Addiction Medicine Lecture Day

Notes from Lectures

September 30, 2022

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| Engaging Patients & Families in Recovery *Shawna Lupori, Jen Eisenbeis* |

Holistic care in addiction medicine takes into account the mental, social factors which contribute to symptoms and treatment plans.

Supporting one another and sharing the load increases quality of care patients can expect.

* Evaluator clinicians (ED or detox) assess level of care using ASAM criteria, begin insurance authorizations, complete psych evaluations
* Peer navigatorsbuild a relationship, lead recovery group, share resources/coping skills
* Physicians/nursing: admission assessment, medical history, patient care, minor wound care and pass medications throughout the day (can encounter challenging patient behaviors) and are a liaison between patient and doctor
* Social workers: groups, psychoeducation, psychosocial assessments, motivational interviewing (seeks to resolve ambivalence and empower patients to work towards goals), aftercare referrals and coordination which encourages appropriate movement through levels of care, patient advocacy
* Patient care technicians (PCT): see patients in moments of vulnerability. vitals, patient care, conflict management, observations
* LPC: Groups, family sessions, individual sessions, behavioral management, patient advocacy
* Health Unit Coordinator: clerical work, admissions paperwork, charting, patient care
* Milieu therapists: a therapeutic presence group/psychoeducation, conflict resolution, stages of change assessment.

Addiction is chronic, compulsive, uncontrollable drug seeking & use despite consequences. No one sets out with the hope of their drug use making their lives unmanageable.

* No single treatment is right for everyone. Pathways in and out of addiction are many.
* Treat quickly: addiction’s impact on the brain makes motivation fleeting and in competition with strong cravings and ingrained patterns of behavior
* Effective treatment addresses all of the patient’s needs, not just their substance use
* Stay in treatment long enough for it to be helpful
* Medications (can address cravings; used for a year or more in combination with behavioral therapy increases likelihood of patient success)

Person-centered care: advocate for patients to have agency over their treatments. This increases the quality of their experience even w/r/t the barriers we face as providers.

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| Current Drugs of Misuse & Alcohol Withdrawal Management *Carin Malley MD, Anthony Piizon MD* |

**Alcohol Withdrawal Management**

Alcohol withdrawal peaks ~72 hours after cessation

* 50% of patients with heavy, long-term use will develop some symptoms of alcohol withdrawal and 3.3% of patients with symptomatic AWS progress to delirium tremens
* Alcoholic hallucinosis: typically visual or tactile. Orientation remains intact (as opposed to DTs). Auditory hallucinations should raise concern for primary psychiatric disorder.
* Seizures: typically self-limited and generalized. Repeated seizing or status epilepticus should raise concern for alternative explanation
* Most severe AWS: Delirium tremens. Admission to Toxicology or ICU
  + Mortality 2-3% (historically 50%)
  + Vast majority exhibit autonomic hyperactivity and severe tremor

Predicting who will develop AWS: *all the scales have severe limitations, PAWSS has best evidence*

Treatment:

* Mainstays include GABA agonists: benzos, barbiturates, propofol
* Symptom-triggered benzos reduce total dose of medication given/length of stay
* Debate continues: fixed dose barbs/symptom-triggered benzos//symptom-triggered barbs
* Adjuncts: NMDA agonists (ketamine)
* Fever from AWS does NOT improve with antipyretics
* If patient goes to sleep after one dose of GABA agonist but remains febrile and tachycardic, probably not alcohol

**Current Drugs of Misuse**

Chemically synthesized novel drugs overseas. “If it fits, it ships.”

* Poisoning via unintentional injury skyrocketing in recent use
* Variability of dosing size is huge, but individuals still take big risks
* Routine urine drug tests detect morphine and heroin. Cannot detect many synthetics (tramadol, methadone, fentanyl), new psychoactive substances (NPS)
* Suboxone can precipitate/worsen fentanyl withdrawal: *unknown why*

Marijuana remains unapproved by the FDA for any indication

* Schedule 1 drug at greatest danger to teenagers and children. Toxicitity generally only a true danger to children (accidental ingestion)

Stimulants: new cathinones (Western PA not a hotbed)

* Synthetic (ex: bath salts)
* Ecstasy, Methylone (bk-MDMA), MDPV (high for days)
* Bupropion

Benzodiazepines

* Not FDA regulated. You can have “research chemicals” shipped to your house

Phenibut (high use in western PA, unregulated)

* Developed in Russia as a sedative. GABA-B agonist (benzos are GABA-A). Terrible withdrawal.

Acid usually a 2C-x compound, very rarely LSD

Trank (xylazine) rarely seen in PGH

*1-800-222-1222 Pittsburgh Poison Center*

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| Pain in Patients Taking Medication for OUD *Julie Childers, MD* |

Goals: eradicate stigma, differentiate types of pain, understand tolerance.

