Dr. Middleton has no conflicts of interest to report

He's not receiving compensation or corporate grant monies in any form

He doesn't intend to discuss any off label medication usage
WHY DO PEOPLE START USING?

1. To Feel Good (get high)
2. To Feel Better (to mask undesirable feelings like depression or anxiety)
3. To Do Better (perceived performance enhancement)
4. To Fit In (peer or cultural pressure)

MODELS OF ADDICTION

1. THE MORAL MODEL
2. THE ENLIGHTENMENT MODEL
3. THE MEDICAL MODEL
4. THE COMPENSATORY MODEL
THE MEDICAL MODEL

The addict is neither responsible for his disease or its resolution. Genetics and brain remodeling are the cause and medical therapy is the answer.

THE COMPENSATORY MODEL

ALSO CALLED

THE BIOPSYCHOSOCIAL MODEL

PEOPLE ARE NOT RESPONSIBLE FOR THE CAUSE OF THEIR PROBLEM, BUT ARE RESPONSIBLE FOR THE RECOVERY.

GENETICS, EARLY LIFE EXPERIENCE, SOCIAL AND CULTURAL FACTORS ARE ALL CONSIDERED INTEGRAL
SCREENING FOR ADDICTION

CAGE
AUDIT

DEFINITION OF ADDICTION

ASAM 2011 Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.
DEFINITION OF ADDICTION

ASAM 2019: Addiction is a treatable, chronic disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experience. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

SYMPTOMS OF S.U.D.

IMPAIRED CONTROL — Cravings/urges when not using. Desire or failed attempts to modify use.

SOCIAL PROBLEMS — Activities at work, social, or home are not completed, withdrawn from or ignored because of use.

RISKY BEHAVIOR — Use in risky situations or places or risky behavior undertaken because of use, which continues despite known risks/bad outcomes.

PHYSICAL EFFECTS — Tolerance and/or withdrawal.
**SUBSTANCE USE DISORDER DIAGNOSIS**

1. Taking the substance in larger amounts or longer duration than intended
2. Unable to successfully cut down or stop the substance
3. Increased time getting, using, and recovering from use
4. Cravings or urges for use
5. Difficulty managing work, school or home because of use
6. Continued use in spite of relationship problems
7. Giving up important activities because of use
8. Using despite having been in danger from past use
9. Withdrawal symptoms that can be relieved from using again
10. Using even though it is causing or worsening another psychological condition

**TREATMENT TYPES**

**Self Directed** – self help books, various support groups, counseling

**Detoxification** – typically 3 to 7 days of medical support in order to mitigate withdrawal symptoms

**Intensive Out Patient (IOP)** – several hours a week, typically three hours three days a week, and stay at home or sober living

**Partial Hospital Program (PHP)** – at least 4 hours a day of group and individual work. May or may not actually stay in the hospital

**In Patient** – 28 to 90 days residential care. Allows supportive situation isolated from the substance
GETTING INTO TREATMENT

Self determined need

Physician recommendation (SBIRT)

Workplace culture – EAPs, Peer support, Random urine testing

Professional monitoring boards

Criminal justice referral

“Rock bottom”

Intervention

Question: Is involuntary treatment of addiction of any benefit

RELAPSE

According to the National Institute on Drug Abuse, between 40-60% of addicts relapse.

That’s the same as therapeutic setbacks in other diseases like diabetes, asthma, and hypertension. As with these diseases, it’s important to apply guilt rather than shame.

Very emotionally charged situation especially for families that have invested a great deal of time, effort, and fortune.

The provider is frequently the only one to remind everyone that this is a chronic brain disease, and that relapses, while not ideal happen and don’t mean failure.
RELAPSE PREVENTION

Relapse DOES NOT start with the first use. That's the end of the relapse.

Planning should begin day one of the patient's sobriety.

Examine previous relapses to look for patterns.

Spend time frequently evaluating triggers for emotional, physical, and spiritual discomfort. Plan to avoid or mitigate these known triggers. HALT

MAT induction with appropriate hand off to the next provider.

IOP, Sober living, identifying and making appointments for doctors and counselors, identifying multiple support group options and perhaps a temporary sponsor.

RECOVERY — MAJOR DIMENSIONS

**Health** — Managing the addictive disease and any other concomitant illness, and living a physically and emotionally healthy lifestyle

**Home** — A stable and safe place to live

**Purpose** — meaningful daily activities. Participating in job, school, home, volunteerism, or creative endeavors, and the resources to do so.

**Community** — relationships and social networks that provide support, friendship, love and hope
RECOVERY IS:

**Individual** - many pathways depending on individual strength, severity of disease, resources available, and support system

**Personal** – self determination and self direction should be increasingly stressed.

**Social** – recovery groups, individual cultural support, family and friend systems. Battling isolation is paramount.

**Professional** – screening and treatment for any trauma experiences or concomitant psychiatric illness.

**Holistic** – mind, body, community and spiritual

ALCOHOLICS ANONYMOUS

Started in 1935

12-step program stresses using spiritual principals in self evaluation to improve negative self talk, clean up relationships damaged while using, and pay forward new comers to the program.

Can find meetings on line – approximately 1600/week in Phoenix

Most are open to anyone, including non-addicts. Non-denominational; individual defines their own spiritual path. Some are specific group oriented like Caduceus for physicians.

Major criticisms are non-professionals giving advise and for some, the use of the word God
SMART RECOVERY

Self Recovery And Management Training

Started in 1994 by several groups desiring a secular option to A.A.

Denies the chronic brain disease model of addiction, opting to define it as a behavioral issue fixable by self determination.

Meetings found online currently 20/week in Phoenix

Major criticism is its denial of the long lasting value of a community of other addicts

"I'M IN RECOVERY"

12 Step community claims that term as its own meaning abstinence + "working the program"

This is opposed to abstinence and doing nothing to further self improvement also known as "dry drunk"

"Working the program" is a fluid term that means 1. working the 12 steps with a sponsor 2. going to an ill-defined number of meetings 3. being available to help pay it forward if asked.

Data on 12 step effectiveness is, as expected, poor due to an infinite number of endpoint variables (how long? Did the person go to treatment? In-patient/out-patient? Does a slip mean failure? What if they aren't doing heroin, but marijuana was recommended by their doctor for their back pain?)
MEDICAL VIEW OF RECOVERY

ASAM definition:
An active process of continual growth that addresses biological, psychological, social, and spiritual disturbances common in the addictive presentation

1. Improve quality of life and enhance wellness as defined by the individual.
2. Consistent pursuit of abstinence.
3. Relief of cravings.
4. Improved individual’s own behavioral control.
5. Enhanced interpersonal, and social connectedness.
6. Improvement in an individual’s emotional self-regulation.

MEDICAL ROLE IN RECOVERY

Screening and providing information if abusive or addictive use is identified
Support detoxification
Repair physical damage from chronic use and address any underlying chronic pain that may have helped trigger the initial use.
Ameliorate cravings.
Provide needed psychiatric medications for mental illness
Encourage concomitant preventative care
WHY DOCTORS AREN’T USING BUPRENORPHINE

Don’t want to be inundated with suboxone patients – 29%
Concerned about diversion – 25%
Don’t feel educated enough about addiction – 15%
Lack in belief that buprenorphine is effective – 13.5%
Lack of time for additional patients – 12%
Denies knowledge of how to get waived - 9.5%
Believe reimbursement is insufficient – 5.4%
Opioids not a problem in my community – 3%