CRB Training
Eugene, Oregon
May 6, 2016

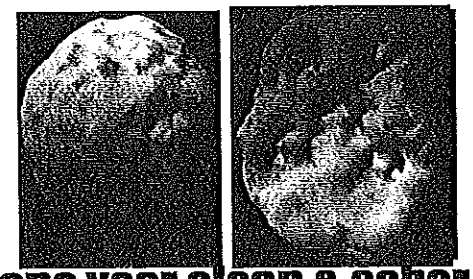
Jay M. Wurscher, CADC
Oregon Department of Human Services
Child Welfare – Addiction Services Coordinator

Understanding Addiction

Where We Start

We don't see things
as they are,
we see things
as we are.
-Anais Nin

Hope for Recovery
Client With Years of
Alcohol, Meth, Marijuana and Cocaine

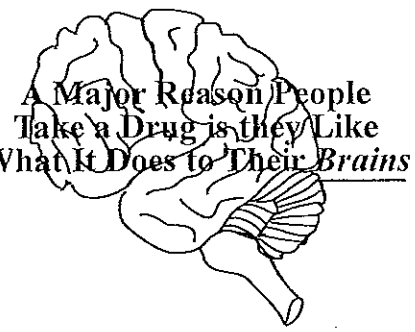


one year clean & sober

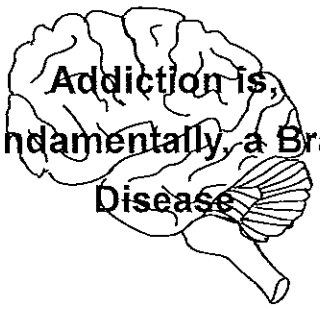
"The greatest motivation any addicted parent has to achieve recovery is the right to parent their own child."

Addiction is a *Chronic Illness*

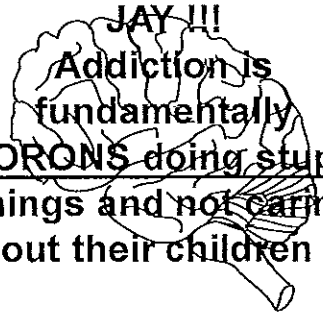
- Diabetes
- Depression
- Heart Disease
- Family disease – like other chronic illnesses – it affects the entire family
- Those who lack control -- seek to control others
- Those who feel hopeless – need HOPE



A Major Reason People Take a Drug is they Like What It Does to Their *Brains*



Addiction is, Fundamentally, a Brain Disease



JAY !!!
Addiction is fundamentally MORONS doing stupid things and not caring about their children !!!!

Initial Drug Use Is A *Voluntary* Behavior…

A Person *Chooses* to Take a Drug … the First Time

Drug Abuse Risk Factors

Community

⇧

Peer Cluster

⇩

Family - *TRAUMA ???*

⇩

Individual

Science Has Generated A Lot of Evidence Showing That…

Prolonged Drug Use Changes the Brain In Fundamental and Long-Lasting Ways

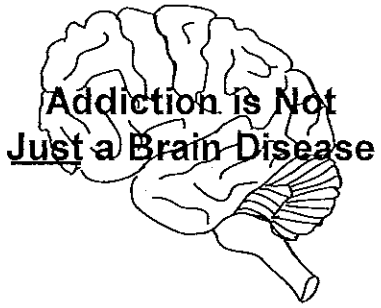
AND…

We Have Evidence That These Changes Can Be Both *Structural* and *Functional*

Implication:

Brain changes resulting from prolonged use of drugs may be reflected in compromised cognitive functioning

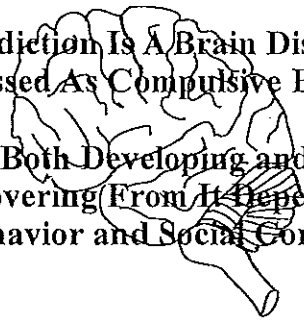
Is there recovery?



Addiction is Not Just a Brain Disease

Addiction Is A Brain Disease Expressed As Compulsive Behavior

Both Developing and Recovering From It Depend on Behavior and Social Context



Compulsion

- The user can't NOT do it.
- She/he is compelled to use.
- Compulsion is not rational.
- Compulsion is driven by non-rational, physical craving, stress induced thought.
- One does not plan to be compulsive.

