The underlying theme of both of this week’s lead articles is access: the lack of adequate access to opioid addiction treatment with methadone due to lack of public financing, and the growth of outpatient treatment under the aegis of some of the country’s best known residential programs.

Experts: Treat co-occurring SUDs and MI in teens concurrently

College-age youths need information on opioid overdose

ONDCP gives $2.5 million to police-treatment linkages

Opioid treatment programs: Why aren’t there more of them?

The opioid epidemic — prescription and heroin — is persisting as a public health crisis, and medications to treat opioid addiction are increasingly supported by public health authorities. So why is the opioid treatment program (OTP) with its methadone maintenance treatment not getting more attention? We talked to Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD), a membership organization representing OTPs, to gain some insight.

Parrino has been involved in the OTP field for decades, first as a clinic owner, and then for more than 30 years as head of the trade organization. Over the past 10 years, as many people became addicted to prescription opioids and then transferred to heroin when the prescription medications became harder to get, OTPs seemed the logical solution, as they had been successfully treating opioid dependence with methadone since the 1950s. Because of the 1914 Harrison Narcotics Act, which makes it illegal to treat opioid addiction with an opioid, OTPs are highly regulated.

However, 15 years ago, the federal Drug Addiction Treatment Act (DATA) made it possible for another opioid medication — buprenorphine — to be used to treat opioid addiction, this time with far less regulation than an OTP. Physicians could be

The Business of Treatment

Historically strong residential sites building major outpatient capacity

Many addiction treatment organizations that built their reputation on residential treatment services are now moving aggressively to expand their outpatient service capacity. Their leaders see this not as a short-term business trend but as the building block for what will be essential for them as payment becomes tied less to encounters and more to results.

The chief executives of two such organizations, the Hazelden Betty Ford Foundation and Seabrook House, spoke with ADAW about their fast-growing outpatient services and the community ties that are being forged as a result. Hazelden Betty Ford has stated in the strategic plan that it adopted at the beginning of this year that it expects to double its current outpatient service capacity by 2020. Seabrook House announced the opening of its fourth outpatient location in New Jersey this month, in Morristown, and two

Bottom Line...

Payer and patient preferences both are being seen as driving many traditionally residential-focused treatment centers to accelerate their outpatient program growth, in what they see as a development that will benefit them over the long haul.
Experts: Treat co-occurring SUDs and MI in teens concurrently

All adolescents entering treatment for either a substance use disorder (SUD) or a mental disorder should be assessed for both, according to experts. There was a time when it was believed that an adolescent with an SUD and a co-occurring mental illness needed to have the SUD treated first, and then the mental illness, said Larke Nahme Huang, Ph.D., director of the Office of Behavioral Health Equity at the Substance Abuse and Mental Health Services Administration (SAMHSA). “We’re not saying you need to treat them in a parallel fashion, but in an integrated fashion,” Huang, a clinical psychologist, told ADAW last week. “They interplay with each other, and it’s hard to tease apart the dynamics.”

However, many care providers on both sides — addiction and mental health — don’t have the training to treat both. “These are newer emerging models of integrated treatment,” said Huang. “On the mental health side, whoever is doing the treatment, whether it’s a social worker, a psychologist or a psychiatrist, needs to have the expertise to treat the co-occurring condition,” she said. They also need to have the training to simultaneously screen for both conditions, she said.

For providers who prefer to treat only mental illness in their adolescent patients with co-occurring disorders, Huang urges them to partner with or refer to an addiction provider for concurrent care.

All mental health providers can screen for substance use disorders, using a simple evidence-based questionnaire like the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble), recommended by the American Academy of Pediatrics. The six-question screen takes two minutes to administer, is simple to score and has good sensitivity and specificity.

Residential

“Any behavioral health provider worth their salt will do an integrated treatment of both issues concurrently,” said David Rotenberg, executive vice president and chief clinical officer of Caron Treatment Centers, based in Wernersville, Pennsylvania. Just providing addiction treatment but not treating the co-occurring mental disorder means “sending that young patient into the world with built-in relapse triggers,” he said.

