Mind Matters ECHO

Module: Substance Use

Session 2: Effective Treatments for Substance Use

January 11, 2023

Mount Sinai Health Partners

Welcome!

- Pre-survey: bit.ly/sudmeeting2
- Hub team introductions
- Disclosures
- Questions during presentations

Case Presentation

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Patient Information

Demographic Information	• 61 year old cis male • Medicaid • Lives alone
Main Area of Concern	• Patient has a history of psychosis and has been institutionalized in the past, cannot function in the community, is increasingly paranoid, hallucinating, and is physically debilitated due to multiple sclerosis
Medical History	• Multiple sclerosis, wheelchair bound as a result
Current Psychiatric Diagnoses	• Schizophrenia
Current Treatment Plan	• None
Substance Use	• No known current substance use • Past significant substance use (not corroborated)
Current Medications	• None
Previous Psychiatric Hospitalization	• Prolonged stay in a chronic care facility many years ago

Patient's Apartment

Patient Information

History of Trauma	• Unknown
Symptoms of Depression	• Lack of motivation • Feelings of hopelessness, helplessness, and/or guilt • Thoughts of suicide • Unclear if these symptoms reflect depressive disorder or are a result of psychosis, MS, and concomitant frailty
Symptoms of Anxiety/Panic	• Fear of losing control • Intrusive worrisome thoughts • Above symptoms may be due to psychosis
Other Psychiatric Symptoms	• Hallucinations, paranoia, feelings of persecution, battling with the devil, being told (by the devil, by his father) that he should kill himself
Suicidality	• Past passive ideation (thoughts without plan and/or intent)
Areas of Support and Consultation Being Sought	• Psychotherapeutic consultation • Identify appropriate behavioral health referrals, placement options

Effective Treatments for Substance Use

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Mount Sinai Health Partners

Didactic Presentation

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Learning objectives

- Understand the modalities for treatment of substance use disorders
- Learn the basic principles of non-pharmacological interventions
- Learn about the use of pharmacological agents to treat substance use disorders in the PCP's office

Approaches to treatment

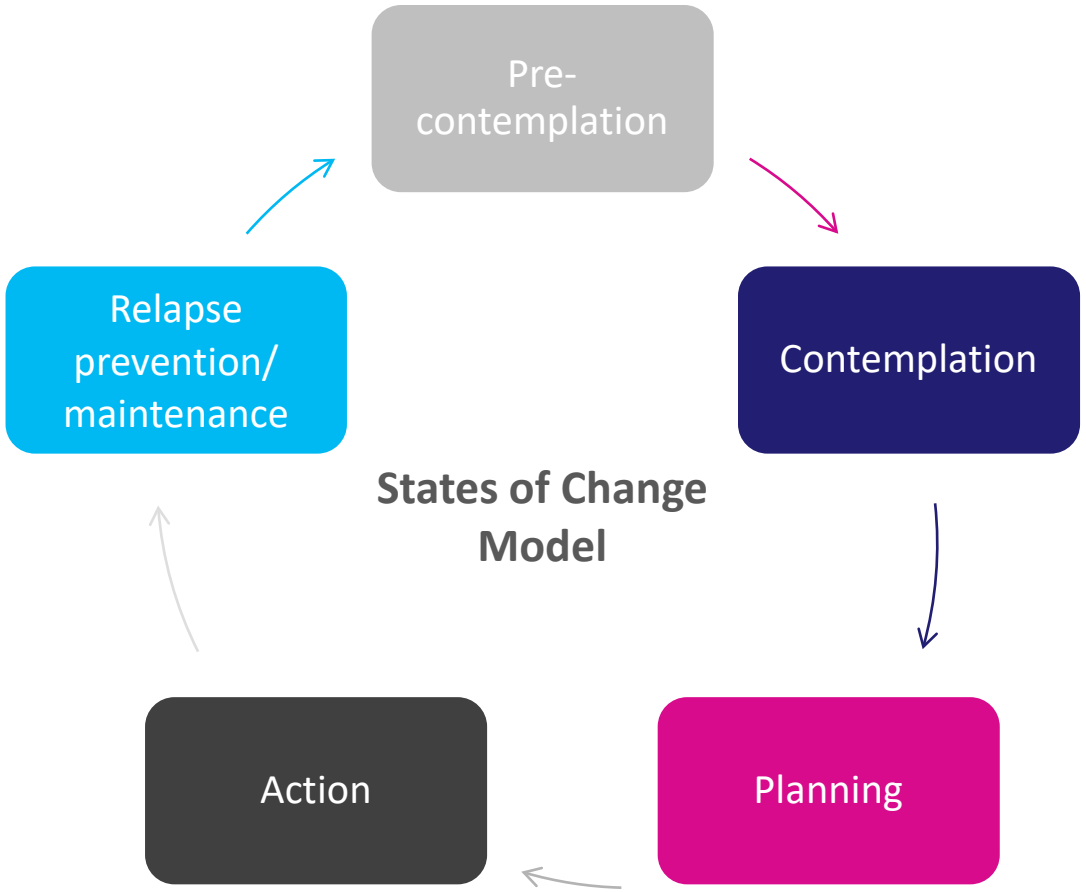
- **Non-pharmacologic treatments**
  - Promoting motivation and adherence
  - Skills to reduce or stop using
  - Skills to stay stopped (relapse prevention)
  - 12-step groups and facilitation (TSF)
  - **S**elf **M**anagement **A**nd **R**ecovery **T**raining
- **Pharmacological agents**
  - Agonists
  - Anti-craving drugs
  - Antagonists or blockers

