming habits
  - Unusual smells on breath, body, or clothing
  - Tremors, slurred speech, or impaired coordination
- **Behavioral signs of drug abuse**
  - Drop in attendance and performance at work or school
  - Unexplained need for money or financial problems; may borrow or steal to get it.
  - Engaging in secretive or suspicious behaviors
  - Frequently getting into trouble (fights, accidents, illegal activities)
- **Psychological warning signs of drug abuse**
  - Unexplained change in personality or attitude
  - Sudden mood swings, irritability, or angry outbursts
  - Periods of unusual hyperactivity, agitation, or giddiness
  - Lack of motivation; appears lethargic or "spaced out"
  - Appears fearful, anxious, or paranoid, with no reason

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Overdose

- **Signs of an overdose:**
  - Slow or shallow breathing.
  - Very sleepy and unable to talk, or unconscious.
  - Does not respond to attempts to rouse to consciousness.
  - Skin color is blue or grayish, with dark lips and fingernails.
  - Snoring or gurgling sounds
- **If there are symptoms of an overdose:**
  - Lightly tap, shake, and shout at the person to get a response. If there is still no response, rub knuckles on the breast bone.
  - If the person responds, keep them awake.
  - Call 911

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Naloxone and Act 139

- **How do I get naloxone?**
  - Family members and friends can access this medication by obtaining a prescription from their family doctor or by using the standing order (a prescription written for the general public, rather than specifically for an individual) issued by Rachel Levine, M.D., PA Physician General.
- **What types of naloxone are available?**
  - Nasal Spray (Narcan by Adapt Pharma)
  - Auto Injector (Evzio by Kaleo)
- **Is additional training available?**
  - Training is available at one of the Department of Health approved training sites www.getnaloxonenow.org or https://www.pavtn.net/act-139-training.

Over 2,300 reversals as of January 2017

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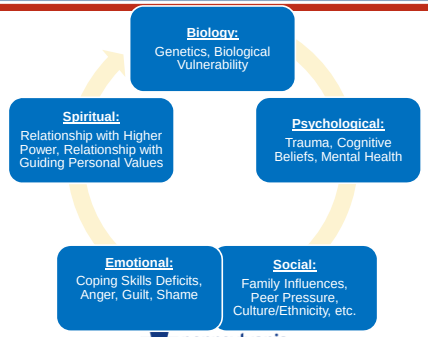
Risk Factors



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- Why does one become addicted?

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Why does one become addicted?

Causes	
Biology Genes, Biochemistry, Brains, Autopilot Learning	
Relationships with Others Peer Pressure, Family, "Enabling", Isolation, Lies	
Relationship with Self Shame, Guilt, Negative Beliefs, "Hate Self"	
Relationship with Higher Power Lack of Connection with Personal Values, Anger/Shame with God	

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Why does one become addicted?

Causes	Solutions
Biology Genes, Biochemistry, Brains, Autopilot Learning	Medication, Meditation Exercise, Diet, Sleep, Stress Management Decisional Actions
Relationships with Others Peer Pressure, Family, "Enabling", Isolation, Lies	Limit Setting, Relationship Building, Honesty, Clear Communication Family/Couples Therapy Positive Peer Pressure
Relationship with Self Shame, Guilt, Negative Beliefs, "Hate Self"	Forgive Self, Gratitude Practice Engage in Healthy Behaviors Today Healthy Coping Skills Training
Relationship with Higher Power Lack of Connection with Personal Values, Anger/Shame with God	Define Values, Live by Personal Values Pray, Meditate, Other Spiritual Practice

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Why does one become addicted?