Continued Use Despite Adverse Consequences

- An addict is one who uses even though she/he knows it is causing problems. The addict can't NOT do it.
- Their thinking process is compromised and their decisions are driven by physical and mental states of their addiction.
- Rational prioritization of needs and personal values are COMPLETELY compromised.

Craving

- Craving is the daily, sometimes hourly symptom of the disease.
- The use experiences intense psychological preoccupation with getting the drug. The user's thought process is COMPLETELY overrun by prioritization of obtaining the drug.
- Physiological withdrawal and the user's desire to avoid pain is often the underpinning of craving.

We don't see things as they are, we see them as we are.

-Anais Nin

DSM-V Diagnostic Criteria

Diagnostic and Statistical Manual of Mental Disorders

Criteria for Substance Use Disorders

2 or more occurring any time in the same 12 month period: SUD

Amount	Substance taken in larger amounts or over longer period than was intended
Stop Attempts	Persistent desire, unsuccessful efforts to cut down or control substance use
Pre-Occupation	Great deal of time spent in activities to obtain substance –(doc shopping, theft) or to recover from use of substance
Craving	Craving, or a strong desire or urge to use substance
Obligations	Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home.
Use Anyway - Social/Personal	Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of use.
Activities	Important, social, occupational, recreational activities given up/reduced to use substances
Physical	Recurrent use in situations in which it is physically hazardous
Use Anyway - Phys/Psychol.	Continued use despite having persistent or recurrent physical or psychological problems caused or exacerbated by the effects of use.
Tolerance	a. need for more to get same effect b. diminished effect with use of same amount
Withdrawal	***Drug Specific*** – nausea, tremors, vomiting, insomnia, hyper-somnia, anxiety, fatigue, increased or decreased appetite, irritability, anger, frustration, heart rate change, muscle aches, fever, diarrhea, etc.
SEVERITY CLASS	**Mild: 2-3 / Moderate: 4-5 / Severe: 6 or more**

ASAM Placement Criteria – 6 Dimensions

American Society of Addiction Medicine - Patient Placement Criteria

Basic Levels of Care: Medical Detox – Detox - Residential - Outpatient

1.	Acute Intoxication and/or Withdrawal
2.	Biomedical Conditions and Complications
3.	Emotional, Behavioral or Cognitive Conditions & Complications
4.	Degree of TX Acceptance & Readiness to Change
5.	Relapse, Continued Use or Continued Problem Potential
6.	Recovery / Living Environment

What is the difference between Subutex®, Suboxone®, and Buprenorphine?

Buprenorphine is a *generic name for a chemical compound* and is short for *Buprenorphine Hydrochloride* and is a semi-synthetic opioid. **Suboxone and Subutex are *brand names* of Buprenorphine-based medications**. Suboxone contains 4 parts Buprenorphine and 1 part naloxone. Subutex only contains Buprenorphine as an active ingredient. Subutex is used little in the US. Subutex has been used in Europe, mainly France, for many years. Most physicians prefer Suboxone because it is less likely to be misused due to presence of the naloxone.

Buprenorphine (BYOO-pre-**NOR**-feen) ('bu-pre-'nôr-fen) (C29H41NO4) has been used in the US to treat pain and in Europe to treat both pain and opioid dependence for over 10 years. Buprenorphine is a semi-synthetic opioid with properties of a partial *agonist*, **and** partial *antagonist*.

Even if the patient decides to take opioid drugs after taking Buprenorphine, he or she will not get high.

- ***Agonists*** are drugs that cause an opioid effect like heroin, OxyContin, and methadone.
- ***Antagonists*** are drugs that block and reverse the effects of agonist drugs. Narcan® is an antagonist and is used to reverse heroin overdoses. Another antagonist is Naltrexone, which *blocks* agonists drugs like heroin.

The agonist property of the medication *tricks* the opioid receptors in the brain into *thinking* that they have received opioids without making the patient feel euphoric and reinforceing the addictive cycle. The antagonist property of the medication makes it virtually impossible for other opioids to attach to the opioid receptor sites.