Promoting motivation and adherence

- Utilize the Stages of Change Model
- Motivational interviewing
- Motivational enhancement therapy (MET)

Stages of change

- Pre-contemplation
- Contemplation
- Planning
- Action
- Relapse prevention/maintenance



Tips to cut down or stop

- Avoid exposure
- Avoid cues
- Prepare for and prevent response to cue

Relapse prevention

- Preventing the abstinence violation effect
- Identifying high-risk situations
- Highlighting tools to prevent use
- Reducing harm

12-step groups

- Concepts
- Common misconceptions
- Advantages
- Disadvantages
- Twelve-step facilitation (TSF)

SMART Recovery

- Uses CBT and MET
- Focus on 4-Point Programming
  - Building motivation
  - Coping with urges
  - Managing thoughts, feelings, and behaviors
  - Living a balanced life

Pharmacological Agents

Agonists	• Methadone • Buprenorphine
Antagonists	• Naltrexone • Disulfiram (aversive)
Anti-craving agents	• Acamprosate • Naltrexone for alcohol

Pharmacological options by drug class

Opiates

- Blocker: naltrexone
- Agonist: buprenorphine, methadone
- Anti-craving: both agonists

Alcohol

- Anti-craving: naltrexone, acamprosate
- Aversive/blocker: disulfiram (Antabuse)

Stimulants, hallucinogens, cannabinoids

- No FDA-approved agents

Naltrexone

- FDA approved for Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD)
- Pure mu opioid antagonist
- Modifies HPA axis to suppress ethanol consumption

Route	Brand Name	Dosage	Notes
Oral	Revia	50-100 mg daily	Significant first-pass metabolism
Depot injection	Vivitrol	380 mg deep IM every 4 weeks	Half life = 10-12 days

Naltrexone adverse effects

- Three-fold increase in ALT and AST in 20% of patients receiving IM form
- No other consistent side effects
- Some patients report a mild dysphoria or decreased experience of pleasure

Acamprosate

- NMDA antagonist effect
- Increases beta-endorphins
- May influence GABA transmission
- Purported mechanism is alleviating sub-syndromal protracted withdrawal

Disulfiram (Antabuse)

- Alcohol dehydrogenase II inhibitor
- Also inhibits dopamine beta-hydroxylase
- Allows accumulation of aldehydes
- Diaphoresis, nausea, headache, facial flushing, hypotension, tachycardia
  - Can occur UP TO 14 days after last dose
- Adverse effects
  - Common: headache, tiredness, metallic taste
  - Rare (1/1000): dermatitis, hepatitis, neuropathy

Buprenorphine

- Partial agonist or agonist – antagonist at mu receptor
- Very high affinity and very long receptor occupancy
- Ceiling agonist effect
- Safe in pregnancy

Methadone

- Nyswander and Dole 1966
- Long-acting, pure agonist
- Slow onset of action
- Long half life
- Extensive protein binding
- Analgesia is short lived: after 4-6 hours tolerance is built
- 70mg is considered an effective blocking dose

Opioid (methadone) treatment programs

- Uniquely regulated
- Must meet full criteria
- Gradual increase in dose and decrease in required attendance with “take homes”
- Buprenorphine is a far better option for most

Summary

- Numerous options exist both in the pharmacological and non-pharmacological realm
- Adherence to treatment is key and is a target of interventions
- Treatment should be matched to stage of change
- Non-pharmacological treatment takes as little time as pharmacological and is just as easy in the PCP's office
- **Combination of approaches is best**
- Assess stage of change and match accordingly

Summary (continued)

- Medication-assisted treatment (MAT) options are FDA approved only for Opioid Use Disorder (OUD) and Alcohol Use Disorder
- It is now the standard of care to offer MAT
- Methadone's analgesic effects are very short lived compared to its half life
- Medication agonist treatment for OUD has 2 options but buprenorphine is superior for almost all patients

THANK YOU!

ANY QUESTIONS?