Treating Opioid Use Disorder and Co-Occurring Disorders

Amy L. Harrington
University of Massachusetts Medical School

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Substance Use Disorder Webinar Series

Harm Reduction, Medication Assisted Treatment and Considering Comorbid Disorders When Deciding Treatment
Amy Harrington, MD
Assistant Professor of Psychiatry, University of Massachusetts
Medical Director for Acute Addiction Continuum, Community Healthlink, Worcester, MA

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About Your Host:

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About Your Instructor:

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Assistant Professor of Psychiatry, University of Massachusetts
Medical Director for Acute Addiction Continuum, Community Healthlink, Worcester, MA

This webinar is being recorded.

Presentation slides and class materials will be available with the recording after the webinar.
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The University of Massachusetts Medical School Library serves as the New England Regional Medical Library, essentially a partner, for a network of health science libraries, public libraries, and special libraries located in New England called the National Network of Libraries of Medicine, New England Region, NNLM NER for short. There are 7 other regions across the country that are part of this nationwide network. NNLM works to advance the progress of medicine and improve public health by providing equal access to biomedical information. We are funded by the NIH. Everything we offer is free. Take a look at the NER website - https://nnlm.gov/ner/

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Professional medical librarians provide training on:
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Customized programs highlighting the NLM resources for staff meetings, conferences and the public is also part of the training we provide.
Individualized Treatment and Understanding the Non-pharmacologic Components that are Part of Recovery

January 9, 2018 10-11AM

Dr. Gerardo Gonzalez, MD, Director of the Division of Addiction Psychiatry and Associate Professor in Psychiatry, Medical Director, Washburn House, Worcester, MA
Lindsey Silva, RN, MSN, Director of Quality and Compliance, Washburn House, Worcester, MA

Learn about the non-pharmacologic components of recovery. When developing individualized treatment plans, what factors are considered? The Medical Director and the Director of Quality and Compliance for Washburn House, a new treatment facility in Worcester, Massachusetts, will share their stories of starting a new treatment facility, and the challenges of putting evidence-based practices into practical use.

Learning Objectives: Individualized Treatment and Understanding the non-pharmacologic Components that are Part of Recovery
Understand the rationale and treatment options for managed withdrawal of a patient with opioid use disorder
Understand the rationale and treatment options for Medication Assisted Treatment in a patient with opioid use disorder
Understand the non-pharmacologic components that are part of recovery
Treating Opioid Use Disorder and Co-Occurring Disorders

Amy L. Harrington, MD, FAPA
Assistant Professor, Psychiatry, UMass Medical School
Medical Director, Acute Addiction Continuum, Community Healthlink
Disclosures

• No financial disclosures

• I have attempted to use generic names for medications whenever possible. Any use of the brand names Suboxone or Vivitrol is because these are the terms by which patients and the community usually refer to these medications, and are not an endorsement of a specific brand.
Syringe Exchange Program

The Syringe Exchange Program (SEP) is the longest-running service provided by PPP and is the only legal syringe exchange in Philadelphia. The SEP has been a major factor in reducing the spread of HIV among people who inject drugs in Philadelphia and is one of the largest exchanges in the country. The exchange is an anonymous program and will never ask for a participant’s name.

Prevention Point’s syringe exchange is one of the largest in the country.

For more information regarding the SEP, please contact Charles Thomas:
charles@ppponline.org
215-634-5272 ext. 1108
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<th>Learning Objectives</th>
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<td>Describe</td>
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<td>List</td>
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<td>Explain</td>
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How did we get here?

• In the 90’s and 2000’s, there was a push to treat pain more aggressively.

• There was also a misconception that people who were prescribed opiates for medical reasons were at low risk of becoming dependent on them and developing behaviors associated with addiction.

• As prescriptions for opiates increased, so did admissions for treatment of opiate use disorder and deaths from opiate overdose.
Pain: The 5th Vital Sign

1. Temperature
2. Blood Pressure
3. Pulse
4. Respiratory Rate

5. Pain Assessment

American Pain Society. 1998

Pain Standards of the Joint Commission on Accreditation of Healthcare Organizations

- Recommendation: make pain assessment/management a priority in daily practice
- Consider pain intensity the fifth vital sign: measure along with temperature, pulse, respiration, and BP
- Patients' rights: full pain work-up when pain is not easily characterized or treated

DPH data on Worcester County

![Graph showing Opiate deaths per 100,000 population from 2000 to 2014. The graph shows a steady increase in the number of deaths from 2000 to 2014.]
Harm Reduction

• Strategies for safer use

• Reduce negative consequences

• Meet the consumer “where they’re at”
Bystander-administered intranasal naloxone

- In areas where there is high-implementation, there are lower rates of death from opiate overdose than in areas with low-implementation

- No significant difference in rates of overdose, any outcome
Syringe Exchange Programs

• Provide free sterile syringes in exchange for used ones

• Also provide supplies like sterile water for diluting opiates for injection and alcohol pads to sterilize the injection site.