Causes	Tools
Biology Genes, Biochemistry, Brains, Autopilot Learning	Medication
Relationships with Others Peer Pressure, Family, "Enabling", Isolation, Lies	Family/Couples Therapy Peer Support
Relationship with Self Shame, Guilt, Negative Beliefs, "Hate Self"	Psychosocial Therapy
Relationship with Higher Power Lack of Connection with Personal Values, Anger/Shame with God	12-Step Meetings Religious/Spiritual Services

Other Ancillary Tools: Employment, Housing, Other Medical Treatment

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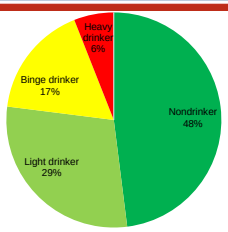
Percentage of drinking in past 30 days (age 12 and older)



- Nondrinkers: Reported no alcohol use
- Light drinkers: Reported use with no binges
- Binge drinkers: Reported 5 or more drinks in one day
- Heavy drinkers: Reported 5 or more binges
  - NSDUH (2011) survey of approximately 67,500 individuals

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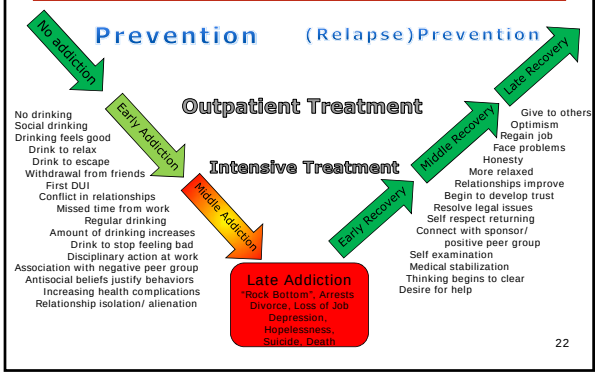
Progression of a Disease and Recovery



- What is all this talk of “brain disease”?

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ASAM Definition

ASAM Definition of Addiction:

- Addiction is a **primary, chronic disease of brain reward, motivation, memory and related circuitry.** Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

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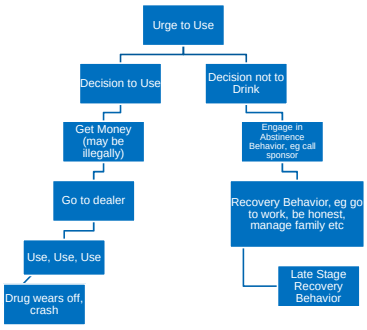
Biology
Example of 2 Brain pathways



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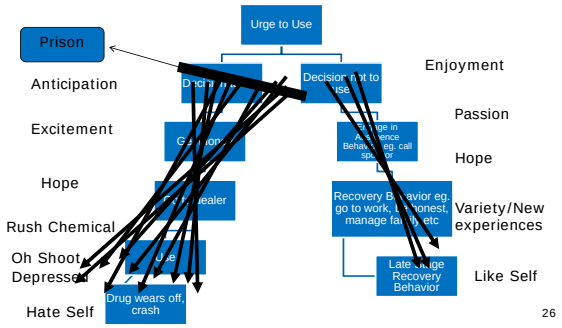
Biology
Example of 2 Brain pathways



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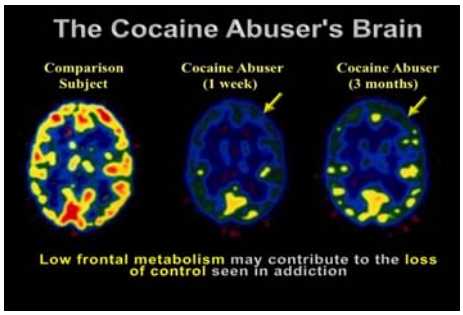
Biology
Example of 2 Brain pathways

Which Brain do You Want?



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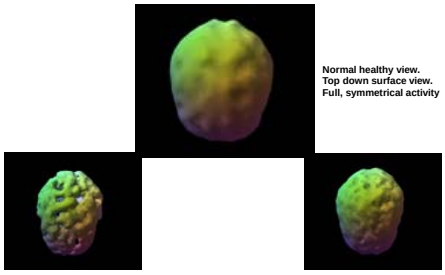
Which Brain do You Want?



Normal healthy view.
Top down surface view.
Full, symmetrical activity

During substance abuse

One year drug and alcohol free

Notice the overall holes and shriveled appearance during abuse and marked improvement with abstinence.

