Substance Abuse

Presented By:

Craig P Cleveland, MD

Medical Director - Milford

Sunrise TREATMENT CENTER

Thanks to Jessica Woodard and the Atrium Medical Center Foundation

About Me

Graduated from University of Cincinnati College of Medicine

Residency in Internal Medicine at the Jewish Hospital

Began private practice in April 1984 and retired in June 2017

Additional experience working about a decade in the emergency room, as well as treating workers compensation injuries and addiction patients

Left my practice after 33 years to join Sunrise Treatment Center as a Medical Director in July 2017

Today's Agenda

- Definitions
- Drugs
- Patient Presentation and Treatment
- Long Term Outlook

Definitions

Substance Use and Abuse

- Prescribed or purchased off the streets
- Can lead to **Dependance**

Addiction

- A dependance on a substance but **involves specific behaviors**
- Generally thought to have a genetic component

Definitions

ASAM definition of Addiction

- Addiction is a primary, chronic disease of the brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in the individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Definitions

ASAM definition of Addiction, continued

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse in remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Symptoms of Addiction

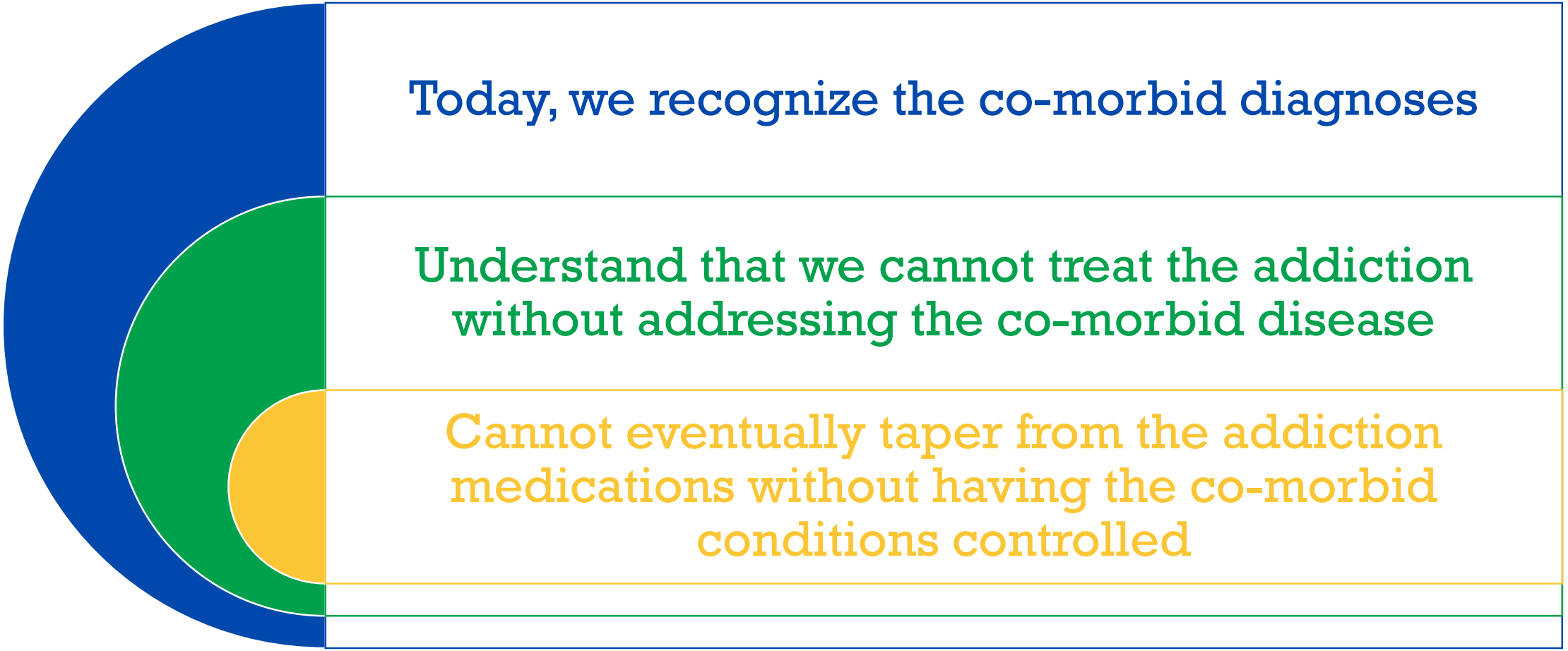
Symptoms of Addiction

- **Continuing to use** the drug, even though you know it's causing problems in your life or causing you physical or psychological harm
- **Doing things to get the drug that you normally wouldn't do**, such as stealing
- Driving or doing other **risky activities** when you're under the influence of the drug
- **Spending a good deal of time** getting the drug, using the drug or recovering from the effects of the drug
- **Failing in your attempts** to stop using the drug
- Experiencing **withdrawal symptoms** when you attempt to stop taking the drug

Co-morbid Diagnoses

- When I started treating addiction, co-morbid diagnoses were not considered
  - Everything was addiction
    - Not **anxiety,** but addiction to Benzodiazepine
    - Not **depression,** but addiction to Stimulants
    - Not **ADD/ADHD,** but addiction to Stimulants

Co-morbid Diagnoses



Drugs

- Opiates (OPI)
  - Heroin and Fentanyl
  - Some pills – Vicodin (hydrocodone), Percocet (oxycodone)
- Marijuana (THC)
