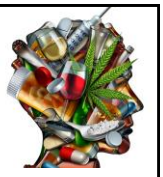
POMA
Substance Use Disorder Education Series
LIVE WEBINAR



Session II

"Impaired Physicians: Substance Use in the Workplace" – Ben Park, DO

"Addiction 101" – James Latronica, DO

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"Addiction 101" and Medications Used in the Treatment of Substance Use Disorders

James R. Latronica, DO, FASAM
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University of Pittsburgh School of Medicine
Associate Editor
Journal of Addictive Diseases

University of Pittsburgh UPMC

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Conflicts

- No financial conflicts of interest to disclose
- I will be mentioning the off-label use of medication
- I do not believe that carceral solutions are appropriate for any medical condition

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Learning Objectives

1. Review medications commonly used in the treatment of Substance Use Disorders (SUD)
2. Discuss the prevalence of SUD and the importance of treating SUD (e.g. epidemiology, complications, and emergencies/overdoses)
3. Discuss how both medical and criminal-legal system barriers reinforce inequality and under-treatment, and what physicians of all specialties can do to decrease these barriers (e.g. triggers, barriers, and compassionate care)

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Prevalence of SUD and the Importance of Treating SUD

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Substance Use ≠ Hazardous Use ≠ Use Disorder

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DSM-5 Named Substances

- Alcohol
- Caffeine
- Cannabis
- Hallucinogen
- Inhalant
- Opioid
- Other/Unknown → “atypicals”
- Sedative-Hypnotic
- Stimulant
- Tobacco

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SBIRT

- Screening
- Brief Intervention
- Referral to Treatment

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Screening Guidelines

- USPSTF
  - recommends universal screening for "unhealthy drug use" in adults age 18+ (Grade: B)
  - *does not* recommend screening in adolescents (Grade: I)
- NIAAA
  - screening for alcohol use starting at age 9
- AAP
  - Screen for alcohol and other substance use starting at age 12

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Screening Tools

- What's the best screening tool?

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Screening Tools

- CAGE
  - Short and simple
  - Not effective in adolescents (Knight, *et al.*)
- AUDIT
  - Developed by WHO in 1982
- POSIT
  - Designed by NIDA for ages 12-19
- CRAFFT
  - Specifically designed for adolescents

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Spectrum of Alcohol Use/AUD

NIAAA recs: Men < 4/d, 14/wk; Women < 3/d, 7/wk

	Drinking Pattern	AUD Criteria
Abstinent/Low Risk	< NIAA limits	None
At Risk Drinking	>NIAA daily limit, 1-7 days/wk	0-2
Harmful Drinking	Episodic to daily	0-2
Dependent Drinking	Daily or near daily (5-10 drinks daily)	3-5
Chronic Dependence	Daily or near daily (10+ drinks daily)	6-7

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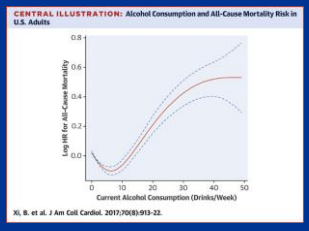
Why Are Those Numbers Important?



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Diagnosis: DSM IV-TR vs. DSM V

	DSM-IV Abuse[a]		DSM-IV Dependence[b]		DSM-5 Substance Use Disorders[c]	
Hazardous use	X	≥1 criterion	–		X	≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal[d]	–		X	≥3 criteria	X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

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DSM V Criteria (OUD—categorized)

TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	• Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids

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Social impairment	• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use • Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems • Reduced or given up important social, occupational, or recreational activities because of opioid use

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Risky use	• Opioid use in physically hazardous situations • Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use

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Pharmacological properties	• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect, diminished effect with continued use of the same amount • Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

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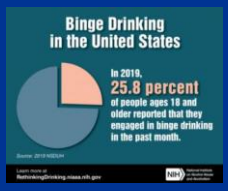
Epidemiology (AUD)



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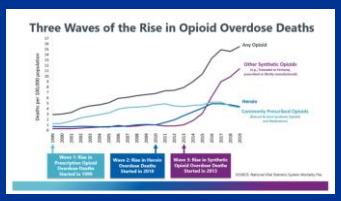
Epidemiology (OUD)

"Misuse" = 3.7%

OUD = 0.48%



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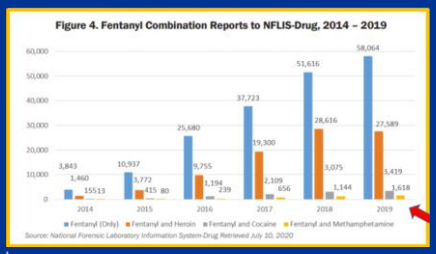
Epidemiology (OUD)



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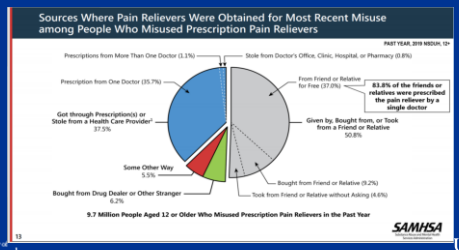
Epidemiology (OUD)



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Epidemiology (Comparison)

- Diabetes = 35 million (10.5%)
- Asthma = 25 million (7.6%)
- AUD = 14.5 million (4.4%)
- Opioid "Misuse" = 10.1 million (3.7%)
- Opioid Use Disorder = 1.6 million (0.48%)
- Rheumatoid Arthritis = ~1.5 million (0.45%)
- Breast Cancer = 13% lifetime risk in women