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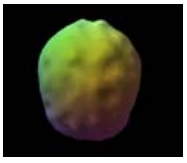
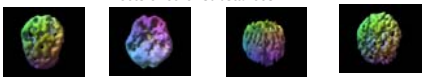
Which Brain do You Want?



Normal healthy view.
Top down surface view.
Full, symmetrical activity

Effects of other substances:



Long term alcohol abuse	57 y/o 30 years marijuana abuse (underside view)	39 y/o – 25 years frequent heroin use	40 y/o, 7 years on methadone. Heroin 10 years prior.

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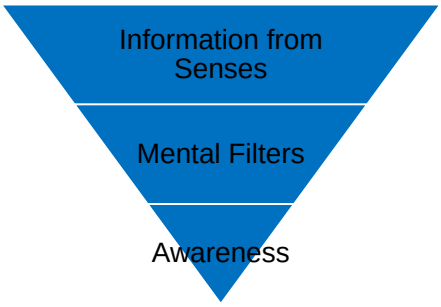
Mental Filters



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Mental Filters

- **State Dependent Memory:**
  - **It is easier to remember sad memories when you are sad and easier to remember happy memories when you are happy.**

Can you see only the options you expect, or can you direct awareness to see option C, D, E…

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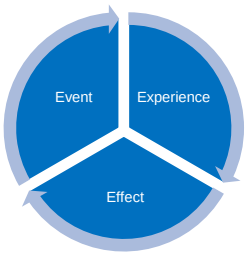
Trauma/Stress

Acute: e.g. Violent assault
Chronic: e.g. Ongoing abuse

Intensity: Low/high

Flashbulb Memory



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- What is this “treatment” thing anyway? And what does “recovery” look like?

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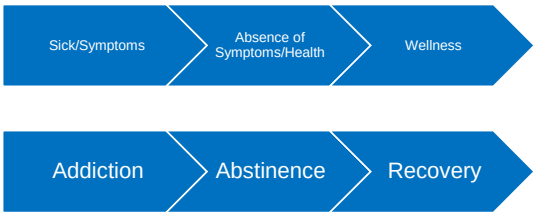
Treatment Goals



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Treatment Goals

Addiction	Abstinence	Recovery
Chemical addiction	Withdrawal	“Addiction” to recovery behaviors
Dysfunctional relationships	Tension/ distrust/ judgment in relationships	Trust, partnership, respect in relationships
Negative self image	Lack of confidence/ doubts	Self respect
Lack of values/spiritual connection	Questioning of values	Knowing personal values and following them
Motivation to use/drink	Motivation to stop drinking/avoid pain	Motivation to seek pleasure/ health

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Treatment Goals

Addiction	Abstinence	Recovery
Mental health issues	Awareness of mental health as triggers	Management/ remission of mental health issues
Depression	Boredom, blunted emotion	Happiness, range of emotion
Avoidance /numbing of feelings	Aware of uncomfortable feelings	Able to tolerate unpleasant feelings as they arise
Lack of range of coping skills	Novice at identifying coping strategies	Competent at a range of coping strategies
Unresolved trauma/grief	Aware of losses	Able to "let go" of past
Personality disorder(s)	Aware of personal issues	Able to reduce negative impact of personality style
Unmedicated (bipolar, ADHD etc)	Finding proper medication combination	Stable on effective medication

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Treatment Issues

- Pennsylvania's Client Placement Criteria (PCPC)
- Treatment targets Risks/Needs
- Continuum of care
- Access to treatment

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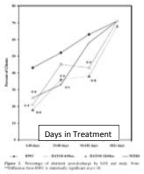
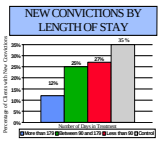
Length of Stay

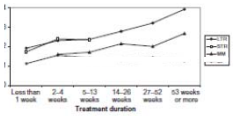
Studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment and continuum of care.



