Opioid Addiction Treatment ECHO
For Providers and Primary Care Teams at Neighborhood Health Centers of the Lehigh Valley

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Selected Co-Occurring Physical and Mental Health Disorders in patients with OUD

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NIH- NIDA-AFSP
  * Harm Reduction Counseling and Injectable Naltrexone in Homeless persons with Severe Alcohol Dep.
  * Preventing Addiction Related Suicide
  * PTSD Treatment in Persons with Severe Cannabis Dep
  * Contingency Management of Alcohol in Mentally Ill
  * Comparing CAMS to TAU after recent suicide attempts

Department of Defense
  * Suicide Prevention in Active Duty Soldiers

Abby Letcher has no conflicts of interest to disclose
Hepatitis C

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Learning Objectives

• Describe the epidemiology of HCV in the United States
• Interpret HCV testing
• Recognize the Importance of addressing HCV in the primary care setting
HCV Deaths and Deaths from Other Nationally Notifiable Infectious Diseases,* 2003-2013

* TB, HIV, Hepatitis B and 57 other infectious conditions reported to CDC
Hepatitis C Prevalence in the United States

- **NHANES (2003-2010)**
  - 3.6 million chronically infected (anti-HCV)
  - 2.7 million currently infected (82% of anti-HCV positive)
- **Populations not included in NHANES:**

<table>
<thead>
<tr>
<th>Population</th>
<th>Estimated Size</th>
<th>Prevalence (anti-HCV, %)</th>
<th>Number Chronically Infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incarcerated</td>
<td>2,186,230</td>
<td>23.1</td>
<td>505,350</td>
</tr>
<tr>
<td>Homeless</td>
<td>691,899</td>
<td>32.1</td>
<td>222,100</td>
</tr>
<tr>
<td>Hospitalized</td>
<td>478,054</td>
<td>15.6</td>
<td>74,576</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>1,446,959</td>
<td>4.5</td>
<td>65,113</td>
</tr>
<tr>
<td>Active-duty military</td>
<td>1,404,060</td>
<td>0.5</td>
<td>7,020</td>
</tr>
<tr>
<td>Indian reservations</td>
<td>1,069,411</td>
<td>11.5</td>
<td>123,224</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>997,384</strong></td>
</tr>
</tbody>
</table>

PREVALENCE OF HCV ANTIBODY, BY YEAR OF BIRTH

Reported Number of Acute Hepatitis C cases — United States, 2000–2015

Source: National Notifiable Diseases Surveillance System (NNDSS)
NHANES SURVEY, UNITED STATES, 2001-2008
NEED FOR SCREENING!

The Evolution of Highly Effective Treatment

- **IFN**: 6 mos
- **IFN/RBV**: 6 mos
- **IFN/RBV 12 mos**: 34%
- **PegIFN 12 mos**: 39%
- **PegIFN RBV 12 mos**: 55%
- **PegIFN/RBV/BOC or TPV 6-12 mos**: 70+
- **SMV**: 80+
- **SOF**: 89+
- **LDV/SOF >90**: 2011
- **PrOD >90**: 2013
- **DCV+ SOF >90**: 2014
- **EBR/ GZR >90**: 2016
- **SVR (%)**

- 1991: 6%
- 1998: 16%
- 2001: 42%
- 2011: 55%
- 2013: 70+
- 2014: 80+
- 2016: 89+
WHAT DO WE GET WITH HCV TREATMENT?

SVR (cure) of HCV is associated with:

• 70% Reduction of Liver Cancer
• 50% Reduction in All-cause Mortality
• 90% Reduction in Liver Failure

Lok A. NEJM 2012; Ghany M. Hepatol 2009; Van der Meer AJ. JAMA 2012
HEPATITIS C CASCADE OF CARE IN UNITED STATES

HCV Treatment in PWID

• Treatment of HCV in PWID has been very limited
  – Stigma
  – Drug use status as a criterion for treatment exclusion
  – Incarceration in prisons where treatment is limited
  – Concern for HCV reinfection

• Current AASLD/IDSA HCV Treatment Guidelines recommend HCV treatment for all persons including PWID

• PWID can be successfully treated for HCV on-site in an opioid treatment program rather than being referred

Mehta et al., 2008; Grebely, Oser, Taylor, & Dore, 2013; Oramasionwu, Moore, & Toliver, 2014; Wolfe et al., 2015; Butner, 2017.
Co-Occurring Psychiatric and Substance Use Disorder in OUD

Brant Hager MD, University of New Mexico
Richard Ries MD, University of Washington
Lifetime Prevalence of Psychiatric Disorders: General Population vs OUD

Lifetime Prevalence of Substance Use Disorders: General Population vs OUD

Psychiatric Disorders and Opioid Dependence Reciprocally Increase Risk

• Pre-existing psychiatric disorders:
  • Generalized anxiety disorder: 11x risk of developing opioid dependence
  • Bipolar I disorder: 10x risk of developing opioid dependence
  • Panic disorder: 7x risk of developing opioid dependence
  • Major depression: 5x risk of developing opioid dependence

• Pre-existing opioid dependence:
  • 9x risk of developing panic disorder
  • 5x risk of developing major depression
  • 5x risk of developing bipolar I disorder
  • 4x risk of developing generalized anxiety disorder

Martins et al 2009
Questions for Co-Occurring Disorders in Primary Care Settings

• Are psychiatric symptoms present only during substance use disorder?
  → Likely psychiatric disorder due to substance

