Substance Use Disorders in People Living with HIV

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Division of Infectious Diseases
Vanderbilt University Medical Center
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I have no disclosures.
Learning Objectives

Participants will be able to:

• Discuss the scope of the current opioid crisis
• Define addiction and substance use disorder (SUD)
• List infectious diseases complications of injection drug use
• Discuss rates of SUD among PLWH and impact on HIV treatment outcomes
• Discuss the chronic disease model of addiction
• Explain the role of medication-assisted treatment in addiction treatment
• Describe the rationale for new, systematic approaches to the clinical management of substance use disorders
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Drug Overdose Is the Leading Cause of Accidental Death in the United States

https://www.statista.com/chart/6805/drugs-are-killing-more-americans-than-road-crashes
2019 Drug Overdose Death Rates (per 100,000 people)

Drugs Involved in U.S. Overdose Deaths
1999 to 2017

Three Waves of the Rise in Opioid Overdose Deaths

- **Wave 1:** Rise in Prescription Opioid Overdose Deaths
- **Wave 2:** Rise in Heroin Overdose Deaths
- **Wave 3:** Rise in Synthetic Opioid Overdose Deaths

CDC: https://www.cdc.gov/drugoverdose/epidemic/index.html
Two Milligrams of Fentanyl...a Potentially Lethal Dose
2012: Healthcare Providers Wrote 259 MILLION Prescriptions for Opioid Medications

State of Tennessee: 96-143 opioid prescriptions per 100 people

CDC Vital Signs, July 2014. cdc.gov/vitalsigns
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Spectrum of Substance Use

- Abstainers
- Low Risk
- High Risk
- Hazardous
- Harmful
- Mild
- Moderate
- Severe
- Co-occurring

Aberrant drug-taking behaviors
Non-medical use
What is Addiction?

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

SMART Recovery:
“Maladaptive behaviors with physiological underpinnings.”
What is Addiction?

DSMV Diagnostic Criteria

- Mild OUD: 2-3 items co-occurring in a 12 month period
- Moderate OUD: 4-5 items co-occurring in a 12 month period
- Severe OUD: 6 or more items co-occurring in a 12 month period

Table 1. Diagnostic Criteria for an Opioid-Use Disorder. *

| Use of an opioid in increased amounts or longer than intended |
| Persistent wish or unsuccessful effort to cut down or control opioid use |
| Excessive time spent to obtain, use, or recover from opioid use |
| Strong desire or urge to use an opioid |
| Interference of opioid use with important obligations |
| Continued opioid use despite resulting interpersonal problems, social problems (e.g., interference with work), or both |
| Elimination or reduction of important activities because of opioid use |
| Use of an opioid in physically hazardous situations (e.g., while driving) |
| Continued opioid use despite resulting physical problems, psychological problems, or both |
| Need for increased doses of an opioid for effects, diminished effect per dose, or both† |
| Withdrawal when dose of an opioid is decreased, use of drug to relieve withdrawal, or both† |

What is Addiction?

**DSMV  Substance-Related and Addictive Disorders**

*Ten classes of substances included*

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens
- Phencyclidine
- Inhalants
- Opioids
- Sedatives/Hypnotics/Anxiolytics
- Stimulants
- Tobacco
Key Features of Addiction

### Loss of Control
- Inability (or persistent desire) to stop or reduce substance use

### Cravings
- Strong psychological urge to use

### Consequences
- Continued use despite knowledge of physical, psychological, and social consequences
What is Addiction?

