An Overview of the Opioid Treatment Landscape

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When I knew I was going to talk for a half hour, which is in trial lawyers’ terms about three minutes, I started gathering information about this, besides what I already knew. I tried to identify a few issues where I could opine a little bit on or tell you my experience with them.

Just so you know who I am, I am lawyer who was a high functioning alcoholic. It was before the days when it was acceptable for a lawyer to use heroin. I just finished at the Caron Foundation treating two different women attorneys who were both absolute heroin addicts, that’s it.

If any of you caught the piece in The New York Times several months ago about a 49-year-old Silicon Valley lawyer who was a top lawyer. Nobody knew he was addicted to heroin. His ex-wife walked into his apartment after two days of absence, found him dead with a needle in his arm. It’s a wonderful three-page article in the New York Times. Interestingly enough, his last phone call was a conference call with his clients as high as a kite.

But it’s really interesting how much I see it now with our younger lawyers, in particular with the millennials now who are a part of this opioid group that they start with their parents’ medical cabinet and then they get a script for some oxies, and then all of a sudden, oxies – I came from Hazelden Betty Ford two years ago, at that point oxies were $80 a pill on the street and a bag of heroin is $10. So, the progress to heroin hasn’t necessarily been chasing a better high, it’s been an economic decision by lots of people.

I'm not going to talk today about lawyers and addiction and opioids, even though at our last night which we chatted a little bit about that being a possible offshoot of what we do today. I'm just going to talk about the addiction in general and give you a little bit of a framework, at least, in terms of how I see it.

When I started learning about this, and I went to grad school and got a masters, sobriety was pretty much, “you had a problem with addiction, usually alcohol, and you went to a spiritual program like AA or something like it, and
there were treatment centers. The two first big ones were Hazelden Betty Ford in Minnesota and the Caron Foundation in Philadelphia. One 70 years old. One 60 years old. It progressed from tough love where they put you in a room, and literally, you didn’t come out of there until you’d developed a little willingness and to a more sophisticated profession.

But, at the end of the day, the treatment has always been very much based on spirituality, not necessarily religion, but spirituality, willingness, connection with other people, things like that. And it’s only recently with this opioid crisis that we’re seeing medication play a major part in addiction. It’s called Medically Assisted Treatment. MAT is the word you see all the time. I’ve been around this long enough that I’ve seen it go from MAT being sort of old time AA and stuff, it’s sort of like, oh, no, nobody takes anything that’s mood altering, you don’t even take anti-depressive, you don’t change your mood at all. To now being, what I personally believe, is the critical aspect of an effective opioid medication and treatment.

I was lucky enough to be at Hazelden Betty Ford when they created one of the first opioid treatment programs using the three key drugs that are used. They call it COR-12. I’ve now been at Caron when they started a similar program. Indeed, both facilities have separate new buildings for opioids. The behavior of people on opioids – especially, younger people – can be more disruptive, more erratic, more difficult. And they’re also people without life experiences.

A 25-year-old heroin addict is different than a 60-year-old lawyer. They don’t have life experiences. If they started using in their teens their brain was sort of stopped. They don’t have the same coping skills or sense of what a quality reward is in life, like you work hard, and here’s something that feels good, and your endorphins actually shoot out when you accomplish something. They don’t even have that context. So imagine a drug like heroin when you’re 16 years old taking it and how it feels.

I have a sad story or two. My first wife – because I was an active alcoholic for 25 years, and that does include multiple wives just so you know, who were willing to live with this round headed crazy guy. My first wife, we got divorced in our mid-30s, she remarried, had two beautiful daughters, one 19 and one 17: beautiful, smart, everything. And her daughters started going out, her little daughter started going out with a drug addict. And I said, be careful, you know, maybe not a good thing. She said, oh, no, my daughter is just – she’s a fastball or softball pitcher who’s got a scholarship offers, (dah, dah, dah). And indeed, she developed a problem, they sent her to treatment, they were absolutely in Seattle, like, first class, most beautiful neighborhood. You know, the opposite of how we used to look at heroin, which was very much a lower class, maybe ghetto kind of drug that sort of thing, not in the suburbs, not necessarily white to be honest with you, that's kind of how we used to look at it. Well, all of a sudden, here she is, she’s a news anchor in Seattle, she's prominent, she walks into the bathroom, and her little daughter 17 years old is on the floor with a needle in her arm, dead. And that was just three years ago.

