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- The High Cost of Substance Abuse, and the Need for Standards of Treatment in Primary Care/...

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  By Community Contributor nmmartinez1313|April 22, 2015

****This piece was featured April 22, 2015 in The Chicago Tribune, in a "section" they went on to merge with "Community Contributors," for easier platforming for trusted authors, but inevitably closed the "Community Contributors" section and lost all authors content they had merged over to that section. This landing page doesn't 'connect' anymore. This is a PDF of the original article. ****

The High Cost of Substance Abuse, and the Need for Standards of Treatment in Primary Care/ Integrated Behavioral Health

It is no secret that substance abuse is an epidemic, yet there is a huge treatment gap in this country. SAMHSA's 2012 survey estimates that in 2012, an estimated 23.1 million Americans (8.9 % of the population) needed treatment for a problem related to drugs or alcohol, but only about 2.5 million people (1 %) received treatment at a specialty facility. This leaves 20.6 million who needed treatment, but didn't get it.

The fact of the matter is, we can't afford NOT to treat these individuals. The Most recent statistics on drugabuse.gov estimate the costs of substance abuse of tobacco, alcohol, and illicit drugs is costly to our Nation, exacting more than $700 billion annually in costs related to crime, lost work productivity and health care:

	Healthcare	Overall
Tobacco	$130 Billion	$295 Billion
Alcohol	$25 billion	$224 billion
Illicit Drugs	$11 billion	$193 billion

So why aren't they going to treatment? They need to keep their full-time job, rehab is expensive or insurance may not cover these services, they may be uninsured, have family obligations, and live with shame and fear of going to formal treatment. While residential substance abuse treatment is the gold standard, it is often not a viable option, as the numbers indicate. Intensive outpatient substance abuse services (IOP) are also an excellent option, and one that can be a wonderful combination service for physicians and mental health clinicians. Ideally the patient can continue their daily obligations, attend IOP, see their therapist weekly, and have a doctor managing their medical needs, removing any of the

obstacles that were barriers to treatment. So outpatient and primary care becomes a needed option to address these needs.

Ideally a treatment team should consist of Primary Care Doctor, Psychologist, LCSW, or LCPC, and a Psychiatrist with an understanding of addictions. The patient should of course should be attending 12 step meetings, have a sponsor, and their family and significant others should be part of the treatment process. The team should be coordinating treatment planning and practicing detailed information sharing.

Diagnosis often starts at the primary care doctor's level. During medical exams they assess the severity of health issues, do a preliminary mental health screen, blood and urine tests for substances and overall health function, as well as chronic disease, STD, and infectious disease screening if indicated. They can start treatment of any physical illness if needed. If possible, a family and significant other interview to assess the full scope of the issue can be done to further the clinical and medical picture.

Once an issue is identified, further diagnosis by a psychologist, psychiatrist, or addiction counselor is the next step. They will assess them based on current diagnostic criteria for substance abuse, as well as co-occurring mental health and trauma issues that accompany 70-90% of cases of addiction. Together this team can identify the severity of the problem, do some brief interventions, assess the patient's motivation and readiness for change, design a treatment plan, focus on their personal strengths to tailor treatment, and connect them with community resources.

Treatment can be weeks, months or years depending on severity. There are a number of suggestions for pieces to be in place to treatment the individual at this level of care. Ideally there should be a written agreement or contract, in which they agree to be referred to a higher level of care after non-compliance or a certain number of failed attempts at sobriety and this setting. There should be drug testing on a regular basis, as this is often a powerful deterrent to use. Medications should only be prescribed by the doctor on this team (can do prescription checks in system) for substance abuse, mental health, and ongoing health issues. A referral to Detox in the beginning should be made if warranted, with the understanding that detox in and of itself is not treatment. Detox is required if it is believed the person will go into withdrawal. Withdrawal is the sick, unbearable feeling when the person cuts back and stops using drugs and alcohol abruptly. With trained and willing physicians, tapering and monitoring, depending on frequency, length, quantity of use, can be done in an outpatient setting.

The medical team can help with medically assisted detox with a possible gradual taper, substitution drugs, and drugs to reduce cravings. Easing withdrawal symptoms, may simply mean treating symptoms of withdrawal. The type and length of withdrawal symptoms varies by substance. This allows the body to get rid of substances under supervised care, and for the individual to stop taking drug as quickly as possible, as safely as possible. Physical addiction and repeated use of drugs alters the way your brain feels pleasure, and causes physical changes to some nerve cells (neurons) in the brain. Drugs alter brains structure & functioning, and changes persist long after use is ceased. This is why the patient is at risk for relapse so long after abstinence. No single drug treatment is appropriate for everyone, as it varies by type of drug and length of use.

Medications help with different aspects of treatment, including helping the individual to stop abusing the substance, staying in treatment, learning new behavioral skills, avoiding relapse, addressing dual diagnosis, helping the brain adjust to the absence of abused substance, treating the symptoms of

withdrawal, quieting drug cravings and mental agitation, and helping the patient focus on counseling. Drugs can be used to treat withdrawal and suppress withdrawal symptoms during detox. Stimulants cause fatigue, depression, and sleep problems. Barbiturates and Benzodiazepine's can cause rebound seizures. Medications help the brain adjust to the absence of abused substance. They act slowly to quiet cravings and mental agitation.