Addiction is a chronic brain disease that can be effectively prevented and treated.
Heritability of Substance Dependence

Estimated genetic heritable risk from twin studies:
• Hypertension: 0.25 – 0.50
• Type I Diabetes: 0.30 – 0.50
• Type II Diabetes: 0.80
• Asthma: 0.36 – 0.70
• Substance Dependence:
  • 0.34 for heroin addicted males
  • 0.55 for alcohol addicted males
  • 0.52 for marijuana addicted females

Drug Dependence, a Chronic Medical Illness
Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O’Brien, MD, PhD
Herbert D. Kleber, MD

Many expensive and disturbing social problems can be traced directly to drug dependence. Recent studies estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems. These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.
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People Who Inject Drugs (PWID) are at high risk for:

- Bacterial, viral, and fungal infections
  - Skin and soft tissue infections (SSTI)
  - Infectious endocarditis
  - Bone and joint infections
  - Viral hepatitides (hepatitis A, B and C)
  - HIV
### OUD and Infectious Diseases: Serious Infections

#### National estimates of hospitalizations related to OUD and associated infections 2002 and 2012

<table>
<thead>
<tr>
<th></th>
<th>2002 (N = 36,523,831)</th>
<th>2012 (N = 36,484,846)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>OUD/dependence</td>
<td>301,707</td>
<td>520,275 **</td>
</tr>
<tr>
<td>OUD/dependence with infection #</td>
<td>3,421</td>
<td>6,535 **</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>2,077</td>
<td>3,035 *</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>458</td>
<td>985 **</td>
</tr>
<tr>
<td>Septic arthritis</td>
<td>729</td>
<td>1,940 **</td>
</tr>
<tr>
<td>Epidural abscess</td>
<td>411</td>
<td>1,085 **</td>
</tr>
</tbody>
</table>

#Infection: endocarditis, osteomyelitis, septic arthritis, or epidural abscess

* *p < 0.01
** *p < 0.001

OUD and Infectious Diseases: Infective Endocarditis

Incidence of SUD-associated infective endocarditis
Hepatitis C virus (HCV) is the most common infection transmitted through drug injection, and a large proportion of new HCV infections are associated with injection-drug use.

In the United States, the annual incidence rate of acute HCV infection increased more than 2-fold from 2004 to 2014.

Largest increase in cases among those aged 30-39 years, consistent with age groups most impacted by the nation’s opioid crisis.

Among the reported cases with injection drug use (IDU) information available, 72% report IDU.

Of reported acute cases of HCV, IDU is most common risk/exposure identified.
OUD and Infectious Diseases: Hepatitis C Virus

Number of reported acute hepatitis C cases and estimated infections in the United States 2011 - 2018

CDC: National Notifiable Diseases Surveillance System
OUD and Infectious Diseases: HIV

• HIV incidence and IDU illustrate concomitant other high risk behaviors of people who inject drugs
  • Multiple sex partners, unprotected sex, transactional sex

• 10% of new HIV diagnoses in the U.S. are attributed to IDU or MSM and IDU (in men who report both risk factors)

• In 2016, IDU with opioids responsible for clustered HIV outbreaks in Indiana and Massachusetts

• Sharing syringes is second riskiest behavior for HIV transmission (MSM is the first)
OUD and Vaccine-Preventable Infectious Diseases

Hepatitis A Virus:

- HAV outbreak present in Tennessee since 12/1/2017
- As of 5/8/2020:
  - 3036 cases of acute HAV diagnosed
  - 1839 hospitalizations (61%)
  - 28 deaths

Reported HAV Cases 12/1/2017 – 12/11/2020

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SUD Among PLWH

<table>
<thead>
<tr>
<th>Past year DSM-V dependence</th>
<th>Unadjusted OR (95% CI) (HIV+ vs HIV-)</th>
<th>Adjusted OR* (95% CI) (HIV+ vs HIV-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>1.86 (1.10, 3.12)</td>
<td>1.17 (0.69, 1.99)</td>
</tr>
<tr>
<td>Marijuana</td>
<td>3.12 (1.80, 5.41)</td>
<td>2.31 (1.32, 4.06)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>14.00 (7.88, 24.86)</td>
<td>6.01 (3.22, 11.21)</td>
</tr>
<tr>
<td>Heroin</td>
<td>11.02 (2.97, 40.91)</td>
<td>5.19 (1.39, 19.31)</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>6.23 (2.09, 19.17)</td>
<td>5.74 (1.84, 17.94)</td>
</tr>
<tr>
<td>Any illicit drug</td>
<td>6.14 (4.16, 9.07)</td>
<td>4.34 (2.87, 6.57)</td>
</tr>
</tbody>
</table>

*Adjusted for sex, age, race/ethnicity, education, total family income, marital status. Analysis of National Survey on Drug Use and Health (NSDUH) data, 2005-2014.