Source: Greenfield et al, (2004). *Effectiveness of Long Term Residential Treatment for Women: Findings from 3 National Studies*



Source: Pennsylvania Department of Corrections (1997) *Pennsylvania FIR Evaluation*



Source: Zhang (2002). *Does retention matter? Treatment duration and improvement in drug use. (4,005 clients)*

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Length Of Stay

Studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment and continuum of care.

- Improvements in criminal recidivism and relapse rates are correlated to length of treatment, with highest rates of improvement among those with 9 months of treatment, and reduced effectiveness for treatment of less than 90 days (NIDA, 2002)
- Highest improvements were found in long term treatment with least improvement found in methadone maintenance (Friedmann et al, 2004)
- Lengths of stay are the number one predictor of outcomes for treatment (President's Commission on Model State Drug Laws, 1993)
- Average length of stay for Medicaid clients was 90 days (Villanova Study, 1995). Best outcomes were found for longer lengths of stay and more complete continuum of care, measured as lack of criminal recidivism, abstinence, employment and higher paying jobs. No benefit was found for treatment less than 90 days. Currently, average length of stay in treatment for long term residential is 47 days (DPW, 2011)
- Length of stay has a direct linear relationship with improved outcomes (Toumbourou, 1998)

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Treatment Works: But what is treatment?

- Treat addresses a wide range of clinical issues that cause and exacerbate risks of substance abuse.
  - These include the needs for habilitation and rehabilitation, including vocational supports, addressing trauma, learning coping skills, learning relapse prevention skills, improving relationships etc.
- This is not to be confused with supporting services such as detoxification, medications, peer supports, 12-step programs, housing and other similar approaches which complement the core treatment program.

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PCPC

- PCPC is a highly acclaimed system based on the criteria from the American Society of Addiction Medicine (ASAM)
- Using a detailed assessment, the criteria suggest what level of care is needed for an individual (eg. Detox, Long term residential, Intensive outpatient, or outpatient)
- Almost by definition, those in the criminal justice system are the most severe levels of addiction and in need of the highest levels of care

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PCPC

- Importance of Level of Care
  - Under treating can lead to treatment resistance or increased progression of the disease
    - What happens if you take a half dose of antibiotic?
    - What happens if you take a half dose of insulin?
    - What happens if you take a half dose of treatment?
  - Answer:
    - It doesn't work
    - Individuals get sicker
    - Individuals and providers "give up" believing that there is no hope

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Successful Offender Reentry

A COMPREHENSIVE CONTINUUM OF CARE

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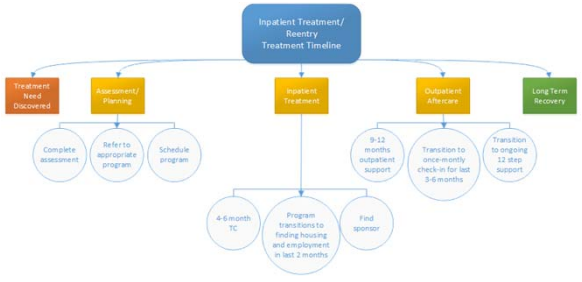
Transition Timeline



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Cognitive Therapy

- In CBT, Behaviors are motivated by beliefs
- Behavioral change is made by changing the belief patterns
  - Police car example.
- Examples of Addiction Generating Beliefs
  - I can't do anything else.
  - I need it.
  - I can't survive without the (drug).
  - I tried, but I'm not able to do it (terminally unique).
  - It is easier to avoid than to face life's difficulties and self-responsibilities.
  - I must have certain and perfect control over things.