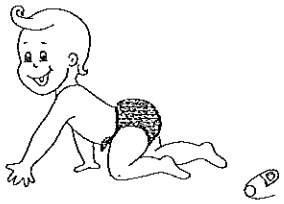
Therefore, even if the patient decides to take opioid drugs after taking Buprenorphine, he or she will not receive any additional effect. In addition to this *blocking* effect, Buprenorphine has a ceiling effect adding to its safety. Other opioids continue to provide more effect as more is taken, eventually leading to respiratory depression and death. Buprenorphine is different; its effects level off at a relatively low dose. That is, even if more is taken, there are no significant increased effects. Therefore, the risk of overdose is much lower than with other opioids.

Opioids attach to receptors in the brain, with three main effects; reduced respiration, euphoria, decreased pain. The more opioids ingested the more of an effect. As a person increases their daily intake, the brain actually changes and produces more opioid receptors. This is why it takes more opioids for the same effect as the tolerance progresses. The process of opioids binding to the opioid receptors can be thought of as a mechanical union, the better the fit the more the opioid effect. Buprenorphine is different. It too binds to the receptors but with an imperfect fit. As a result the Buprenorphine tends to occupy the receptors without all of the opioid effects. Buprenorphine tends to stay with the receptors, blocking them, much longer then other opioids do. This *stickiness*, is what makes Buprenorphine last so long, up to 3 days.

The National Alliance of Advocates for Buprenorphine Treatment naabt.org

METHADONE.....

* is a synthetic opiate similar to heroin.
* is processed more slowly than heroin.
* is NOT a "perfect treatment" in and of itself.
* does NOT produce a "euphoria" or "high".
* is NOT "more addictive" than heroin.
* provides the ability to function at an "even level" by occupying opiate receptor sites, thereby preventing craving and withdrawal.
* is taken orally and stored in the liver for "timed release".
* is capable of producing side effects of other opiates: constipation, menstrual cycle changes, sweating.
* withdrawal is capable of producing withdrawal symptoms similar to withdrawal from other opiates such as: sleep disturbance, muscle aches, and stomach cramping.
* dose effects last 24-36 hours (vs. 4-6 hours of heroin).
* detoxification takes longer than for other drugs (up to 10 days), as it stays in the body longer.
* psychological dependence, as with other drugs, may linger up to a year.
* can replace dependence on street drugs, thereby, lowering risk of hepatitis, liver disease, endocarditis (heart infection), tuberculosis, cotton fever, skin abscesses, phlebitis (infection of a vein), cellulitis (infection of tissue surrounding the injection sight), and HIV.
* produces its own tolerance changes.
* tolerance does not alter the lethal levels related to respiratory depression with overdose of concurrent use of other sedative drugs and alcohol.



Methadone and Effects on the Newborn:

* when used by pregnant women will almost always produce a physical dependency requiring withdrawal in the newborn.
* demands consistent pre-natal care preferably by a "high risk" obstetrician who is well versed in the issues of opiate abuse and pregnancy.
* neo-natal withdrawal problems include restlessness/irritability, tremulousness, disturbed sleep and feedings, twitching, stuffy nose, vomiting and diarrhea, hiccups, high pitched cry, fever, irregular breathing, seizures (usually start within 48-72 hours). Symptoms may last up to six months.
* pre-natal drug effects, post natal environmental interactions, and genetic susceptibility, together, are the factors that contribute to each child's outcome.

Commentary:
Countering the Myths About Methadone

By EDWIN A. SALSITZ, MD

Methadone maintenance has been used in the United States for approximately 50 years as an effective treatment for opioid addiction. Yet many myths about its use persist, discouraging patients from using methadone, and leading family members to pressure patients using the treatment to stop.

Dr. Vincent Dole of Rockefeller University in New York, who pioneered the use of methadone as an opioid addiction treatment, found his patients no longer craved heroin. They were able to return to work and school, and participate in family life and community affairs.

As methadone's use grew, the federal government decided it should only be dispensed in licensed treatment programs, which would provide a whole range of services such as counseling, vocational help and medical and psychiatric treatment.

This creation of the clinic system developed into a double-edged sword. On the one hand, it was advantageous to have many services available in the methadone clinic, but very stringent regulations came along with the clinic concept, including the requirement that patients come to the clinic daily for their methadone. Clinic hours often conflict with patients' work schedules, and make it very difficult to take a vacation. In some areas of the country, the clinics are few and far between, requiring traveling many miles each day. The biggest and probably most important obstacle has been the stigma associated with being seen entering or exiting a methadone clinic.