- **Substance use: is a barrier to optimal engagement in the HIV care continuum, may increase likelihood of risk-taking behaviors, and potential for drug-drug interactions**

Shiau et al., Patterns of Drug Use and HIV Among Adults in a Nationally Representative Sample. Addictive Behaviors 2017; 68: 39-44.
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Spectrum of Substance Use

- Pre-diagnostic Substances Use Disorders
  - Aberrant drug-taking behaviors
  - Non-medical use

- Co-occurring substance use disorders
  - Severe

Risk Levels:
- Abstainers
- Low Risk
- High Risk
- Hazardous
- Harmful
- Mild
- Moderate
Neuroscience of Addiction

- **Positive reinforcement** leads to initial repeated use
- Decreased function of brain reward systems that normally mediate natural rewards

- **Negative reinforcement** involves avoidance of withdrawal syndromes
- Recruitment of brain stress/anti-reward systems that drive adverse states

Positive and Negative Reinforcement

How Does Neurobiology Impact Medication Prescribing for Treatment of Addiction?

• Target reward pathways
  • Blocking agents (naltrexone)
  • Opioid agonists (methadone and buprenorphine)
  • Disulfiram (Antabuse)
  • Treat underlying “reward system disruption” i.e. major depression

• Target stress pathways
  • Decrease withdrawal symptoms
    • Opioid agonist treatment for OUD
    • GABA modulators for AUD like benzodiazepines acutely and gabapentin/acamprosate/topiramate
  • Treat underlying comorbid anxiety and other disorders

• Target executive function pathways
  • Treat comorbid ADHD, bipolar disorder, etc.
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# Evidence Based Treatments for SUD

<table>
<thead>
<tr>
<th>Non-pharmacologic</th>
<th>Pharmacologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivational Enhancement Therapy</td>
<td>Treat withdrawal</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>Medications for Addiction Treatment (MAT)</td>
</tr>
<tr>
<td>Community Reinforcement</td>
<td>Treat co-occurring illness</td>
</tr>
<tr>
<td>Contingency Management</td>
<td></td>
</tr>
<tr>
<td>12-Step Facilitation</td>
<td></td>
</tr>
<tr>
<td>Some family therapies</td>
<td></td>
</tr>
</tbody>
</table>
Various Treatments Work for Relapse Prevention

- Psychosocial Treatments
- Medication for Addiction Treatment (MAT)

- Stimulant use disorder
- Cannabis use disorder

- Opioid use disorder
- Nicotine use disorder

- Alcohol use disorder


# Medication for Opioid Use Disorder (MOUD)

<table>
<thead>
<tr>
<th></th>
<th>Methadone</th>
<th>Buprenorphine (Oral)</th>
<th>Naltrexone (IM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mechanism of Action</strong></td>
<td>Full Agonist on Opioid Receptor</td>
<td>Partial Agonist on Opioid Receptor</td>
<td>Antagonist on Opioid Receptor</td>
</tr>
<tr>
<td><strong>Dosing</strong></td>
<td>80mg-100mg (Usual Dose)</td>
<td>4-32mg</td>
<td>380mg Depot Injection</td>
</tr>
</tbody>
</table>
| **Advantages**          | ▪ Provided in a highly structured supervised setting where additional services can be provided on-site and diversion is unlikely  
                          | ▪ Maybe effective for individuals who have not benefited sufficiently from partial agonists or antagonists | ▪ Improved safety due to partial agonism  
                          | ▪ Availability in office-based settings | ▪ No addictive potential or diversion risk  
                          |                                               | ▪ Available in office-based settings  
                          |                                               | ▪ Option for individuals seeking to avoid any opioids |