- Methamphetamine / Cocaine (MET, COC)
- Benzodiazepines (BZO)
- Alcohol (ETOH)
- Others

Opiates (OPI)

By history, patients will start using in their teen years

At any time, about half started with recreational use, others prescribed

About half have support from family or significant other

The remainder with family as an aggravating factor, toxic environment

Typically, will start with experimenting with pills, then will transition to habitual use, oral intake or nasal (snorting)

In general, about 6 months from the time of initial use to injection

Opiates (OPI)

- Generally present after several OD's or incarceration
- Many have tried the medications – buprenorphine (BUP) and methadone (MTD) - off the streets prior to coming in
- Must be the patient's decision to come in for treatment
- Court ordered invariably poor long-term abstinence
- Inpatient involuntary treatment with high relapse rate

Opiates (OPI)

Must have comprehensive treatment including counseling alone or with medication assisted treatment (MAT), with community meetings

Two modes of outpatient counseling – individual therapy vs groups / IOP

Relapse are fairly common, not with OPI when on BUP but with other drugs

As a treatment center, must understand that relapse is a symptom of the disease and cannot be a reason for dismissing from the program

Early relapses understandable, best to occur mid-treatment to allow further investigating what we missed

Opiates (OPI)

Late relapses more concerning since patients feel they are more confident but had not developed the needed coping techniques

Patient must understand that relapse is expected and will not result in dismissal

We will see patient who have been to 3 or more inpatient programs, or outpatient treatment facilities

Marijuana (THC)

- Drug that has been used for thousands of years
- Patients starting at a very young age and continue for years, alone or with addition of other drugs
- Readily available
- Seen often with OPI use
- Much confusion now with being state legal, federal illegal

Methamphetamine (MET) / Cocaine (COC)

- Seen in our population
- Many times used when OPI are not available
- No effective treatment for stimulants
- A significant issue when using Sublocade (BUP) or Vivitrol (naltrexone)
- When using the combination as Suboxone, increasing the dose is associated with a decrease in stimulant use

Benzodiazepines (BZO)