I had a good relationship with her and worked through some of that with her. She’s done what a lot of people do now, which, I hope is part of what comes out of today. She started her own foundation, and she knows a lot of people, and she's brought lots of resources together. So in Seattle, she has her own foundation.

And so, the things I hope we’re going to talk about today are more personal touches more what can you do in the role you have, whether it’s the ABA, whether it’s your own community, whether you’re involved in the government. There's nobody in the world, whatever your position is in your community or your job, that can't play a role in handling this.

We were talking last night about how there’s a similarity with this in AIDS, you know. I'm old enough that I remember AIDS when it was like, did you even shake their hand, we were all spooked, did you use the same bathroom? Was the world going to end in 10 years? I mean, all of that paranoia and fear. It’s based largely on lack of education, but also, a lack of urgency. I remember President Reagan had pulled the money up to help with AIDS.

From the ground up came this amazing effort with AIDS, where you know there’s a country like Africa that still suffers. But, today, that's not at the front of our lens. I think we're here because this is at the front of our lens. I don't think you can miss it. I read about three or four newspapers a day. Every one of them, once or twice a week, we’re talking front page something about opioids. Either it’s a human story, it’s a personal story, it’s a
government decision, it’s a new program. And I don’t say that scenically. It’s just we finally caught the attention of this country. And today, I think, there’s going to be one reflection of that.

The medical part of this disease is the MAT. I’ll just give you three quick drugs that are involved. Buprenorphine which is also known more commonly as Suboxone. It is a drug that is used now quite often in residential and physician settings. It is a drug that, partially, allows the negative effects of opioids. But if you stop using opioids and start using that, you will not have as many cravings, you will not have a strong withdrawal, and it has been shown to be very effective in stopping the death and the death.

And I will tell you both the treatment centers I worked for, that was the thing that got them with the deaths. Because, we have somebody come into the bubble of Hazelden Betty Ford 28 days, and guess what, they don’t use, and they’re given comfort meds, and they’re fine.

There was a reluctance to send anybody home with medication that has an opioid aspect to it. You just didn’t do that. You didn’t let him go home with that. So we cut it off. So they’d be taking Suboxone and we cut them off and send them home.

Well guess what happened, they’d relapse and they’re tolerance is down, and they have — it’s a heroin relapse, and (we were) — I mean, two-three times a week we had these deaths. It’s one thing to deal with the entire problem, but another thing when too many people are dying, and that was the impetus to changing those programs to use this medication.

The second medication that is now commonly used, it’s called Naloxone which is known as Narcan. A lot of states have started permitting Narcan. It’s the deal that reverses an overdose, so police use it now. It’s in lots of clinics. In some states, people are allowed to buy it for themselves. It has some controversy because, it’s like, I’m a heroin addict and I get to buy it, and that means if I overdose, I just tell my friends to use it on me and it means I can use safely. So most of these issues, they’re gray and they’re difficult. But the point is, Narcan now is becoming way more popular and way more accessible because it will stop people dying from overdoses.

The third medication has been around a long time, and that’s Methadone. Methadone is a full-blown opiate. I think the Germans invented it in the ‘40s. It’s just less powerful and less compelling and less dangerous than heroin. It doesn’t have the same level of intensity. It doesn’t have the same high. It has less serious ongoing withdrawal. It can make sure you’re not withdrawing from something stronger if you cut down cravings some.