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Beliefs

Core Beliefs Shape Reality:

•Filter incoming stimuli based on expectations

•Steer responses/behaviors

- **The world is a safe place**
- **The world is a dangerous place**

- **I need this drug.**
- **I want this drug.**
- **I want this life.**

- **Whether you think you can or you can't, you are right.**

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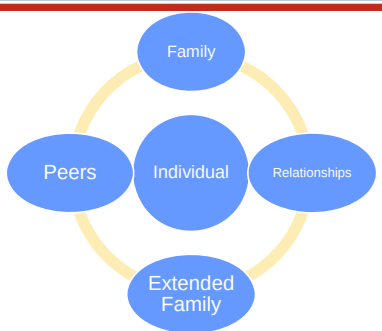
Relationships and the context of Visitation



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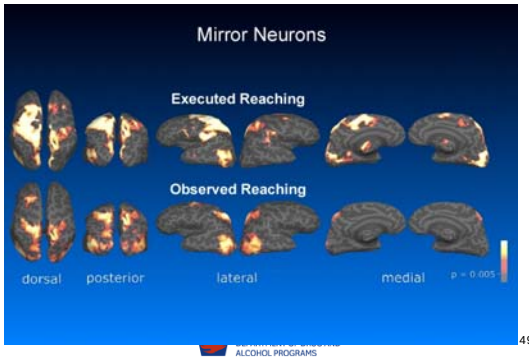
Relationships and the Brain?



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Relationships and the Brain?

- **Relationships are key predictors in the success of treatment.**
  - **Why?**

- **Mirror Neurons:**
  - **What we observe in others is reflected in our brain**
  - **What if we observe other's anger? Judgment etc?**

- **Benefit:**
  - **Observation is an effective learning tool.**
  - **What happens if a colleague/other group member is punished? Rewarded?**

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Meditation

- Meditation has been found to achieve abstinence in 65% to 85% of heroin users with similar findings replicated over decades (Benson & Wallace, 1972 Pruett, et al. 2007, Zgierska et al. 2009, Witkiewitz & Bowen, 2010).
- Meditation is found to help with reduce cravings, anxiety and associated features.
- Meditation has no known negative side effects.

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Peer Supports

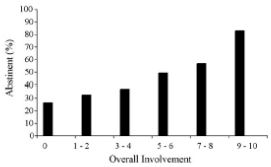

Fig. 2. Percent abstinent from alcohol and drugs at both the first and second six-month follow-ups according to 12-step involvement.

- Increasing attendance at 12-step meetings following treatment are associated with increased rates of abstinence (Timko & DeBenedetti, 2007).
  - This includes a range of activities such as attendance, getting a sponsor, being a sponsor, reading at meetings, calling a 12-step member for help etc.

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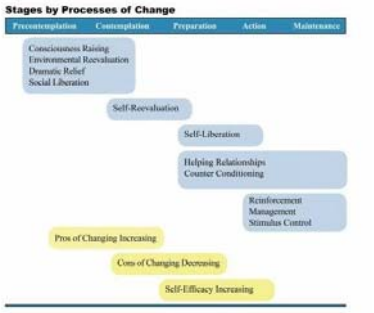
What about Motivation?



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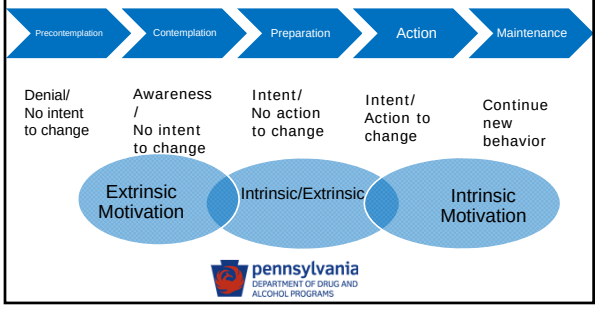
Motivation

- Stages of Change



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What Works?

What Works? Key Issues:

- **Therapeutic dose issues**
  - Level of care
  - Length of stay
  - Continuum
- **Quality issues**
  - Evidence based practices
  - Behavioral practice
  - Cognitive restructuring
  - Emotion/coping
  - Trauma
  - Monitoring/ case management/Advocacy
- **Comprehensive care elements**
  - Recovery supports/12-step
  - Employment
  - Housing
- **Motivation/Engagement**

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- What does “recovery” look like?