In an attempt to reduce that stigma, I present the six most common myths about methadone and explain why they are incorrect.

Myth #1: Methadone is a substitute for heroin or prescription opioids. Methadone is a treatment for opioid addiction, not a substitute for heroin. Methadone is long-acting, requiring one daily dose. Heroin is short-acting, and generally takes at least three to four daily doses to prevent withdrawal symptoms from emerging.

Myth #2: Patients who are on a stable dose of methadone, who are not using any other non-prescribed or illicit medications, are addicted to the methadone. Patients taking methadone are physically dependent on it, but not addicted to it. Methadone does not cause harm, and provides benefits. People with many common chronic illnesses are physically dependent on their medication to keep them well, such as insulin for diabetes, inhalers for asthma and blood pressure pills for hypertension.

Myth #3: Patients who are stable on their methadone dose, who are not using other non-prescribed or illicit drugs, are not able to perform well in many jobs. People who are stable on methadone should be able to do any job they are otherwise qualified to do. A person stabilized on the correct dose is not sedated, in withdrawal or euphoric. The most common description of how a person feels on methadone is "normal."

Myth #4: Methadone rots teeth and bones. After 50 years of use, methadone remains a safe medication. There are side effects from taking methadone and other opioids, such as constipation and increased sweating. These are usually easily manageable. If patients engage in good dental hygiene, they should not have any dental problems.

Myth #5: Methadone is not advisable in pregnant women. The evidence over the years has shown that a pregnant woman addicted to opioids has the best possible outcome for herself and her fetus if she takes either methadone or buprenorphine. A pregnancy's outcomes are better for mother and newborn if the mother remains on methadone than if she tapers off and attempts to be abstinent during pregnancy. Methadone does not cause any abnormalities in the fetus and does not appear to cause cognitive or any other abnormalities in these children as they grow up. Babies born to mothers on methadone will experience neonatal abstinence syndrome, which occurs in most newborns whose mothers were taking opioids during pregnancy. This syndrome is treated and managed somewhat easily and outcomes for the newborn are good—it is not a reason for a pregnant woman to avoid methadone treatment. Mothers on methadone should breastfeed unless there is some other contraindication, such as being HIV-positive.

Myth #6: Methadone makes you sterile. This is untrue. Methadone may lower serum testosterone in men, but this problem is easily diagnosed and treated.

These myths, and the stigma of methadone treatment that accompanies them, are pervasive and persistent issues for methadone patients. They are often embarrassed to tell their other physicians, dentists and family members about their treatment. They may feel they are doing something wrong, when in fact they are doing something very positive for themselves and their loved ones. These misperceptions can only be corrected with more education for patients, families, health care providers and the general public.

Edwin A. Salsitz, MD, FASAM, is Medical Director, Office-Based Opioid Therapy at Beth Israel Medical Center in New York

Going Through Opiates 2014 - the pills, the heroin, the recovery

A synopsis of comments by opiate addicted Oregonians on their personal journey. – Jay M. Wurscher