I’ll talk about it just very briefly. The thing about methadone is you have to go to a clinic to get it. And there are entire states — get this, when you talk about access — there’s whole states that don’t have methadone clinics. I mean an entire state. I read articles about somebody that lived in Long Island and they would have to go to a methadone clinic, I don’t know, in Brooklyn. They — and this is paid for by the government- they’re paid for a two-hour taxi ride, they get their dose, they get one dose, that’s it, a day, and it’s very heavily controlled because it can be abused. They take another two-hour cab ride back and do the same thing every single day. A lot of people survive on that, but the methadone clinics are often in urban areas, they’re not in rural areas as much, they’re efficient economically. So, once again, we have an access issue with that.

It’s the same thing with the Suboxone. Only certain doctors get a waiver to be able to prescribe Suboxone, and that number is limited. And guess what, the number of patients is limited. It’s something like 30 patients the first year is all they can prescribe for. So they create this incredible barrier to being able to get some Suboxone. I mean, God forbid, there’d be barrier on prescription drugs. I mean we had a decade of no barrier on prescription drugs. But, now, on this one drug that works, it’s got to be a certain doctor with a certain license and you got to go to the office, and maybe they’ve already hit their cap. We’ll all of that is changing. And it’s one of the good things that’s changing with the government is they’re starting to allow more doctors to prescribe. They’re starting to let physician assistants prescribe, nurse practitioners, that sort of stuff.

I mean, it’s all catching up. We had a system of recovery and abstinence and sobriety that was not equipped to deal with this crisis. I can’t put it more simply than that. We had a system, it was pretty good about people at least who wanted to get sober. Now, even if you want to get sober from opioids, there’s all these barriers and obstacles that make it really hard, that make it super hard. So, in very broad terms, we’re catching
up in the recovery community to the reality of this opioid crisis. Opioids are not interchangeable with alcohol. AA, by the way, does not work with opioids. I mean just AA all by itself, the evidence is it doesn’t work with opioids. So, if that makes sense to you, what we’re doing today and what we’ve been doing for years now in the treatment communities is just playing catch up. That’s all we’re doing is playing catch up. And if each one of us just does this small thing, it’s making a difference.

The prescriptions of opioids are going way down and the use and distribution of the three drugs I mentioned are going up. I mean that in certainly a fairly broad good trend. It’s one if it keeps going, I would suggest this could be sort of like AIDS in the United States in 10 more years.

The third thing that I wrote down was obstacles. These are just two obstacles I made an observation about. One of the big ones is philosophical, that there are a lot of people in the traditional treatment world and residential centers, and you name it that have good people, and they think it’s not right to quote “exchange an opioid for an opioid.” They think that is not recovery.

Only one-third of all the treatment centers in the country are using MAT. I mean, talk about shocking. That’s like saying, “OK, we’ve got chemotherapy and it’s fantastic and it’s saving hundreds of thousands of lives, but guess what, only a third of the hospitals use chemotherapy.” That’s how silly this is. And that’s how critical it is.

Another huge piece is access. You cannot have good insurance. Medicaid and Medicare decide year to year what they’re going to cover in what state and how expensive it’s going to be.

Private insurance goes up and down. There’s a lot of people who are impoverished or can’t afford things like this. I mean, one shot of Vivrotol, the Suboxone now which is also called (Vivotrol), you can get a shot that lasts for a whole month so you don’t have to take it every day, that shot is a thousand bucks a month. I treat people in therapy that their insurance doesn’t cover it and it’s a thousand bucks a month to get that shot.

There’s a thing now with the Narcan. They can implant it now and it lasts for six months. They implant it with these little things right on your forearm and it last for six months. So people don’t have to remember it. So if people do go sideways for a day, they don’t suddenly forget to take it.

Because, all these technical things are happening at a very fast rate that they’re making this last longer, they’re making it safer, they’re making it more thorough. Taking care and treating the chronic disease is a tricky thing.