Teens with depression may find that drinking alleviates the symptoms temporarily, but in the long run, they get behind on their homework and have other problems that lead to deeper depression, he said. “In general, ongoing drug use leads to greater degrees of mental illness, which feed back into the cycle,” he said. “That’s why the goal of treatment is to treat both simultaneously.”

In the earliest days of addiction treatment, withdrawal predominates as a symptom, so a full evaluation can be difficult, said Rotenberg. “I can’t get a firm diagnosis if the kid you treat or how the patients are treated, all of this is tied together,” he said. “But it requires thought, and I believe now the atmosphere does not lend itself to very careful thought.”

may be used in both settings.

The classes of medications used for mental disorders and addiction are very different. For young people with opioid use disorders, buprenorphine may be recommended in certain situations, said Huang. But regardless of what medication is being used, the best outcomes come from coordinating the medications with psychosocial treatment, she said. This is true for treating mental disorders or SUDs alone, as well as co-occurring, she said. “There are some well-established findings showing that for ADHD, the most common psychiatric diagnosis of children and adolescents, a combination of medications and psychosocial interventions is best,” she said.

Three or four disorders at a time

“Having co-occurring disorders, sometimes three or four at a time, is not uncommon in the addiction field,” said Joseph Lee, M.D., medical director for the Hazelden Betty Ford Foundation’s youth services. “In the addiction world, good programs are staffed to do both, because they see both all the time.”

Treating SUDs is a specialized field, and some mental health clinicians are overconfident in their ability to treat them, said Lee. “They think addiction is just part of the human condition, but you need specialized training,” he said. “If you’re working in a mental health paradigm and patients are using substances, you need to recognize that they won’t want to change, that there’s a lot of manipulation and deception in these patients.”

The number-one co-occurring disorder with SUDs is conduct disorder, said Lee, noting that this problem, if not addressed, can progress to the far more serious antisocial personality disorders.

It’s important to remember that “there’s more to the kid than the diagnosis,” said Lee. Sometimes it’s easier to use labels than to discuss children’s real lives. “We are squeamish about talking about young people’s emerging personalities and the behavioral issues they have,” he said.

Getting through detox first

At Caron, only 10 to 15 percent of teens have SUDs alone, said Rotenberg. “A history of trauma, eating disorder, cutting and other self-injurious behaviors, ADHD — all are very significant,” he said. Not only are there psychologists and psychiatrists at Caron, but there are also teachers and a school, and pastoral staff “who understand loss and grief.”

‘If you’re working in a mental health paradigm and patients are using substances, you need to recognize that they won’t want to change, that there’s a lot of manipulation and deception in these patients.’

Joseph Lee, M.D.

Rotenberg thinks that some of the diagnoses, such as conduct disorder (CD) and oppositional defiant disorder (ODD), may not hold up after detoxification. “You need to differentiate true CD and ODD from a kid who is cheating to support their drug habit,” he said. “It’s important to get them sober and then take a look at their behavior.”

Finally, Rotenberg cautions that office-based professionals treating adolescents may be “getting lied to on a daily basis” by drug users. “That’s why it’s important to get them in front of a psychiatrist when they’re sober,” he said.

High risk in elementary school

Children who had behavioral problems before they ever started using drugs are most at risk for SUDs, said Lee. “They have this high risk early on, in elementary school,” he said. Some, but not all, of this risk can be ameliorated by good parenting and early intervention, he said. “For many of the high-risk kids, their brains are different,” he said. In fact, it’s important to deal with behavioral issues early on, instead of waiting for the problem to reach the end stage of co-occurring disorders in adolescence.

In general, the mental health field, which deals with problems at a diagnostic level, doesn’t recognize the trajectory leading to a diagnosis of conduct disorder, which is met when things are already getting bad for the child. “The lying and cheating, the inconsistent apathy, the lack of thought about consequences, the high-risk-taking — these are issues indicating brain differences,” he said.

Many parents want to believe that their child has mental health problems instead of an SUD, said Lee. There’s more stigma behind addiction, he said. “If the issue is depression and the child is self-medicating, that makes them feel better,” he said. “When things go wrong with their kid, they want to know why — they want to believe that mental health issues are the core of the problem.” Research shows that teens with SUDs who have mental health problems do just as well in treatment as those with SUDs and no co-occurring disorders, said Lee.