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Barriers: Triggers

- "Trigger" is a broad and vague term
  - May include imagery (even "negative")
  - Specific city blocks
  - Specific people
  - HALT: Hungry, Angry, Lonely, Tired
- Triggers are mainly an issue because treatment and understanding of SUD are so variable

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Barriers: Treatment

- OUD Treatment Rate = 24-30% [1]
  - ~50% of all inpatient drug and alcohol rehabilitation facilities in Pennsylvania offer MOUD
- AUD Treatment Rate = 7.3% [2]
  - Less than 4% of patients seeking treatment for AUD received MAUD
- Imagine if other chronic, treatable medical conditions had such a low treatment rate…

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Barriers: Treatment (OUD)

- OUD = only 3 FDA-approved meds, all with their own barriers
- **Methadone**: daily dosing at Opioid Treatment Program
  - 3 years of program compliance to get one week of "take homes" in PA
- **Buprenorphine**: requires DATA 2000 waiver via DEA
  - 900,000 practicing physicians → <90,000 w/ "X=waiver"
- **Naltrexone**: requires minimum 7 days (usually more) non-use/abstinence prior to induction
  - This was the plot of the terrible Mila Kunis movie "One Good Week"

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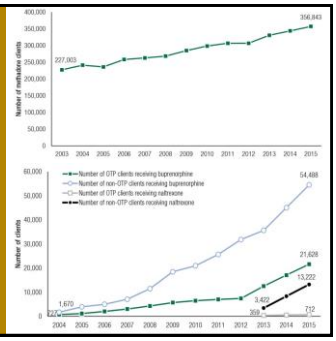
Barriers: Treatment (OUD)



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Barriers: Treatment (OUD)

- Pharmacy Level
  - Pharmacists can simply refuse to fill scripts due to "professional judgement" (this has personally happened to my patients more than once)
  - DEA conducts random audits
    - "Suspicious" amount of buprenorphine ("bupe") scripts trigger investigation
    - Operating on interdiction of "pill mills" paradigm
    - Some pharmacies will simply not carry it due to this burden
- "House of Medicine"
  - "We don't treat those patients"
  - Happened during my residency training

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Barriers: Treatment (AUD)

- AUD: barriers are slightly different
- Also only have 3 FDA-approved meds (several evidence-based "off-label" medications
- Barriers generally fall more into Societal/Criminal barriers (to follow) or simply lack of knowledge that there are effective medical treatments

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Barriers: Societal

- "Moral Failing" Paradigm
  - Has persisted since the United States has been a country
  - fMRI studies show definitive structural changes
- Specifically for Medications for Opioid Use Disorder (MOUD)
  - Seen as a "crutch" → "trading one addiction for another"
  - PA House Bill from 2019: limit prescribing bupe for one year without state approval
  - PA SB 675 (2020): additional fees and oversight for physicians prescribing MOUD
- Specifically for Medications for Alcohol Use Disorder (MAUD)
  - "Abstinence" is the only way to be "cured"
  - Slip-up/return to use = total failure = need to "hit rock bottom" again
  - 2021 *JAM* paper[3] shows "non-abstinent" recovery works

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Barriers: Criminal Legal

- United States contains 5% of the world's population and contains 20-25% of the world's entire incarcerated population
  - Most by gross and *per capita*
- MOUD is scattershot in carceral institutions
  - State prisons often notably better than county jails
  - Massachusetts DOH Study[4]: **6-month mortality 50x greater** for formerly-incarcerated people with OUD than without, after release
    - **120x higher** than general adult population

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Barriers: Criminal Legal

- "Revolving Door"
  - Parole requires non-use of substances
  - Addiction is defined as continued use despite negative consequences
- Many released from jail owe fees (including for "room and board"!)
  - Traps people in a cycle of poverty, bench warrants, and re-incarceration
- Criminalization/interdiction does not meaningfully affect the usage rates of any substances
  - Portugal Model: complete decriminalization; funds for policing/incarceration shifted to jobs training and public health

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Barriers: Criminal Legal

- "Fentanyl Panic"
  - Erroneous thought that "passive" fentanyl overdose can happen by touching fentanyl
  - American College of Medical Toxicology[5] explains this is untrue
  - Some departments won't have LEO carry Narcan due to fears
  - Huge, unnecessary expenditures on "biohazard" level equipment
    - Always more money for the carceral state

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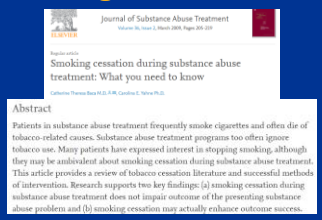
The "Forgotten Substance"


Journal of Substance Abuse Treatment

Smoking cessation during substance abuse treatment: What you need to know

Abstract

Patients in substance abuse treatment frequently smoke cigarettes and often die of tobacco-related causes. Substance abuse treatment programs too often ignore tobacco use. Many patients have expressed interest in stopping smoking, although they may be ambivalent about smoking cessation during substance abuse treatment. This article provides a review of tobacco cessation literature and successful methods of intervention. Research supports two key findings: (a) smoking cessation during substance abuse treatment does not impair outcome of the presenting substance abuse problem and (b) smoking cessation may actually enhance outcome success.

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In Closing

- Substance Use Disorders are chronic, treatable medical conditions that do not reflect morality
- Evidence-based medication and public health saves lives
- Every barrier that currently exists can be broken down
- Better things are possible, and we have to fight for them

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