It’s not like people that have diabetes like a hundred percent of them comply with their treatment, they don’t. Same thing with hypertension, same thing with cancer. There’s about a 60 percent or 70 percent rate of compliance. The same is true with addiction.

There’s a lack of resources and they’re trying to catch up. So you’ve got the philosophical barrier, you’ve got a lack of actual resources, the government is just catching up to it. You’ve got people that don’t understand the disease model and feel shame about this, just like they feel ashamed with primary addiction. They’d rather die than tell people they’re an alcoholic or they’ve got a problem. And especially true illicit drugs, I mean, my gosh, who’s going to admit to their spouse or their parents, or their kids, or anyone that they’re a heroin addict? I mean, we are still several years away from that. So that’s another barrier.

The speed of it has been unbelievable that this has happened so quickly. It went from just prescription drugs and as the doctor described this incredible influx of prescription drugs, it went from that to, all of a sudden, it became heroin, and all of a sudden, people were dying, and that’s when we started reading newspapers. And it happened — really, when you look at the whole timeframe, it’s been very short, and we are — we’re so much playing catch up.

The scope of it has no limits. It takes place in little towns in West Virginia, in Kentucky, it takes place in major cities and on Wall Street. And the rural cities by the way are where they’re getting hit the hardest: they’re insulated, they’re poor, they don’t have jobs, and it goes inter-generationally. I used to work in New Mexico where the Hispanic population (move up in the mountains), and granddad and son and his son would be on the same porch doing black tar heroin. And it was part of their culture, and it was — it was mutigenerational. The same thing is happening now in these small towns. The highest percentage of opioid use is in the 10 poorest states in the United States. That is not an accident.

We’ll wrap up with what I call my good news, bad news section. The good news here is
that this is starting to hit home, it’s starting to provoke meetings like this, with the kind of enthusiasm and commitment all of have to get here. We are all stakeholders to this. We are at the point where, I think, creativity is being rewarded. I have a friend whose boyfriend died of an overdose in Minnesota and she formed her own company, her own business in Minnesota, her own lobbying group, to help Narcan become part of every single EMT squad, every single doctor’s office, you name it, and that became her job, and she was the president of this nonprofit.

That’s the kind of stuff that can happen, whether it’s my ex-wife having a foundation, whether it’s her being motivated by this, I’m just amazed at the grassroots creativity we’re seeing addressing this problem, because it lends itself to working within your own community. It very much lends itself to that.

But I’m seeing things that programs with needles, so we’re making sure people get clean needs. There’s organizations that create safe spaces where you can actually shoot up in a safe space, where you’re not going to be taking other things with it, you’re not going to be drinking with it, you’re not going to be overdosing, it’s going to be monitored.

I mean, it sounds counterintuitive. But that kind of – I hate the term out of the box, but we are truly starting to think out of the box about this.

And during the second portion of today’s breakout, we’re going to encourage you to think out of the box. Like ideas you have that are just creative. Because, I mean, I wrote down, I literally as I was doing this, I wrote down like 40 ideas that I’d never seen done before in addiction, that are specific to opioids.

The only thing I ever saw close to it is there’s a thing called a Wet House for alcoholics, where you go and you can drink safely, and you can die in peace if you want to. And that’s controversial, as are some of these ideas, as are some of the things we’ll talk about this afternoon.

So, with all that said, I didn’t even use my PowerPoint. It’s a beautiful PowerPoint. It is 70 pages that is rich and dense and creative. And at the end of it, I wrote down some of the trends I didn’t mention today. I did almost 40 pages on the medications that are extremely detailed and helpful, if you like digging into that part of it. I wrote down the seven or eight brand new national initiatives, starting with what President Trump did and $6 billion, and I wrote down the new acts. So I’ve given you reference points to things happening governmentally, things happening individually, trends that are starting to happen. So, I encourage you to look at that and use that as a resource.

But, not surprisingly, I didn’t use one slide. So, thanks so much for your attention. I look forward to working with you today.