Something happens to me - I experience physical PAIN.
I experience PAIN at a level where I cannot function.
I choose to be free of pain – I take the pills for my pain - I take the pills to function.
I take pills for my physical pain and it helps with emotional pain.
I keep taking the pills – more than prescribed - but eventually - they don't work.
I can't get off the couch – my brain seems shut down.
I'm immobilized. I'm stuck. The scales have tipped. What happened?
I have to take them all the time. It's hard to get the number of pills I need. Choice is gone.
I took the pills to help me function and now I can't function - at all - without the pills.
I need something better – cheaper – quicker – more accessible - less wasteful.
I find heroin.
I take the heroin to help me function and now I can't function at all without the heroin.
To stay "well" – to survive – I have to take the heroin.
The fear – the absolute terror of withdrawal – it drives everything.
Nothing else matters. No one else matters. Everything else is secondary.
The terror of withdrawal overrides any other need, personal value, or responsibility.
The terror of withdrawal overrides every other human being in my life.
The work, effort, crime and manipulation to avoid withdrawal is all consuming.
I still love people, but I can't respond to them. I can hear only the voice of my own pain.
I still have values but the withdrawal fear has defeated them. They are in hiding.
I take the heroin – but the heroin has taken me – the pain rules me.
I'm in this situation because my brain has changed. I struggle and deny, but ask for help.
I don't care – about anything but the opiate – and I know that is not right.
I can't see how this can change. I fear any change – but I know something needs to change.
I listen.
My helpers say I need a "medicine opiate" to get away from the "problem opiate". What?
Methadone? I hate the idea, fear the idea. I don't trust their plan, but having no plan, I go for it.
I stop taking the "problem opiate" – and I <u>choose</u> to go through physical withdrawal.
Anxiety, nausea, depression, vomiting, cramps, diarrhea, chills, paranoia, panic, cravings.
I survive.
I take the medicine opiate – I survive.
I can function, prioritize, and respond to my values again while on the medicine opiate.
I get sober – and resentful – and grateful – and fearful – and hopeful – and ashamed.
I go through PAWS - Post Acute Withdrawal – a body and brain roller coaster experience.
I survive.
I seek more than sobriety - Recovery. Drug free is <u>my choice</u> now. I celebrate my choice.
I meet others who have mastered their gigantic roller coaster of contrasting emotions.
I manage my emotional roller coaster with the help of others who made the same choice.
I learn to manage the pain without the opiate. In recovery I survive – no, I thrive.
I'm asked why I ever started – to them it sounds like it would be such an easy choice.
It WAS an easy choice back then - I just chose to be free of pain. Who wouldn't?

Thanks to those in Oregon who shared their experience in 2014. -Jay

Addiction is.....

Denial is the true distortion or perception caused by craving. The user, under the pressure of intense craving, is temporarily blinded to risks and consequences of using. Their thought patterns and verbalizations verify their inability to prioritize. They violate personal values and normal priorities. Using is supported by minimization, rationalization, intellectualization and lies.

Compulsion

The user can't NOT do it.

She/he is compelled to use.

Compulsion is not rational.

Compulsion is driven by non-rational, physical craving, stress induced thought.

One does not plan to be compulsive.

Craving is the daily, sometimes hourly symptom of the disease.

The use experiences intense psychological preoccupation with getting the drug. The user's thought process is COMPLETELY overrun by prioritization of obtaining the drug.

Physiological withdrawal and the user's desire to avoid pain is often the underpinning of craving.

Continued Use Despite Adverse Consequences

An addict is one who uses even though she/he knows it is causing problems. The addict can't NOT do it.

Their thinking process is compromised and their decisions are driven by physical and mental states of their addiction.

Rational prioritization of needs and personal values are COMPLETELY compromised.

Denial

- Denial is the true distortion or perception caused by craving. The user, under the pressure of intense craving, is temporarily blinded to risks and consequences of using. Their thought patterns and verbalizations verify their inability to prioritize. They violate personal values and normal priorities. Using is supported by minimization, rationalization, intellectualization and lies.

Addiction vs. Dependence

- ***Addiction***
  - Social & Physical
  - Diagnosis
  - Loss of Control
  - Tolerance
  - NEG - Social Impact
- ***Dependence***
  - Primarily - Physical
  - Withdrawal
  - May be "the plan"
  - May be "necessary"

A Major Task for Drug Treatment is *Changing Brains Back!*

- **Pharmacologically**
- **Behaviorally**

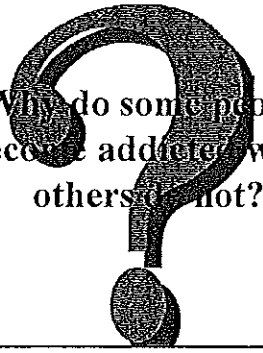
The Most Effective Treatment Strategies Will Attend to All Aspects of Addiction:

- Biology
- Behavior
- Social Context

ASAM and DSM

- A&D Screen
- Clinical Assessment - Evaluation
- **Diagnosis – DSM-5**
- **Levels of Care - ASAM**
- THE MONEY - CCO's ---- *Coordinated Care Organizations*
- Methadone - Suboxone

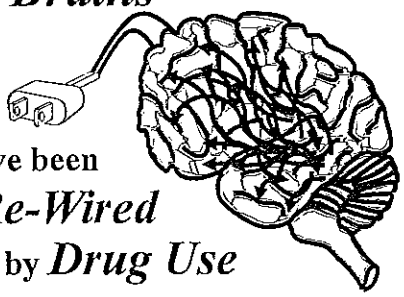
Vulnerability



Why do some people become addicted while others do not?