Correcting myths about SUD

* Methadone/buprenorphine are dosed for withdrawal/cravings: they do NOT treat pain
* Witholding appropriate doses of pain management opioids might lead patients to disengage in care

**Patients fear** withdrawal, untreated pain, judgment and stigma from staff. Fear of relapse also common among those in recovery. Medical team can assist via:

* Discuss substance use openly and non-judgmentally
* Use medical terms and person-centered language
* Show care about their pain and about their individuality
* Titrate dosage appropriately to patient tolerance

Acute and chronic pain are different.

* Acute: short-term, related to a tissue injury, surgery. Effectively treated with opioids
* Chronic: more than 3 months duration. Estimated 20-30% in US population. This is a disease of abnormal pain processing, a point at which opioids may no longer be an effective treatment given. Correlates (below) overlap greatly with correlates of SUD
  + Psych: depression, anxiety, ptsd
  + Low SES
  + Unemployment and disability
  + History of abuse/trauma

MOUD:

* 64-80% of patients with OUD have chronic pain (often contributes to initiation of use)

Chronic pain is typically incurable, severe. Pain as the “fifth vital sign” requires us to set expectations for ourselves and the patient

Assess: chronic or acute (expected duration), and risk (current substance use vs. remission, how the patient is monitored)

* Did you have pain on a daily basis before this injury occurred? How well was your pain controlled?
* How is this current pain different from the pain you’ve had?

Non-opioid treatments (nerve blocks, NSAIDs) equivalent to opioids in musculoskeletal pain

Gabapentin: short course indicated for post-op/acute pain, to decrease opioid requirements, but opioids will likely still be necessary

May require MUCH higher doses: nearly 8 times as much after TKA in one study.

* Begin with double the dose of an opioid-naive patient and increase

Buprenorphine (suboxone, subutex, zubsolv): *continue during acute pain episode*

* Partial opioid agonist. Overdose very unlikely
* Minimal euphoria, respiratory depression
* Sublingual
* Low-dose formulations are approved for pain

Methadone

* Full agonist. Do not change dosing. PRN opioids if needed. Communicate with methadone clinic

Naltrexone

* Pure antagonist: blocks craving and analgesia. Given orally or through a monthly injection. *Does not cause withdrawal when stopped*
* Stop naltrexone if painful procedure planned
* Unplanned pain: take a careful history. Vivitrol peaks 3 days after injection, levels stable for another 15 days.
* Blockade can be overcome with increased doses, higher-affinity opioids such as fentanyl

Harm reduction

* Meet people who use drugs (PWUD) where they’re at
* Drug use is part of our world. Our goal is to minimize negative effects and improve individual/community well-being with non-judgemental, non-coercive interventions
* Offer SUD treatment: recognize ambivalence as normal part of process

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| Overdose: Evaluation, Treatment, and Harm Reduction *Michael Lynch, MD, FACMT* |

Allegheny County has one of the highest OD rates in the state & country.

* Synthetic opioids (fentanyl) biggest driver for overdose deaths
* Heroin OD deaths have decreased
* *Many fatalities involve +1 drug. Cutting agents are causing issues in both overdose and withdrawal and complicate management.*

The effects of stigma: 40.3 million in US meet SUD criteria, only 4.5% will seek mutual support (AA or PCP), 6.9 any type of treatment, 3% will complete a single episode of SUD treatment.

**Use person-centered, clinically accurate language to reduce implicit, explicit, and perceived stigma.** A study by the Recovery Research Institute asked participants how they felt about a “substance abuser” and a “person with SUD” with identical patterns of use

* Participants felt the “substance abuser” was more at moral/behavioral fault for condition, less likely to benefit from treatment, more likely to benefit from punishment

**Harm reduction is at the core of all healthcare, not just SUD. If you have the ability to reduce harm and you don’t, you’re inflicting harm.**

Evidence-based harm reduction strategies:

* Naloxone reduces OD deaths, represents a significant decrease in overall societal cost
* [CDC recommendations re: provision of naloxone](https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf)
* [Fentanyl Test strips](https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/Fact_Sheet_Fentanyl_Testing_Approved_ADA.pdf) are easy to use, highly sensitive.
* [Syringe Service Programs](https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html) (SSPs) reduce HIV/Hep C incidence by 50%
  + New users 5x more likely to enter SUD treatment, 3x more likely to stop using drugs
* [Overdose Prevention Centers](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794326#:~:text=Overdose%20Prevention%20Centers%3A%20An%20Essential%20Strategy%20to%20Address%20the%20Overdose%20Crisis,-Elizabeth%20A.&text=In%202021%2C%20more%20than,or%20other%20stimulants%20increased%2034%25.) reduce deaths, cost-effective, reduce public drug use and litter. NOT associated with increased crime, drug trafficking, or initiation of drug use among people who didn’t previously use drugs.

Local leaders in harm reduction

* Prevention Point Pittsburgh

Opioid Overdose Management: not a lot has changed in the last year (other than potency of fentanyl)

* There are no NarCan resistant opioids.
* The point of Naloxone is breathing.