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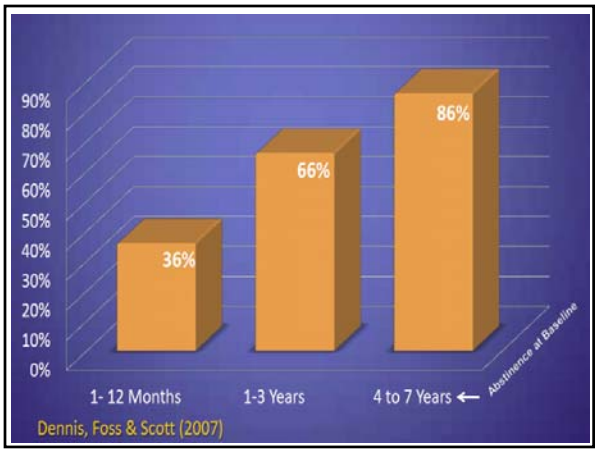

Recovery Lessons Learned

- Faces and Voices of Recovery Survey of 3,200 individuals with an average of 10 years in recovery.
- **Personal Descriptions:**
  - The majority (75%) selected "in recovery";
  - 14% chose "recovered,"
  - 8% "used to have a problem with substances and no longer do,"
  - 3% chose "medication-assisted recovery."
- **Paths to Recovery:**
  - 71% professional addiction treatment
  - 18% had taken prescribed medications (e.g., buprenorphine or methadone).
  - 95% had attended 12-step fellowship meetings (e.g., Alcoholics Anonymous),
  - 22% had participated in non-12-step recovery support groups (e.g., LifeRing, Secular Organizations for Sobriety (S.O.S.).

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Recovery Lessons Learned

Table 5. *What was different on the last quit attempt?*

Reason	*n* (%)
12-Step affiliation (AA/NA/CA)	24
Good support	22
'Tired of the lifestyle'	21
Insight	10
Feeling psychologically prepared	6
Moving away from drug-using peers	5
Benefits of residential rehabilitation	4
Family reasons	3

AA: Alcoholics Anonymous; NA: Narcotics Anonymous; CA: Cocaine Anonymous.

(Best et al. 2008)

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Goal Setting and the Brain

- **Direct the thinking to the positive/solutions**
- **Practice positive solutions: gratitude, pride etc.**
- **Brain does not understand "no"**
  - **Cannot stop addiction**
  - **Can create recovery**
- **Direct thinking to specifics**
  - **Use as many senses as possible to rehearse material**
- **Use Goal-Directed questions**
  - **What else can I do to help my recovery today?**
  - **What else can I successfully accomplish today?**
  - **How many things can I do today that I can be proud of?**
  - **How many new things can I do today to celebrate my recovery?**

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Child Safety Issues

Threats of danger

1) No adult in the home is routinely performing basic and essential parenting duties and responsibilities
2) One or both caregivers' behavior is violent and/or they are acting (behaving) dangerously
3) One or both caregivers' behavior is dangerously impulsive or they will not/cannot control their behavior
4) Caregivers' perception of a child are extremely negative
5) The family does not have or use resources necessary to assure a child's basic needs
6) One or both caregivers are threatening to severely harm a child or are fearful they will maltreat the child and/or request placement
7) One or both caregivers intend(ed) to seriously hurt the child
8) One or both caregivers lac the parenting knowledge, skills, motivation necessary to assure a child's basic needs are met
9) Caregivers largely reject CPS intervention; refuse access to a child; and/or there is some indication that the caregivers will flee
10) Caregiver refusal and/or failure to meet a child's exceptional needs do/can result in severe consequences to the child
11) The child's living arrangements seriously endanger the child's physical health
12) A child has serious physical injuries or serious physical symptoms from maltreatment that have immediate implications for interventions and caregivers are unwilling or unable to arrange or provide necessary care
13) A child shows serious emotional symptoms requiring immediate intervention and/or lacks behavioral control that result in self-destructive behavior or provoking dangerous reactions in caregivers and caregivers are unwilling or unable to arrange or provide necessary care
14) A child is profoundly fearful of the home situation or people within the home
15) Caregiver's cannot will not or do not explain a child's injuries or threatening family conditions.