Not as prevalent use

Associated with a history of anxiety, bipolar

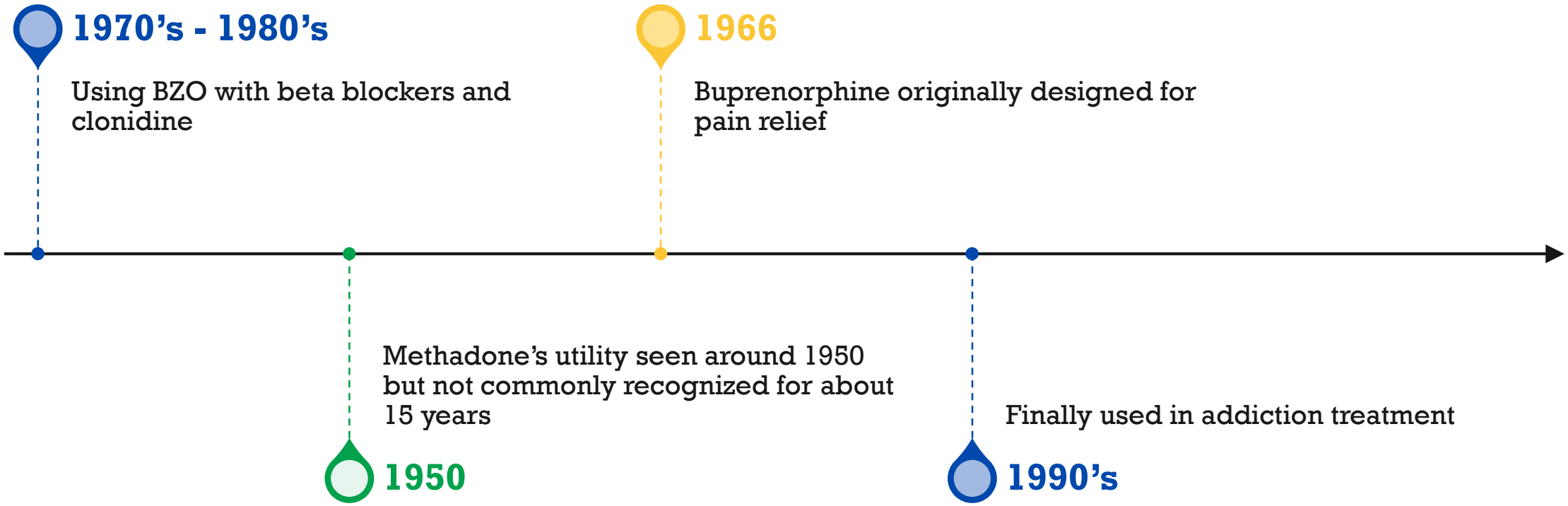
Previously treated solely with BZO's

Now will use more mood stabilizers

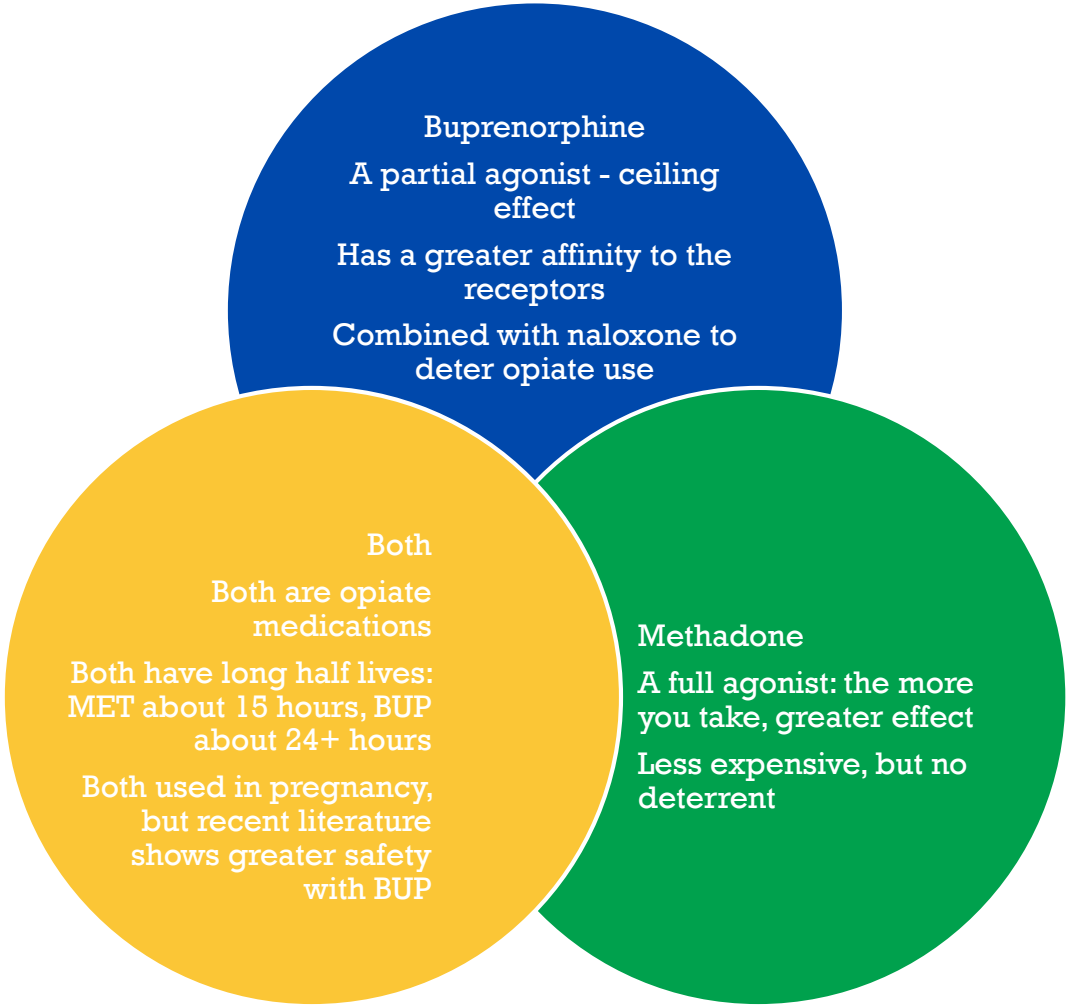
Alcohol (ETOH)

- Highly variable in use
- Seems to be geographical
- Treatable using current medications and counseling

Treatment - Opiates



Treatment – Opiates – Comparison of Methadone & Buprenorphine



Treatment - Opiates

- A push from the judicial system to use injectables
- Already have an individual who may not be ready for treatment
- Generally, no deterrent effect for non-opiate drugs
- Drugs alone don’t work, must have a comprehensive program
- injectables are the most expensive forms

