Outline – Christopher Cook

I can say with certainty the current epidemic, and I chose that word specifically, has never before been seen since I have begun my work. The general consensus among the abstinence-based treatment facilities is in 1999 our admissions rate for the then defined diagnosis of Opioid Dependence (DSM IV-TR) was averaging around 4% of all our total admissions (now known as Opioid Use D/o in DSM 5). In 2012 we broke 70%, 2013 74%, 2014 around 78-80%. This is unheard of. The epidemiological equivalent of smallpox deaths, with all other drugs, including alcohol falling to the wayside; ETOH Dependency was #1 since addiction treatment was formalized – adding all the other classes of drugs together would even come close to the # of alcoholics in USA…. 2012 was the first year Rx Drugs, narcotics, surpassed ETOH and that stat remains today.

Length of Stay Research – ALL shows 90+, the use of recovery coaches, and continued stay engagement + pharmacological approaches are the best odds of success.

A. Addiction treatment has a national success rate of 60%, when delivered in this format, better than diabetes and hypertension which also include behavioral interventions.
B. 74.9% of American Addicts are employed and commercially insured, varying by region of course.
C. Act 106 of 1989: Description and why it is essential it remains.
D. DASPOP Accomplishments
E. Act 139 of PA: Description, the reluctance of Pharmacies, and the reduction in OD deaths by 76% in Mass with Project Lazarus and related programs.

Due to the demographic changes of opioid epidemic, the recovery community has also changed dramatically. 18 year olds and 35 year olds are at fundamentally different points in their lives. With the overwhelming #'s of young opioid addicts, lack of continued support by treatment centers, and the decline of older, more stable role models, the recovery community has suffered. Many clinicians are unwilling to refer clients to NA/AA, despite its overwhelming efficacy. It's hard to study but 75 years of reliable data doesn't lie. With the treatment centers being able to bill for peer supports we not only engage our patients longer, but also help the recovery community's stability. Recovery centers enable the building of a community support system, but that support is declining. With funding and the insertion of professionals into the recovery community we are giving young people in recovery a more stable environment to facilitate their own recovery while assisting new recovering addicts at the same time.

Community services are necessary, and demonstrate to the recovering addict that there is hope in working a recovery program. Peer support groups also help addicts to know that they are not alone in their path of recovery, that there are others who are experiencing the same challenges, and that connectivity within the support groups enable them to be steadfast in their recovery efforts.

The more the community is involved in supporting recovery centers and peer support groups and the more visible they are to the community there may be less stigma associated with being an addict. As a result addicts may be more likely to seek out these services and participate.

*(Chris's additional comments regarding the community's ability to provide the necessary support services for their continued care)

Additional points:

a) Current treatment's: Non-addictive and novel approaches to addiction treatment exist, backed by science yet aren't fundamentally adopted except by HOPE and a very few others.
b) Agonist treatment: reduces symptoms of SUD in short term, but in long term they do not enter into communities of recovery, almost every clinician in US agrees psychosocial support is fundamental, including Reckitt Benkieser the makers of suboxone.
c) Commercial and MA support for Antagonist treatment – non addictive, helps reverse the physiological changes that occur in addiction
d) The introduction of non-addictive pharmacological treatments – the evidence exists but is not being utilized.
e) LOS is crucial to Long-Term Recovery – 90+ days of actual treatment plus the addition of Peer Supports.
f) Maintaining of Act 106, Act 139, Act 53 and inpatient treatment is crucial. PA is a unique state, with higher than average levels of long-term recovery and some of the best treatment centers in the US.
g) Increase funding by MA providers
    i) One way is to do away with the SCA Case Management Model (IF YOU WANT I CAN EASILY AND WOULD LOVE TO ELABORATE ON THIS – IT KILLS MORE PEOPLE THAN IT HELPS) and move to Capitation
h) Commercial INS should have to fund all levels of care, HWH, as they do in physical illness (FED PARITY LAW)
i) ALL PAYORS must develop a method of payment for Peer Services and Tx Centers along with PCB and other leaders should develop programs to offer these services as HOPE will be doing.