Drugs are also used for detoxification and craving management. The medications help patients disengage drug seeking and criminal behavior, and increase openness to behavioral treatment. They have the same targets in the brain as heroin and morphine. They suppress withdrawal symptoms and relieve cravings. Ativan is used for alcohol withdrawal. Naltrexone, Acamprosate and Disulfiram help with ongoing alcohol cravings. Disulfiram interferes with the degradation of alcohol, causes the accumulation of acetaldehyde which causes an unpleasant reaction to alcohol such as flushing, nausea, and palpitations, but has compliance issues. Acamprosate decreases the symptoms of protracted withdrawal such as insomnia, anxiety, restlessness, dysphoria, depression, irritability, and is more effective with severe dependence. Naltrexone blocks opioid receptors involved in the rewarding effects of alcohol. It reduces relapse to heavy drinking, and is highly effective in some, but not all. Drugs to help with Opiate abuse are substitution drugs such as methadone, Suboxone (buprenorphine), Subutex, and naltroxene. There are numerous tobacco replacement therapies' such as the patch, gum, spray, lozenges, buproprion, and varenicline. There is currently research underway to develop medications for stimulants, depressants, and cannabis abuse.

With the medical management in place the rest of the outpatient treatment team comes into the picture in an active role. Standards of care, as outlines by NCBI include treatment that addresses the physical, psychological, social, medical and economic implications of continued use. Treatment must be appropriate to individual's age, gender, ethnicity, and culture. No single treatment works for all substance abusers or substances, so it should be tailored to each patient. It should include a combination of treatments including: Pharmacological, psychological, psychoeducational, medical, social learning theories, support services, and non-traditional healing techniques. The frequency and intensity of treatment is dependent on the individual's level of use, co-occurring mental health issues, concerns of harmful behaviors, and readiness to change. Longer treatment episodes are associated with better treatment outcomes. Despite what previously thought, treatment does not need to be voluntary to be effective. Sanctions from family, employers, and the criminal justice system, increase entry, retention and success.

Continued use and drug seeking is compulsive, even in the face of devastating consequences. It often helps to teach the Medical/Disease Model. That like diabetes, substance abuse is chronic and relapsing. Relapse does not mean treatment has failed. It means it should be started over or adjusted, like trying various high blood pressure medications until the right fit is found. A lapse does not have to become a relapse. Addiction is a medical illness, not a moral failing. Addiction is serious, but treatable. Treatment helps reduce the effects of drugs on the body and brain, and treatment helps improve physical health and everyday functioning. The individual can regain control of their life.

With some training and focused treatment, therapists can help treat the addicted patient by engaging them in individual, group, family, couples, cognitive behavioral therapy, and dialectical behavioral therapy. Group therapy can be an essential component as the person will be challenged by peers and supported by others in treatment. 12 step, AA, NA, and CA are the most well established

group treatment organizations. Individual treatment is essential for the common dual diagnosis of depression, anxiety, bipolar disorder and trauma history.

Cognitive behavioral therapy (CBT) teaches the patient to recognize their moods, thoughts, feelings and situations that cause cravings. They learn to avoid triggers, replace negative thoughts and feelings with healthy ones, and skills learned in CBT can last a lifetime. The patient can gain an increased understanding of themselves and what leads to using behaviors. It can be confrontational to address denial, lies, and manipulation, as well as break down walls and accept responsibility for their behaviors. Dialectical Behavioral Therapy focuses on the emotional dysregulation associated with substance abuse. It helps to decrease self-destructive behavior and increase functioning. It increases motivation for change and coping skills.

Family therapy and Couples Therapy should be a part of treatment if possible, as substance abuse affects the whole family, and strong relationships are essential for success. It can be a powerful force for change, and increases the likelihood of them staying in treatment. It offers the family a chance to begin to heal damage that the addiction has caused. Studies show, family therapy results in decreased relapse rates, increased happiness in family, and increased functioning in children of addicted parents. Motivational Interviewing is another powerful tool for clinicians and physicians to utilize. It is non-confrontational, and seeks to understand and enforce a person's natural motivation for change. These motivations become focus of treatment so they can build a plan, make a commitment to change, create discrepancy and movement.

Relapse Prevention includes developing and using coping skills to avoid relapse. The patient can identify, anticipate, avoid and cope in high risk situations. They can keep one lapse from becoming multiple relapses and feel more capable and in control. They can learn positive activities and scheduling, as well as change unhealthy habits for healthy ones. Skill Building is essential to this. The patient needs to develop problem-solving skills and interpersonal skills. They work to get past denial, develop enlightenment, and work on mindfulness and distress tolerance. Mindfulness is also an important piece, as it is awareness and non-judgment of self. It is also awareness of subtle thoughts and triggers. They can catch themselves and take corrective action. If they recognize it, they don't shame themselves and act like things are unforgiveable. They can take immediate steps to not repeat past behaviors. They can learn to pay attention to internal thoughts and feelings. They can address their physical and social environments such as what they are returning home to, removing triggering items from the home, staying away from using friends and family and learning how to fill healthy free time.

In closing, I think it is clear that addiction is a complicated and unfortunately all too common issue in our country. May need treatment, but few receive services. While there is no denying that formal inpatient treatment is ideal for recovery, the numbers demonstrate that most of those suffering will never utilize those services due to various barriers. Standards of treatment, and a willing treatment team in Primary Care and Integrated Behavioral Health settings can be the setting where the individual receives lifesaving treatment and regains control of their lives.

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