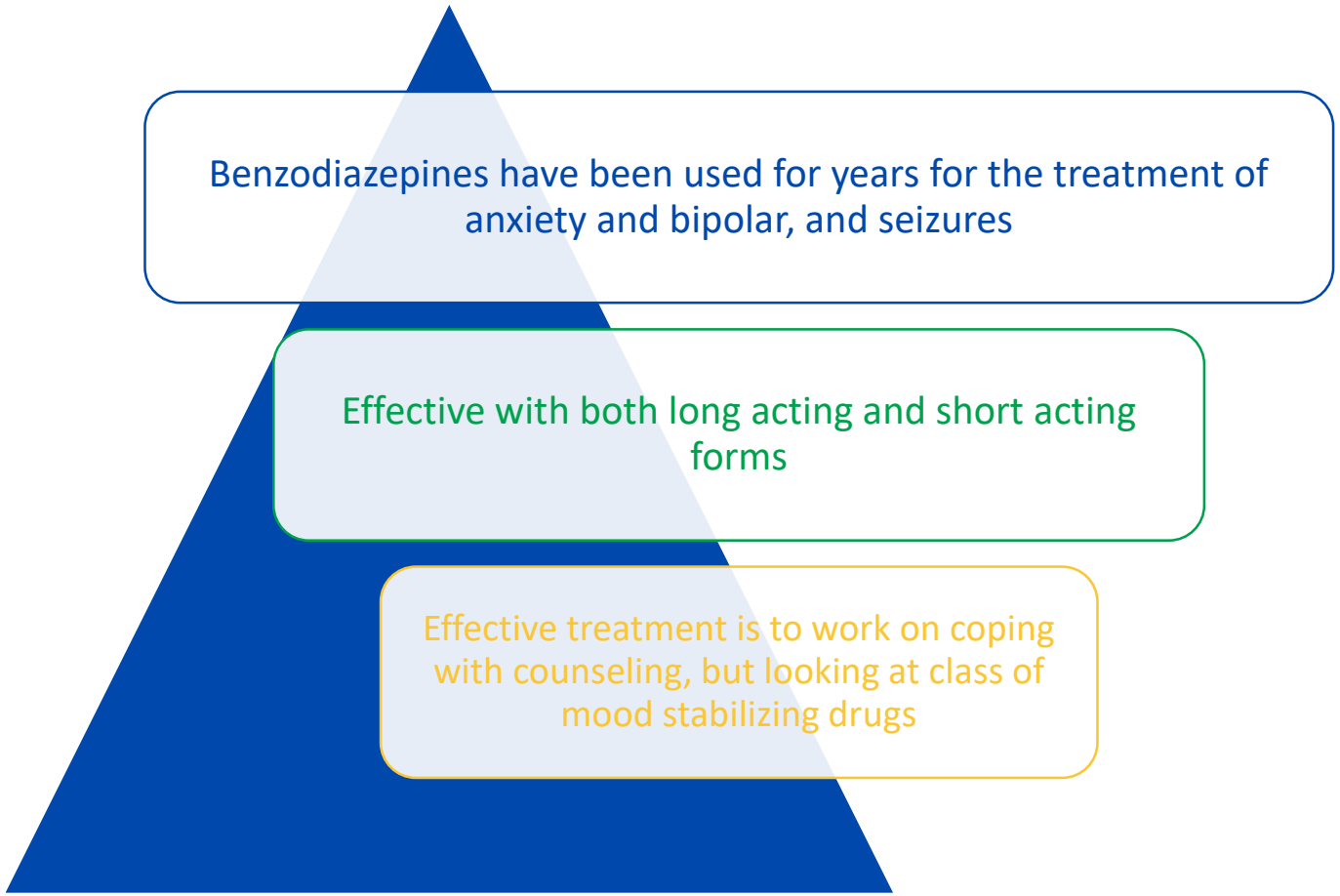
Treatment - Marijuana (THC)

- No specific drugs to help with treatment
- Look for underlying reason for using the drug - anxiety, bipolar
- Treating the underlying issue effective

Treatment - Methamphetamine/ cocaine

- No specific medication for treating these drugs
- Cognitive-behavioral therapy most effective
- Have found using an increase dose of the BUP/naloxone will help deter
- Studies looking at bupropion or combining BUP with bupropion

Treatment - Benzodiazepines (BZO)



Treatment - Alcohol (ETOH)

Alcohol has been around for centuries

Legal, readily available

Strong familial history (genetic)

Greatly benefited by counseling and group activities (12 Step)

We have deterrent drugs like disulfiram or ones to modify cravings like acamprosate

Treatment: Most Important Point to Emphasize

Need to Treat the Co-morbid Conditions

Anxiety
Depression
Bipolar
ADD/ADHD

Will not be able to get the patients off the BUP until the MH issues are controlled

Long Term Outlook

- What are the factors for success?
- Treatment facility providing
  - Education
    - Seminars to groups in community
  - Having a presence
    - Offices around the community
    - Be present at community events with literature

Long Term Outlook

- What are the factors for success?
- Treatment facility providing
  - Doing it right
    - Have the full spectrum of treatment with Medical evaluations, individual and group therapy, network for appropriate referrals (hepatitis C , pregnancy, etc)
    - Dispensing onsite