‘Hybridization’ of providers

Lee noted that it is expensive to have a full SUD staff and mental health staff. “That doubles your overhead,” he said. And it’s one reason for the “hybridization” of spe-

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clonies, in which one provider can
treat both SUDs and mental illness.
“[I] do see the collapsing of the hier-
archy of mental health and sub-
stance use providers,” he said. “That
will save dollars.”

The bottom line: SUDs are a
mental illness. “They’re both in the
brain, they both manifest behavior-
ally,” said Lee. “We’ve gotten so
compartmentalized,” he said. “I’m
triple boarded — I can do detox,
counseling, family therapy, medica-
tion management — and because I
walk in all worlds I can tell you hy-
bridization is possible.” But for it to
work, reimbursement must be ade-
quate. “You can’t have poorly fund-
ed state agencies who are going into
battle with a pea shooter,” he said.

For more information, go to
http://1.usa.gov/1HE7Avb and http://
1.usa.gov/1MGiMnVs. For more on
the CRAFFT screening tool, go to
http://1.usa.gov/1Pc1Y2d.

College-age youths need information on opioid overdose

A survey of college-age youth
has found that 37 percent would not
know how to get help if someone
overdosed on opioids. The survey
also found that 16 percent have used
prescription opioid analgesics that
were not prescribed to them. Com-
misioned by the Hazelden Betty
Ford Institute for Recovery Advocacy
and The Christie Foundation, the sur-
vey found that despite the growing
concerns about opioids, young peo-
ple of college age do not think these
medications are very dangerous.

“Prescription pain pills are simi-
lar to having heroin in the medicine
cabinet,” said Marvin D. Seppala,
M.D., chief medical officer of the
Hazelden Betty Ford Foundation,
said in unveiling the survey at a June
Capitol Hill symposium. “It’s clear
from this survey and from our orga-
nization’s experience that young
people don’t fully grasp the dangers
of these highly addictive and lethal
substances,” he said. “Young people
get these drugs for legitimate rea-
sons in many cases, but their avail-
ability feeds into a culture of risk-
that puts our young people’s
still-developing brains in danger.”

Deaths from drug overdose out-
number deaths from car accidents,
averaging 110 overdose deaths a day.
More than half of the deaths involve
opioids, either alone or in combina-
tion with other drugs and/or alcohol.
The survey also found little differ-
ence in the responses whether the
young people were in college or not.

“The death toll from opioids is
rising among young people,” said
Frederick Chicos, founder of The
Foundation has accepted the chal-
lenge to inform and educate college
and university leaders that they need
to publicly discuss the dangers of
opioids on their campuses and work

The survey, conducted by Q
Market Research of Minnesota, also
found that while 16 percent of the
young people misused prescription
opioid analgesics, this figure was
higher among those in intercolle-
giate sports (23 percent). A third of
the college-age students said it was
easy to obtain prescription pain
pills, with half of these saying they
could obtain them within 24 hours.

Almost 60 percent said that
while prescription opioid analgesics
are dangerous, they are not as dan-
gerous as heroin. One in 10 of the
respondents was currently taking a
pain medication prescribed to them;

For more information, including
the full survey results, go to www.
haazelden.org/web/public/youth-
opoid-survey.page.

ONDCP gives $2.5 million to police-treatment linkages

The Office of National Drug
Control Policy (ONDCP) last week
announced the awarding of $13.4
million in funding under the High In-
tensity Drug Trafficking Areas (HID-
TA) program, $2.5 million of which
would go toward increased commu-
nication about opioids between pub-
lc health and police. The awards
were announced August 17 but
leaked to The Washington Post in ad-

The headline in the Post is “In
heroin fight, White House will push
treatment,” but to be clear, there is
no funding for treatment in that $13.4
million. Still, with the traditional law
enforcement focus of HIDTA, this is
a reflection of the ONDCP’s contin-
ued stress on treatment.

Of the $13.4 million, $5 million
would go toward reducing heroin
trafficking, with $2.5 million funding
a “Heroin Response Strategy,” which
will consist of tracking problem ar-

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