HALTING THE YOUTH
OPIOID EPIDEMIC:
CONGREGATIONS AND
COMMUNITY-CENTRIC
SOLUTIONS
Kimberly Jeffries Leonard, PhD
Deputy Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health & Human Services
NACoA Webinar April 14, 2015

Communities In Crises:
Prescription Pain Relievers & Heroin
• The threat from controlled prescription drug (CPD) abuse is persistent; and opioid analgesics are the most commonly abused CPD.
  – CPD overdose deaths continue to be a major public health issue
  – Pain relievers are second only to marijuana as the first drug of abuse
• Heroin use is increasingly a concern, notably in the Northeast and North Central regions of the country.

2011 Congressionally Mandated Institute of Medicine Report on Pain
• Recognized the serious problems of diversion and abuse of opioid drugs, as well as questions about their long term usefulness.
• Determined:
  • When opioids are prescribed and monitored appropriately, they can be safe and effective
  • The effectiveness of pain treatments depends greatly on the strength of the clinician–patient relationship

Intertwined Challenges, Intertwined Solutions:
Research and Practice
• HHS Convened 2014 Scientific Workshop: What do we really know about prescription opioids & pain management?
  • Insufficient data on efficacy, risks, & best practice guidelines for long-term use of opioids for pain management
    – Documented adverse effects of opioid use & misuse
  • Need to develop client-centric, individualized, pain management plans based on more robust scientific evidence
  • Escalate & accelerate research efforts; and rapid, effective translation of research to evidence-based
Prescription Pain Analgesics & Heroin

U.S. Snapshot

Specific Ilicit Drug Dependence or Abuse in the Past Year among Persons >12 years old in 2013

- Marijuana
- Pain Relievers
- Cocaine
- Heroin
- Stimulants
- Tranquilizers
- Hallucinogens
- Inhalants
- Sedatives

Numbers in Thousands

<table>
<thead>
<tr>
<th>Substance</th>
<th>Numbers in Thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>4,206</td>
</tr>
<tr>
<td>Pain Relievers</td>
<td>1,879</td>
</tr>
<tr>
<td>Cocaine</td>
<td>835</td>
</tr>
<tr>
<td>Heroin</td>
<td>517</td>
</tr>
<tr>
<td>Stimulants</td>
<td>440</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>423</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>277</td>
</tr>
<tr>
<td>Inhalants</td>
<td>132</td>
</tr>
<tr>
<td>Sedatives</td>
<td>99</td>
</tr>
</tbody>
</table>

Past Year Heroin Use among Persons >12 years old

- Numbers in Thousands
- Aged 26 or Older
- Aged 18 to 25
- Aged 12 to 17

Top Six Substances for Admissions to Substance Abuse Treatment

- Six substance groups accounted for 96% of all TEDS admissions aged ≥12 in 2012: Alcohol, marijuana, heroin, cocaine, methamphetamine/amphetamines, and opiates other than heroin.

  - Admission rates for opiates other than heroin were higher in 2012 than in 2002 in 48 states reporting in both years, while it decreased marginally for New Mexico.
  - Overall heroin admission rates were lower in 2012 than in 2002, but rates in 2012 were higher in 35 of the 48 states and jurisdictions reporting in both years.

Primary Opiates*/Synthetics Admission Rates 2002-2012 (Per 100,000 >12 years old)

- Treatment admission rate for opiates other than heroin was 236% higher in 2012 than in 2002.
- Rates increased 2002 through 2011, & decreased in 2012.