Long Term Outlook

- What are the factors for success?
- Insurance providing
  - **TRANSPORTATION**
  - Coverage for the medications
  - Coverage for laboratory testing
  - Housing stability
- Community providing
  - Job opportunities

Long Term Outlook

- What are the factors that are in the way?
  - Community perception
    - Treatment with BUP, and Needle Exchange Programs
  - **Primary care providers**
  - Psychiatrists
  - Emergency rooms
  - Pharmacists
  - Police

HSS J. 2019 Feb;15(1):31-36. doi: 10.1007/s11420-018-9643-3. Epub 2018 Nov 1.

Improvement in Residents' Attitudes Toward Individuals with Substance Use Disorders Following an Online Training Module on Stigma.

Avery J[1], Knoepflmacher D[1], Mauer E[1], Kast KA[1], Greiner M[1], Avery J[2], Penzner JB[1].

Author information

Abstract

BACKGROUND: Resident physicians have been shown to possess negative attitudes toward individuals with substance use disorders (SUDs), even if the residents believe they have adequate knowledge and skills to care for these patients. Residents' negative attitudes may

CONCLUSION: Residents' attitudes toward individuals with SUDs improved after taking an online training module. This is encouraging, as studies have shown that attitudes toward individuals with SUDs tend to decline during residency training and negatively affect patient care. Larger studies are needed to determine if such online modules can improve attitudes of other groups of clinicians, result in sustained change over time, and improve patient outcomes.

METHODS: A web-based questionnaire, including demographic information and the Medical Condition Regard Scale (MCRS) about individuals with alcohol and opioid use disorders, was sent to internal medicine and psychiatry residents before and 6 months after they took an online training module on stigma toward individuals with SUDs.

RESULTS: A total of 46 residents completed the initial questionnaire and 29 completed the follow-up questionnaire 6 months later. Attitudes toward individuals with SUDs, as reflected by an increase in MCRS scores, were improved 6 months after the online training module.

CONCLUSION: Residents' attitudes toward individuals with SUDs improved after taking an online training module. This is encouraging, as studies have shown that attitudes toward individuals with SUDs tend to decline during residency training and negatively affect patient care. Larger studies are needed to determine if such online modules can improve attitudes of other groups of clinicians, result in sustained change over time, and improve patient outcomes.

Long Term Outlook

- What are the factors that are in the way?
  - Community perception
    - Treatment with BUP, and Needle Exchange Programs
  - Primary care provides
  - **Psychiatrists**
  - Emergency rooms
  - Pharmacists
  - Police

Am J Addict. 2017 Jan;26(1):75-79. doi: 10.1111/ajad.12406. Epub 2016 Oct 17.

Changes in psychiatry residents' attitudes towards individuals with substance use disorders over the course of residency training.

Avery J[1], Han BH[1], Zerbo E[2], Wu G[1], Mauer E[1], Avery J[3], Ross S[4], Penzner JB[1].

Author information

Abstract

BACKGROUND AND OBJECTIVES: Psychiatry residents provide care for individuals diagnosed with co-occurring mental illness and substance use disorders (SUDs). Small studies have shown that clinicians in general possess negative attitudes towards these dually diagnosed individuals. This is a serious concern, as clinicians' stigmatizing attitudes towards individuals with mental illnesses may have a

DISCUSSION AND CONCLUSIONS: The attitudes of psychiatry residents' towards individuals with SUDs with and without schizophrenia were negative and were worse among senior residents. There were many potential reasons for these findings, including repeat negative experiences in providing care for these individuals.

for individuals with the four different diagnoses.

RESULTS: Psychiatry residents had more stigmatizing attitudes towards individuals with diagnoses of SUDs with and without schizophrenia than towards those individuals with diagnoses of schizophrenia or major depressive disorder alone. Senior residents possessed more negative attitudes towards individuals with SUDs than junior residents.