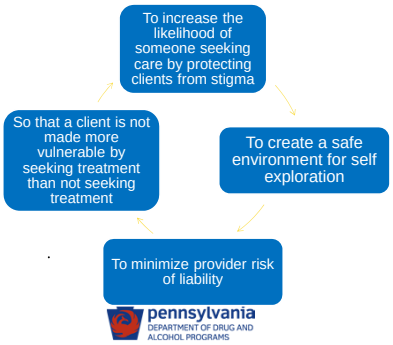
Child safety: A guide for judges and attorneys, American Bar Association, 2009

Substance use, misuse, or abuse alone may not be sufficient to trigger the risk of danger.

What is the big deal about:

Confidentiality?

Why Confidentiality?



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How do we work within the law?

Needed Information

Trust/ Collaboration

Wanted Information

- Whether or not the client is or is not in treatment
- Client's prognosis
- The nature of the Project
- A brief description of the client's progress
- A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

?

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- Is it the proper level of care?
- Is it the proper length of stay? (And have appeals been used?)
- Is it treatment (not just other supports)?
- Has the individual had time for the brain to heal and stabilize changes?

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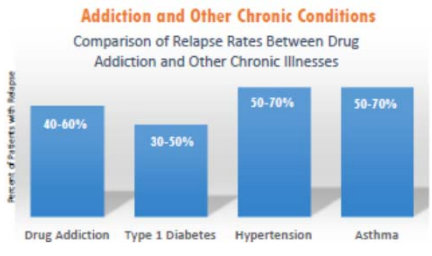

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Treatment Benefits

Table 1: Summary of Costs and Benefits Associated with Substance Abuse Treatment (Based on the Social Planner Perspective)

	All Treatment Modalities (N = 2,567)	*Methadone Maintenance (N = 115)*	*Outpatient Treatment (N = 1,585)*	*Residential Treatment (N = 867)*
Average cost per substance abuse treatment episode (based on weighted per diem prices)	$1,583 ($1,506, $1,660)	$2,757 ($2,469, $3,004)	$838 ($806, $871)	$2,791 ($2,600, $2,984)
Average cost per substance abuse treatment episode (based on unweighted per diem prices)	$3,336 ($3,150, $3,524)	$2,867 ($2,440, $3,249)	$1,505 ($1,443, $1,567)	$6,743 ($6,282, $7,215)
Average benefits	$11,487 ($9,794, $13,180)	$5,313 (−$2,419, $8,265)	$9,049 ($7,934, $11,225)	$16,257 ($13,192, $19,078)
Net benefits (benefits minus cost of treatment, based on weighted per diem prices)	$9,903 ($8,295, $11,592)	$2,575 (−$321, $5,529)	$8,211 ($6,028, $10,385)	$13,467 ($10,706, $16,269)
Cost-benefit ratio (based on weighted per diem cost estimates)	7:1	No statistically significant benefits	11: 1	6: 1

Note: The follow-up period is 9 months. Ninety-five percent confidence intervals (shown in parentheses) were bootstrapped using normal-based methods and 10,000 replicate samples.

Ettner, et al., 2006

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Challenges- Summary

- Funding
- Stigma
- Access
- Rapid Escalation of SUD/Overdose

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The Solution (cont.)

- Awareness of Insurance and other Protections
  - Act 106
    - Protects group health insurance plans
  - Act 152
    - Protects services in Medicaid plans
  - Mental Health and Parity and Addiction Equity Act
    - Requires SUD to be treated with equivalent coverage as other medical conditions
  - Patient Protection and Affordable Care Act
    - Requires the coverage of SUD as an essential benefit

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Why use the PCPC?