Source of Prescription Pain Relievers for Most Recent Nonmedical Use among Past Year Users

- 68% came from relatives and friends

*Non-Heroin
Percentage of Heroin Initiates by Prior and Past Year Dependence/Abuse of NMPR

Persons 12-49 yrs old (2002-2011)

<table>
<thead>
<tr>
<th></th>
<th>% Heroin Initiates</th>
</tr>
</thead>
<tbody>
<tr>
<td>No prior use</td>
<td>20.5%</td>
</tr>
<tr>
<td>Prior use &amp; past yr dependence/abuse</td>
<td>31.3%</td>
</tr>
<tr>
<td>Prior use but no past yr dependence/abuse</td>
<td>48.2%</td>
</tr>
</tbody>
</table>

Changes in Heroin Use in Relation to OxyContin Reformulation

Unmet Needs: Over 20 Million Individuals in the U.S. went Untreated for SUDs in 2012

<table>
<thead>
<tr>
<th></th>
<th>% of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>94.6%</td>
<td></td>
</tr>
<tr>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>1.7%</td>
<td></td>
</tr>
</tbody>
</table>

Solutions: Health Care Reform & the ACA

- Expanded Coverage
- Free Preventive Care
- 10 Essential Health Benefits
- MHPAEA

Good News: ACA Medicaid Expansion

Health Care Reform & the ACA: Free Prevention Services for Adults

- All Marketplace plans and many others must cover a number of preventive services w/out charging you a copayment or coinsurance when done by network providers, even if you haven’t met your yearly deductible.
- Adult services include:
  - Alcohol misuse screening and counseling
  - Tobacco use screening & cessation interventions
  - Depression screening
  - HIV screening for everyone ages 15-65, & other ages for those at higher risk

https://www.healthcare.gov/preventive-care-benefits/
Health Care Reform & the ACA: Free Prevention Services for Children

- Alcohol and Drug Use assessments for adolescents
- Depression screening for adolescents
- Developmental screening for children under age 3
- Behavioral assessments for children of all ages:
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- HIV screening for adolescents at higher risk
- And more...


Overdose is common for opioid users

- OD common among opioid-users
  - ≥ 50 - 70% of IDUs personally experience or witness OD
- OD commonly witnessed
  - Median # of lifetime witnessed OD is 5
- Majority of OD-related deaths occur in company of others

OD is costly

- Cost of prescription opioid abuse is about $55.7 B/year
  - 20.4 B/year for OD-related costs
    - 2.2 B direct costs
      - Medical care: Hospital, ED, Ambulance
    - 18.2 B indirect costs
      - Lost productivity from absenteeism and mortality
- $37,274 cost per opioid overdose event

Basic OD education:

1. Prevention - the risks:
   - Effects of abstinence on tolerance
   - Riskier use behavior (using alone, unknown supplier)
   - Impact of medical comorbidities

2. Recognition of OD
   - Warning signs of OD

3. Response - What to do
   - Seeking emergency support
   - Rescue breathing
   - Naloxone administration

Congregation and Community-Centric Solutions: Multi-Tiered

Prevention + Treatment & Recovery + OD Reduction

Prevent, treat, and reduce OD & its sequelae

Examples of SAMHSA Prevention Strategies

- New Strategic Initiative focused on community-based prevention of prescription drug abuse
- Ongoing Community & Prescriber Education and Outreach
- State-run Prescription Drug Monitoring Programs (PDMPs)
Key goal is to prevent/reduce Rx Drug SUDs:
- Comprehensive prevention, treatment, & recovery programs
- Public/prescriber education & clinical support tools
- Collaboration with states’ public health & Medicaid authorities, & other key stakeholders
- PDMP integration with health care systems
- OD prevention; & reduction of OD morbidity and mortality

Examples of SAMHSA’s Treatment & Recovery Efforts

Prevention → Treatment & Recovery → OD Reduction
Prevent, treat, and reduce OD & its sequelae

- Block Grants + Discretionary Grants for treatment & recovery services that address health determinants
- Treatment locators & treatment guidelines
- Opioid Treatment Programs Certification & monitoring
- Technical assistance & clinical support tools

High Rates of Overdose (OD)
- Over 43,000 deaths 2/2 opioid overdoses.
  - Rate in 2013 nearly double that of 1999
- More OD deaths in the United States involve opioid analgesics than either heroin or cocaine combined
- In 2013 in Maryland:
  - OD is the leading cause of accidental death for adults.
  - 858 drug and alcohol-related intoxication deaths