Because...

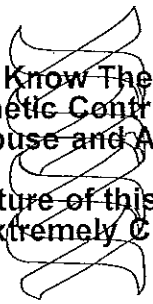
Their ***Brains***



have been

Re-Wired

by ***Drug Use***



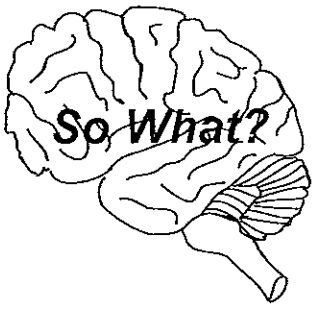
We Know There's A
Big Genetic Contribution To
Drug Abuse and Addiction...

And the Nature of this Contribution
Is Extremely Complex

Drug Abuse is a Preventable Behavior

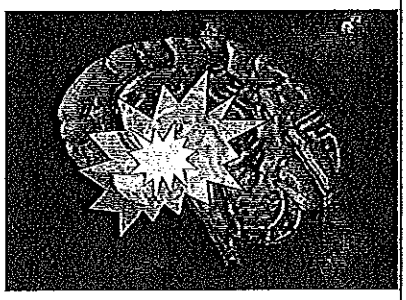
Drug Addiction is a Treatable Disease

Partnership for a Drug Free America



Most drugs of abuse are "dopaminergic"
It is the one and only thing they all have in common…

Marijuana
Nicotine
Caffeine
Alcohol
Cocaine
Crack
Heroin
Opiates
Meth

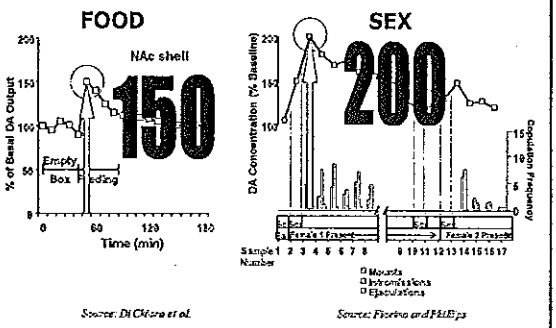


www.nida.nih.gov

Coffee – Tea – Coke – anyone??

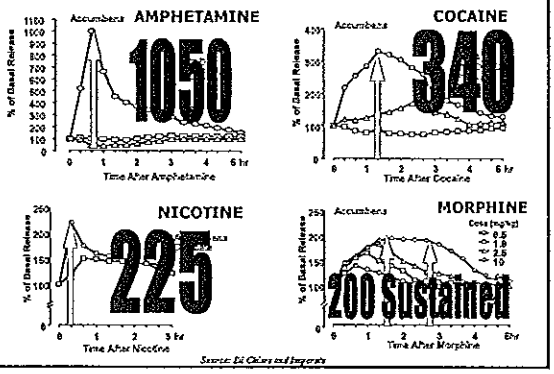
- Caffeine
- Dopamine Release
- Tricks your brain into NOT doing it's job
- Brain becomes DEPENDENT on the caffeine
- Why do you get headaches when you quit???
- How many times have you quit??
- Quit – start – Quit – start – Quit – start - QUIT

Natural Rewards Elevate Dopamine Levels



Source: Di Chiara et al. *Source: Fiorino and Phillips*

Effects of Drugs on Dopamine Levels



Go switch

Stop switch

Orbitofrontal Cortex

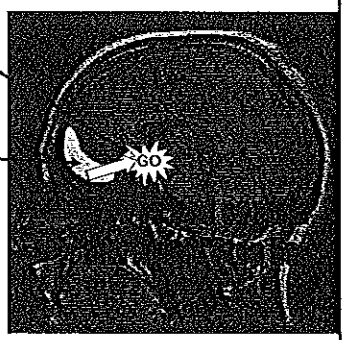
"endorphin mediated stop switch"