Required by Act 152 of 1988

- Added to services covered by Medicaid (previously only covered limited outpatient and hospital services)
  - non-hospital residential detoxification
  - non-hospital residential rehabilitation
  - halfway house
- Requires use of criteria developed and/or approved by DDAP for governing type, level of care and length of stay
  - PCPC for adults
  - ASAM for adolescents

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A note about Act 106 of 1989

- Requires all commercial group health plans, HMOs, and the Children's Health Insurance Program to provide comprehensive treatment for substance use disorders.
- Minimum benefits
  - 30 days residential per year/90 days lifetime
  - 30 sessions outpatient/partial hospitalization per year/120 days lifetime
  - 30 additional outpatient/partial hospitalization sessions that may be exchanged on a 2:1 basis for up to 15 additional residential treatment days
  - Family counseling and intervention services
- Only lawful prerequisite is a certification and referral from a licensed physician or licensed psychologist
- Concurrent reviews are not required during this time

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Parity?

Addiction Treatment Coverage:

- Detoxification – 100%
- Opioid Substitution Therapy – 50%
- Urine Drug Screen – 100%
  - 7 per year
- Wide variety in coverage across states

Diabetes Coverage:

- Physician Visits – 100%
- Clinic Visits – 100%
- Home Health Visits – 100%
- Glucose Tests, Monitors, Supplies – 100%
- Insulin and 4 other Meds – 100%
- HgA1C, eye, foot exams 4x/yr – 100%
- Smoking Cessation – 100%
- Personal Care Visits – 100%
- Language Interpreter – Negotiated

Source: (McLellan, 2013)

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ACA

- SUD treatment is now an "Essential Service"
  1) Ambulatory patient services;
  2) Emergency services;
  3) Hospitalization;
  4) Maternity and newborn care;
  5) Mental health and substance use disorder services, including behavioral health treatment;
  6) Prescription drugs;
  7) Rehabilitative and habilitative services and devices;
  8) Laboratory services;
  9) Preventive and wellness services and chronic disease management;
  10) Pediatric services, including oral and vision care
- Funds full continuum of care
  - Prevention, Intervention, Treatment
- Accesses federal funding

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ACA

- Treatment Services
  - Screening, Brief Intervention, Assessment
  - Evaluation and medication
  - Family Counseling
- Alcohol and Drug Testing
- 4 Maintenance and Anti-Craving Meds
- Monitoring Tests (urine, saliva, other)
- Smoking Cessation

Source: (McLellan, 2013)

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Apply it Now

Case Example

- A 40 year old Caucasian woman with children age 1 and 3
- History of SUD with heroin and alcohol
- Reports 8 months of sustained abstinence from substances confirmed by weekly drug testing

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Recommendations

Why Treatment Fails	Why Treatment Works
Length of Stay (Less than 90 days)	Length of Stay (More than 90 days)
Undertreating (Giving OP instead of TC)	Appropriate Level of Care
Fragmented care (Detox only, 12-step only)	Full Continuum of Care
Weak Enforcement of Insurance Law	Enforcement of State and Federal Laws
Medicating all Pain	Appropriate Prescribing
Stigma (Seeing individuals as "bad")	Humanizing (Treating those with disease)
Locking up Drug Users	Treating those with Substance Use Disorder
Thinking There is a Silver Bullet	Clinical Integrity

What Works: Clinical Integrity

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What Can I Do? Simple Steps for Monday

- Are my programs trained in cross-system needs (criminal justice, child welfare, medical etc.)?
- Are my system partner programs trained in drug and alcohol treatment?
- Are we using adequate lengths of stay or terminating based on funding?
- Are we using a continuum of care?
- Are we educating on proper prescribing practices?
- Does our county have medication take back boxes?
- Are we expanding the use of Naloxone to save overdose victims?
- Are we facilitating access to funding for needed services such as implementing the jail Medicaid project?
- Are we supporting our community efforts for prevention, to reach long term improvement.
- Are we doing SOMETHING? Pick one and keep moving forward.

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Reminders

- What else can I do to effortlessly further recovery practices in my office on Monday?

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Contact Information

Ken Martz, Psy.D. CAS
Special Assistant to the Secretary
Pennsylvania Department of Drug and Alcohol Programs

02 Kline Village
Harrisburg, PA 17104
KeMartz@pa.gov
(717)783-8200

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