Examples of SAMHSA’s Overdose Reduction Strategies

Prevention → Treatment & Recovery → OD Reduction
Prevent, treat, and reduce OD & its sequelae

- Naloxone: SAMHSA’s Block Grant Funds can be used by states to support community-level overdose education and naloxone toolkits
- Dissemination of scientific evidence

Responding to Opioid OD: Naloxone
- Competitive antagonist
- Rapidly disappears from serum
- Half-life of ≈60 min.
Does opioid overdose education and naloxone distribution (OEND) work?

- Feasible to introduce in urban environments
  - Piper et al. Subst Use Misuse 2008: 43; 858-70
  - Enteen et al. J Urban Health 2010;87: 931-41
  - Bennett et al. J Urban Health. 2011; 88; 1020-30
  - Walley et al. JST 2013; 44:241-7

- Programs:
  - Located at detox centers, syringe access sites, drop-in centers
  - Fail to target prescription opioid users or those concerned about stigma of IDU

OEND programs change behavior

- Participants showed increased knowledge and skills
  (rescue breaths, calling 911, staying with patient AND using naloxone)

- Do not lead to increase in use or riskier use
  - Tobin et al. Int J Drug Policy 2009; 20; 131-8
  - Wagner et al. Int J Drug Policy 2010; 21; 186-93

- May lead to decreased use or willingness to engage in treatment

Growing # of OEND nationally

- In 2010:
  - 15 programs
  - 53,032 People enrolled
  - 10,171 OD rescues

Dissemination of Scientific Evidence: SAMHSA’s Opioid Overdose Toolkit

- Free resource for individuals, families, communities, & clinicians.
- Educates individuals, families, first responders, community members, & clinicians.
- Provides practical, plain language information about steps to take to prevent opioid overdose and to treat overdoses including the use of naloxone.

Screening

- Who to screen?
  - All patients admitted to general medicine firms regardless of admission diagnosis.

- Who is at risk? Think risky users and risky use
  - Use:
    - Current injection drug use
    - History of prior OD
    - Using >100 mg of morphine equivalents per day

Risky users

- Impaired metabolism
  - ESLD, ESRD

- At risk for respiratory depression: COPD, Severe OSA

- Concurrent benzo/and heavy etoh use + Opioids at any dose
Examples of SAMHSA’s Discretionary Funding Areas

<table>
<thead>
<tr>
<th>Opioid Treatment Programs (OPT)</th>
<th>Drug Free Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</td>
<td>Criminal Justice Activities</td>
</tr>
<tr>
<td>Recovery Community Services Program (RCSP)</td>
<td>Partnerships for Success State and Tribal Initiative</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>Access to Recovery (ATR)</td>
</tr>
<tr>
<td>Pregnant and Post Partum Women</td>
<td>Treatment Systems for Homeless</td>
</tr>
<tr>
<td>Children and Families</td>
<td>Minority AIDS (MAI)</td>
</tr>
<tr>
<td>Addiction Technology Transfer Centers (ATTCs)</td>
<td>Workforce Development</td>
</tr>
</tbody>
</table>

“We need all stakeholders to come together”

“Opioid drug abuse is a devastating epidemic facing our nation. I have seen firsthand, in my home state of West Virginia, a state struggling with this very real crisis, the impact of opioid addiction. That’s why I’m taking a targeted approach to tackling this issue focused on prevention, treatment and intervention. I also know we can’t do this alone. We need all stakeholders to come together to fight the opioid epidemic.”

-- Secretary Burwell

Closing Thoughts: Achieving Balance

“People in recovery are not strangers: they are our family members, friends, colleagues, and neighbors.” -- President Obama

SAMHSA: Helping People Help Themselves

THANK YOU,
Kimberly.Leonard@samhsa.hhs.gov