Management of stimulant toxicity (cocaine, amphetamine/methamphetamine, stimulants, synthetic cannabinoids

* Primary goal is sedation

MOUD: mortality reduction up to 50%, reduction in crime, improved social functioning, correction of neurobiological dysfunction that leads to relapse. *The benefits are so clear that not offering or discussing this is malpractice.*

* Initiation of medication treatment should not be delayed while completing full assessment and intake
* Medication therapy should not be contingent upon participation in behavioral therapy
* Both office-based and home buprenorphine induction are safe/effective
* Patients seeking addiction treatment 7x more likely to be engaged if they are seen on the same day compared to waiting 2+ days

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| Individuals with a Dual Diagnosis (Co-Occurring Disorders) *Hader Mansour, MD PhD* |

Terminology: *dual diagnosis* was first introduced in the 1980s. Recently, SAMSHA has transitioned towards *co-occurring disorders (COD)*

* *Almost half of those with SUD have a co-occurring disorder*

Challenges: difficult to diagnose, dealing with 2 different service systems, high utilization of time and resources, different approaches, denial

Few patients receive complete treatment for both disorders

Common Co-Occurring Disorders: substance use disorder(s) with depression, anxiety disorder, bipolar disorder, PTSD, schizophrenia

Patient have increased risks: relapse, hospitalization, poor adherence, increased risk behaviors, homelessness, incarceration, risk of suicide

Substance-induced vs primary psychosis

* Primary psychosis has earlier age of onset in general
* Substance-induced psychosis have a weaker family history of psychosis, better degree of insight, fewer positive and negative symptoms, more depressive/anxiety symptoms and higher higher risk of developing of a primary psychotic illness

Feigning/malingering *Psychiatrists are reluctant to diagnose malingering for fear of being sued, assaulted, or wrong. However, if we wrongly diagnose a malingerer as being ill, they will have achieved their goal of evading legal consequences*

* Should be suspected if medicolegal context of representation, marked discrepancy between the individual’s claimed stress and objective findings, lack of cooperation
* Eagerly “thrust forward” their illness, or exaggerate symptoms.
* Reports AVH with no associated delusions, or evidence of preoccupation
* Give opportunity to save face: asking them to “clarify inconsistencies” is more likely to be productive and safer for examiner than accusations of lying

Gold Standard for Treatment of Co-Occurring Disorders: Integrated Model

Integrated model addresses both mental disorder and SUD simultaneously using one team at the same facility.

Successful treatment is highly individualized. Thus, successful treatment depends on developing a trusting, safe relationship with the patient so that they are engaged in their treatment and mutual goals can be developed.

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| Levels of Care for Addiction Medicine *Justin Thiry LCSW, Kelly Moran BSN/RN, David Zimmerman BSN/RN* |

Pennsylvania Department of D&A sets the licensing requirements for level of care and provides funding for programs like McKeesport’s Addiction Medicine unit.

Placement for addiction medicine has very different criteria for admission and insurance. WIth the goal of not “overpromising and under delivering.”

* Inappropriate placements result in inadequate treatment, and readmission

Transitioning from Medical Hospitalization to Addiction Treatment

1. *Does the patient want to go to SUD treatment?* This is all voluntary.
2. *What to include in a referral?* Goal is to advocate for the patient’s admission/maximize the odds of their acceptance. Don’t add to the barriers keeping them out of treatment
3. *Always be advocating.* See your patient’s strengths, paint them in the best possible light
4. Be aware of funding from this very beginning of the process

What to consider?

* Prohibitive chronic mental and physical health conditions
* Medications and MAT as a barrier for acceptance/transition
  + Starting a patient on suboxone or methadone before discharge: many residential treatment locations require that a patent be established with an external provider before admission
* Mandated treatment may be inconsistent with placement recommended through ASAM
* Logistics (lack of transportation, rural areas, etc)

Criteria for level of care is set by ASAM (American Society of Addiction Medicine)

**ASAM dimensions of assessment: (0-4)**

* Dimension 1: acute intoxication and/or withdrawal potential
* Dimension 2: biomedical conditions and complications
* Dimension 3: emotional, behavioral, or cognitive conditions and complications.
* Dimension 4: readiness to change (based in motivational interviewing)
* Dimension 5: relapse, continued use or continued problem potential.
* Dimension 6: Recovery/living environment (safe return?)

*Some funding sources require a risk level of 3 or greater before they will approve treatment*

On insurance and funding:

* Medicare (only covers hospital-based programs) vs Medicaid
* Available county funding
* Private insurance
* Medical vs. behavioral health insurance: D&A is covered under behavioral health. CCBHO (Allegheny, Erie, Blair counties) and Beacon Health (Westmoreland, Washington, Fayette, Beaver, Butler). In Allegheny County, we have ALDA funding for uninsured patients