DISCUSSION AND CONCLUSIONS: The attitudes of psychiatry residents' towards individuals with SUDs with and without schizophrenia were negative and were worse among senior residents. There were many potential reasons for these findings, including repeat negative experiences in providing care for these individuals.

SCIENTIFIC SIGNIFICANCE: The negative attitudes of psychiatry residents towards individuals with SUDs are worrisome. Future work is needed to better understand these attitudes and to develop interventions to improve them. (Am J Addict 2017;26:75-79).

Long Term Outlook

- What are the factors that are in the way?
  - Community perception
    - Treatment with BUP, and Needle Exchange Programs
  - Primary care provides
  - Psychiatrists
  - Emergency rooms
  - Pharmacists
  - Police

Addiction. 2019 Mar 9. doi: 10.1111/add.14608. [Epub ahead of print]

Life after opioid-involved overdose: survivor narratives and their implications for ER/ED interventions.

Elliott L[1,2], Bennett AS[1,2], Wolfson-Stofko B[1,2].

Author information

Abstract

BACKGROUND AND AIMS: Numerous states in the United States are working to stem opioid-involved overdose (OD) by engaging OD survivors before discharge from emergency departments (EDs). This analysis examines interactions between survivors and medical care providers that may influence opioid risk behaviors post-OD.

CONCLUSIONS: Emergency department interventions with opioid-involved overdose (OD) survivors may benefit from training emergency medical staff to assure a continuity of non-judgmental, socially supportive remediation attempts throughout contacts with different care-givers. Brief interventions to educate emergency medical staff about current theories of

a loss of empathy, and most described burnout related to perceived ingratitude or failure to influence patients. Survivors reported being motivated to reduce opioid risk following a non-fatal OD and many described successful risk-reduction efforts post-OD. Intentions to cease opioid use or reduce risk were complicated by unmanaged, naloxone-related withdrawal, lack of social support and perceived disrespect from EMS and/or EDS.

CONCLUSIONS: Emergency department interventions with opioid-involved overdose (OD) survivors may benefit from training emergency medical staff to assure a continuity of non-judgmental, socially supportive remediation attempts throughout contacts with different care-givers. Brief interventions to educate emergency medical staff about current theories of addiction and evidence-based treatment may achieve this goal while reducing care-giver burnout and improving the uptake and efficacy of post-OD interventions delivered in emergency departments.

KEYWORDS: Emergency departments; emergency medical services; naloxone; opioids; overdose; stakeholder analysis

Long Term Outlook

- What are the factors that are in the way?
  - Community perception
    - Treatment with BUP, and Needle Exchange Programs
  - Primary care provides
  - Psychiatrists
  - Emergency rooms
  - **Pharmacists**
  - Police

Journal
Journal of Psychoactive Drugs ›
Volume 38, 2006 - Issue 3

Original Articles

Knowledge, Attitudes and Practices of Pharmacists Concerning Prescription Drug Abuse