• Are psychiatric symptoms present before substance use disorder, and/or during extended periods of sobriety?
  → Likely co-occurring psychiatric disorder

• Are psychiatric symptoms present before substance use disorder, and/or during extended periods of sobriety, as well as during substance use disorder?
  → Likely co-occurring psychiatric disorder, +/- psychiatric disorder due to substance
Co-Occurring Psychiatric Disorders: Treatment Goals

• Acute Phase: 1-3 months
  • Non-response: <25% reduction in symptoms
  • Partial response: 25-50% reduction in symptoms
  • Response: >50% reduction in symptoms
  • Remission: no symptoms, e.g. PHQ-9 <5

• Continuation Phase: 3-12 months
  • Prevent relapse: another episode within 6 months of remission

• Maintenance Phase: 1-3 years
  • Prevent recurrence: another episode after 6 months of remission

• Treatment Goal: Durable remission
Co-Occurring Depressive Disorders

• Co-occurring depressive disorders treatment in OUD
  • Positive RCTs in methadone MT: imipramine, doxepin
  • Negative RCTs in methadone MT: imipramine, doxepin, bupropion, sertraline, fluoxetine
  • No RCTs in buprenorphine MT

• Buprenorphine has empirical support as antidepressant outside OUD

• Lifetime major depression correlates positively with abstinence during buprenorphine MT for OUD

• Depressive symptoms in OUD
  • Buprenorphine and methadone MT equally improve depressive symptoms in patients with OUD – ~50% reduction
  • Naltrexone MT does not appear to worsen depressive sx
Co-Occurring Depressive Disorders: Treatment

• Recommend first stabilizing OUD on MT for ~6 weeks

• Depressive disorder remits?
  • Continue MT as treatment of OUD and depressive disorder

• Depressive disorder persists?
  • Treat depressive disorder per established guidelines
    • Measurement based care: track and respond to depression using serial PHQ-9s
    • Shared decision making and patient activation: educated patient chooses treatment
direction, team uses behavioral activation
    • Systematic follow up: team contacts patient proactively to address symptoms and
concerns
    • Stepped care: proactive treatment titration, consultation with behavioral health in
resistant illness
    • Treat to target: remission defined as PHQ-9 score <5

Co-Occurring Major Depression: Treatment

- Major Depressive Disorder
  - Psychotherapy, e.g.: IPT, CBT, Behavioral Activation
  - Medication
  - Psychotherapy plus medication
  - General treatment sequence: Psychotherapy → SSRI → SNRI → Bupropion → Mirtazapine → TCA → rTMS → ECT → MAOI

Huhn et al 2014, Rush et al 2006
Co-Occurring Anxiety Disorders: Treatment

• Panic Disorder
  • Psychotherapy
  • Medication
  • General treatment sequence: Psychotherapy → SSRI → SNRI → Imipramine

• Social Phobia
  • Psychotherapy
  • Medication
  • General treatment sequence: Psychotherapy → SSRI → SNRI

Huhn et al 2014, Abrahamsson et al 2017
Co-Occurring Anxiety Disorders: Treatment

• Generalized Anxiety Disorder
  • Psychotherapy
  • Medication
    • Pregabalin
    • Hydroxyzine
    • SNRI or SSRI
    • Buspirone
  • General treatment sequence: Psychotherapy → Hydroxyzine → SNRI → SSRI → Pregabalin → Buspirone

• Avoid benzos in MT: 2x risk of all-cause mortality
• Caution pregabalin in MT: 3x risk of overdose death

Co-Occurring PTSD: Treatment

- Psychotherapy, e.g.: CBT, PE, EMDR, SS
  - Positive RCT of PE for PTSD in methadone MT
  - CBT for PTSD in buprenorphine MT reduces positive urines

- Medication
  - Prazosin reduces nightmares and hyper-arousal assoc w PTSD
  - Note: prazosin only studied as augmentation of other PTSD treatment

- General treatment sequence: Psychotherapy → SSRI → SNRI → Prazosin Augmentation → TCA

Insomnia

• Reported in up to 21% of patients on buprenorphine MT
  • Central sleep apnea demonstrated in 33%
  • Nocturnal hypoxemia demonstrated in 39%
  • No RCTs examining insomnia treatment in buprenorphine MT

• Reported in up to 84% of patients on methadone MT
  • Central sleep apnea in up to 60%
  • Positive RCTs of insomnia treatment in methadone MT
    • Cognitive behavioral therapy for insomnia (CBTI)
    • Suan Zao Ren Tang (sour jujube concoction) *GABA-ergic
    • Acupuncture
  • Negative RCTs of insomnia treatment in methadone MT
    • Trazodone

*Robabeh et al 2015, Farney et al 2013; Chan et al 2015; Li et al 2012*
Insomnia: Treatment

• Assess for sleep disordered breathing and treat!

• Psychotherapy
  • CBT-I: stimulus control, sleep restriction, sleep hygiene, relaxation, cognitive restructuring

• General treatment sequence: Psychotherapy → Doxepin → Ramelteon → Trazodone → Melatonin

• Caution z-drugs with opioids: 1.6x risk of overdose death

Summary

• Psychiatric disorders strikingly common in OUD
• Psychiatric disorders and OUD reciprocally increase risk
• Limited direct literature on psychiatric disorders treatment in OUD or MT
• Stabilize OUD with MT
• Psychotherapy first line in major depression, anxiety disorders, PTSD, and insomnia
• Medication first line in dysthymia
• Caution pregabalin, z-drugs
• Avoid benzos
Questions?
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