-Judgment

-Comprehension

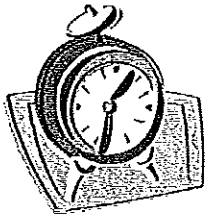
-Impulse Control

-Empathy



Meth & the Human Clock

- The variability of the human clock (time estimation) first discovered by Francois *(Contribution à l'étude du sens du temps, 1921)*
- Newer research shows that erratic sleep/wake patterns, induced by methamphetamine or other stimulants effects time estimation.
  - Over estimating time
  - Under estimating time
  - Extremely late to appointments
  - Very early to appointments
  - General lack of appreciation of time



"When the State took my kids, my caseworker was bugging me to get into treatment. I called and called the treatment center, and no one ever answered the damn phone. After a about a month I realized that no one was working when I was remembering to call – which was at 3 AM in the middle of the night."

– Sherry, recovering meth addict

That's Why Addicts Can't Just Quit

That's Why Treatment Is Essential!

Addiction is the Quintessential Bio-behavioral Disorder

William White

Author: Slaying the Dragon: The History of Addiction & Recovery in America, and Critical Incidents

Addict	Addict +	Addict ++
Oldest onset 16-18	Younger onset 13-15	Youngest onset 9-12
Little/no trauma	Trauma	Early trauma
Believed Immediate intervention	Believed Some intervention	Not believed And/or No intervention
Little to no professional help	Some professional help	Lots of professional help
Low psychiatric Symptomology (older onset) High "self-containment"	Moderate psychiatric Symptomology (earlier onset) Moderate "self-containment"	Acute psychiatric Symptomology (earliest onset) Little "self-containment"
"mature-out" "many roads to recovery"	Single to multiple tx episodes	Chronic many tx episodes

Serenity Prayer

God, grant me the
SERENITY
to accept the things I cannot change, the
COURAGE
to change the things I can, and the
WISDOM
to know the difference.

Going to Meetings

- *Going to church doesn't make you a Christian anymore than standing in a garage makes you a car.*
- *Going to 12 Step meetings doesn't make you a recovering person.*
- *– that takes "working" the steps, not just listening to them.*

So - WHY ??

- Why get mad at an addicted person?
- *--Does anger provide motivation for you/them?*
- *--Does your anger help clear up their brain injury any quicker?*
- Why are you setting those expectations?
- *--What is it about their behavior you are not understanding?*
- *--Why are you expecting behaviors you have rarely seen before?*
- Why won't you believe they are addicted?

We REACT to the Behaviors which are a result of the illness

- *Angry*– about the lies
- *Frustrated*– about the lack of responsibility
- *Fearful*– about the dangerous behavior
- *Exhausted*– from the worry, anger, fear
- *Hopeless*– about the inability to change them
- *Sadness & Anger*- that they will spiritually die, physically die and burden their children forever

We must learn to RESPOND to the *illness*

- It's NOT about you.
- Don't take it personally. DON'T !!!!!!
- You are NOT that important.
- Addiction seeks EMOTIONAL REACTIONS as a justification to use more.
- ASSUME that CRAZY will happen – then make a decision NOT to join it, reflect it, or take responsibility for it.

Al-Anon

- **Surviving the fact you love an addicted person -- Learning about boundaries**
- **Never try and reason with drunk people**
- **Can I be around them at all ???**
- **Can I protect their children from them ?**
- **Didn't Cause it - Can't cure it.**
- **Can: *Cope with it.....***

Summary

- Addiction is an illness - which can be treated.
- Just because you get mad doesn't mean it's not an illness.
- Your personal history with alcohol and drugs doesn't mean others don't have an illness.
- The first tool an addict needs to move toward recovery is **HOPE** – it changes everything.
- You can build hope in the addict – be nice.

Best Thing For Kids

- A knowledgeable, committed, adult advocate
- An advocate with a sense of humor
- An advocate that can model self care

- The calling to help children is one of the greatest and most challenging gifts....
- But please --- Don't assume that calling means leaving their parents behind.
- TX WORKS – RECOVERY HAPPENS

Serenity Prayer for
CASA's & Caseworkers

- ***God, grant me the serenity to accept the people I cannot change, the courage to change the one I can, and the wisdom to know it's me.***

Jay M. Wurscher

- Alcohol & Drug Services Coordinator
- Oregon Dept of Human Services – Child Welfare - Salem, Oregon
- 503-931-1791
- jay.m.wurscher@state.or.us