Lynn Lafferty, Tracy S. Hunter & Wallace A. Marsh

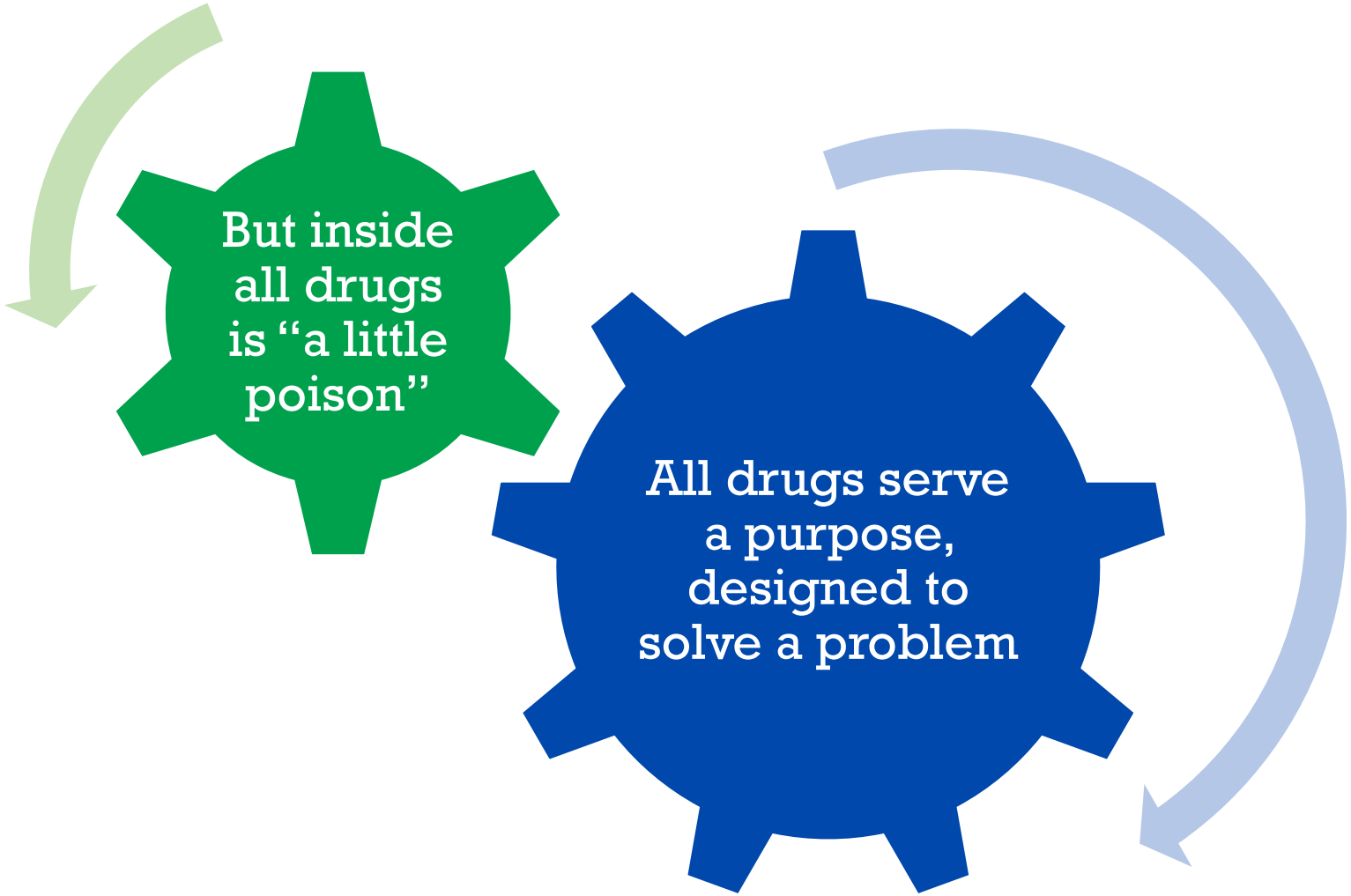
Pages 229-232 | Published online: 09 Sep 2011

https://doi.org/10.1080/02791072.2006.10399848

Long Term Outlook

- Bottom line is to educate the lay community and professionals
- Provide non-judgmental comprehensive treatment
- Provide encouragement to the clients, push for them to strive for more
- Have necessary resources to integrate the patient back in to the community

Final Thought



THANK YOU

QUESTIONS

Sunrise Treatment Center

Outpatient therapy including medical evaluation, individual and group counseling

Locations in West Side Cincinnati (Dent), Forest Park, Milford, Over-the-Rhine, Middletown, Dayton, Piqua, Florence KY, and offices opening soon in Springfield and West Union.

All full-time staff including Physicians, Nurse Practitioners, medication room nurses, and clinicians.

Offer services for Medicaid, Medicare, and most commercial insurances.