• About a third have on-site medical care and vaccination for Hepatitis A and B

• More than half offer testing for Hepatitis C and HIV

• SEP’s can refer people to services like detoxification and other treatment
Supervised Injection Facilities
Supervised Injection Facilities

• “shooting galleries” already in Australia, Canada, Europe

• Sydney Medically Supervised Injecting Facility, 2001-present
  • Decreased rates of injecting in public places
  • No change in overdose rates, but no fatal overdoses at the facility
    • Estimate between 4 and 25 lives saved annually
  • No measurable impact on infectious disease transmission
  • No change in crime rate or “honey-pot effect”
    • Facility placed in area where injection drug use was already high
Supervised injection facilities
Moving on from harm reduction to treatment....
Strategies used in treatment of opioid use disorders

- Acute detoxification
- Residential
- Out-patient therapy
- Peer support, including 12-Step
- Medication
Life on a methadone clinic

• Full agonist at the mu-opiate receptor

• Mean half-life of 22 hours

• Have to go to the clinic daily

• Hard to get take-homes

• Drug-dealers hang out at methadone clinics
Suboxone 101....

-Suboxone has a “blocker” so if you take other opiates, there won’t be any effect.
The more advanced answer...

Buprenorphine binds more strongly to the mu opiate receptor than morphine, methadone and other full agonists.

If you take buprenorphine, a partial agonist, when there are full agonists in your system, you will feel like you are going into withdrawal.

Naloxone, the blocker in Suboxone, really only goes into effect if someone shoots or snorts the pills.
• Many people prefer buprenorphine (Suboxone) to methadone for lifestyle reasons
  • Office-based, so see a doctor in a private office
  • Can get a month’s worth of medication at a time

• Also, the opiate effects of buprenorphine level off, so less of a nod, which people often prefer
Naltrexone

- Opioid antagonist
- Daily oral form
  - Revia
- Need 85% adherence for therapeutic response
- Once a month depot injection available
  - Vivitrol
What about Co-Occurring Disorders?
According to NESARC (2004)...

- Treatment seekers with alcohol use do
  - 40% mood
  - 33% anxiety

- Treatment seekers with drug use do
  - 60% mood
  - 42% anxiety
Results from my QI project:
Purpose to increase access to psych care for patients admitted to CHL addiction continuum with COD

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<tr>
<td>Met criteria for COD</td>
<td>48/77</td>
<td>22/33</td>
<td>26/40</td>
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<tr>
<td></td>
<td>68.3%</td>
<td>66.7%</td>
<td>65%</td>
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<tr>
<td>Seen by psych at some point</td>
<td>25/48</td>
<td>7/22</td>
<td>18/26</td>
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<tr>
<td>during admission</td>
<td>52.1%</td>
<td>31.8%</td>
<td>69.2%</td>
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<tr>
<td>Had appointment in OPD after</td>
<td>11/48</td>
<td>4/22</td>
<td>10/26</td>
</tr>
<tr>
<td>discharge</td>
<td>22.9%</td>
<td>18.2%</td>
<td>38.5%</td>
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Past year treatment for adults with COD

- Treatment for both (8.5%)
- Substance use only (4.1%)
- Mental health only (34.3%)
- No treatment at all (53.0%)
Effects of substance use on course of psychiatric illness

- Decreased adherence with meds
- Increased hospitalization
  - Shorter but more frequent stays
- Risk of victimization
- Increased suicidal ideation and completion
- Higher rates of side effects from medications
Sequential

Treat addiction

Treat psychiatric issues
Parallel

- Treat addiction
- Treat psychiatric issues
Integrated

Treat addiction and Treat psychiatric issues together
Types of Therapy

- Relapse Prevention
- Motivational Interviewing
- Cognitive Behavioral Therapy
- Contingency Management
- 12-step groups
  - 12-step facilitation therapy
Argument not to treat with medication

- Depression/anxiety/psychosis could be caused alcohol or drug use, so wait and see if the symptoms go away with abstinence

- In the past, the medications had a much different side effect profile

- In my own personal experience, the social factors can impact adherence and the success of treatment.
My personal approach....

- Research suggests no reason to delay treating COD
- For patients with a history, restart meds ASAP due to long time before effective
- Address social determinants
- Connect with substance use treatment, including counseling or residential program
- Focus on treatment engagement, symptom relief
- Try to finds medications that are “two birds, one stone” like topiramate, naltrexone, etc.
Conclusions

• Harm reduction strategies can reduce harm caused by drug use and can help engage people with addiction with the health care system.

• Medications like methadone, buprenorphine and naltrexone give the brain a chance to heal the connections that allow for better communication in the brain.

• Co-occurring psychiatric disorders are common, and are best treated by an integrated, multi-disciplinary approach.
References


Opioid Addiction and Treatment Information

https://medlineplus.gov

What if you saw one of these pills on the nightstand of your friend or family member?

How do you find out what type of tablet or pill this is?

Use PILLBOX
NLMs Helpful Pill Identification Tool

Offering programming on addiction and recovery? Consider borrowing one of our Graphic Medicine Book Club Kits featuring *Sobriety: A Graphic Novel*!

From the publisher... “Through rich illustration and narrative, *Sobriety: A Graphic Novel* offers an inside look into recovery from the perspectives of five Twelve Step group members, each with a unique set of addictions, philosophies, struggles, and successes while working the Steps.”

To Request a Kit: [www.nnlm.gov/ner/kits](http://www.nnlm.gov/ner/kits)

For Questions or Further Information, Contact Matthew Noe at Matthew.No@umassmed.edu
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- Current

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https://infograph.venngage.com/s/Kq2dBc2wdI
Questions?

Comments?

Please use the chat box to ask your questions.
Thank you very much for attending this webinar!

Special thanks to Dr. Amy Harrington for sharing her work with us!
Evaluation Information
Harm Reduction, Medication Assisted Treatment, and Considering Comorbid Disorders When Deciding Treatment


enrollment code: subuse
Evaluation Information


enrollment code: subuse

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