Major Features of Buprenorphine

- **Partial agonist** at mu receptor (semi-synthetic analog of thebaine)
  - Comparatively minimal respiratory suppression and no respiratory arrest when used alone
- **Long acting**
  - Half-life ~ 24-36 hours
- **High affinity** for mu receptor
  - Blocks and displaces other opioids; but can be overcome
- **Slow dissociation** from mu receptor
Major Features of Buprenorphine

Treatment retention with buprenorphine vs. placebo with intensive psychosocial support

4/20 subjects dead in placebo group by end of the study

Major Features of Buprenorphine

Treatment retention with buprenorphine vs. methadone with intensive psychosocial support

Duration of Buprenorphine Treatment

Continuous group had 14% fewer ED visits and 18% fewer admissions than those discontinuing at 3-5 months.

Proportion of days when buprenorphine was taken.
Duration of Buprenorphine Treatment

- Treatment Retention (% of patients)
- Weeks since starting treatment

Duration of Buprenorphine Treatment

Evidence is variable.

• Studies as long as 16 weeks show high relapse rates with medication withdrawal
• Improved retention rates in treatment with extended buprenorphine maintenance

Continue maintenance as long as patient is benefitting from treatment (decreased substance use; meeting employment, educational, relationship goals).

• Note: provider can have discussions regarding reduction in dose with improving stability or patient preference however, caution patients about discontinuing medication too early in treatment

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What are the resources do persons with substance use disorder need for successful recovery?
Destigmatizing Substance Use Disorders

Addiction is a chronic brain disease that is preventable and treatable

- **Prevention**: Routine assessment and early intervention when risk factors present
- **Treatment**: Medical therapies, management of co-occurring diseases, lifestyle modification, and social support
## Destigmatizing Substance Use Disorders

### Language matters

<table>
<thead>
<tr>
<th>Commonly Used Term</th>
<th>Preferred Term</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict, abuser, etc.</td>
<td>Person with a substance use disorder</td>
<td>• Focuses on respect, dignity and primacy of personhood</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Substance use disorder</td>
<td>• Avoids implication of willful misconduct</td>
</tr>
<tr>
<td>Opioid substitution therapy/replacement therapy</td>
<td>Opioid agonist therapy</td>
<td>• Shift emphasis to chronic disease model</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoids implication of “switching addiction”</td>
</tr>
<tr>
<td>Clean</td>
<td>Sober/abstinent</td>
<td>• Avoids value-laden, non-clinical terminology</td>
</tr>
<tr>
<td>Dirty or clean urine</td>
<td>Positive or negative urine drug screen</td>
<td>• Avoids value-laden, non-clinical terminology</td>
</tr>
</tbody>
</table>

Brezing and Marcovitz, 2015. [https://www.recoveryanswers.org/addiction-ary/](https://www.recoveryanswers.org/addiction-ary/)
Bio-psycho-social Approach to Addiction Treatment

**Medication**
- Control cravings (block negative reinforcement)
- Prevent relapse (block positive reinforcement)
Bio-psycho-social Approach to Addiction Treatment

**Medication**
- Control cravings (block negative reinforcement)
- Prevent relapse (block positive reinforcement)

**Community Supports**
- Peer support meetings
- Sober social networks
- Family supports
Bio-psycho-social Approach to Addiction Treatment

**Medication**
- Control cravings (block negative reinforcement)
- Prevent relapse (block positive reinforcement)

**Community Supports**
- Peer support meetings
- Sober social networks
- Family supports

**Counseling**
- Learn about addiction and recovery
- Relapse prevention skills
- Treatment of psychiatric co-morbidities
Bio-psycho-social Approach to Addiction Treatment

Co-occurring psychiatric disorders

- SUD and mental illness: 7.9 million
- Mental illness, no SUD: 35.6 million
- SUD, no mental illness: 12.3 million

20.2 million adults had SUD
43.6 million adults had mental illness

SAMHSA 2017
“Traditional” Model of SUD Care

Acute Care → Inpatient Care → Outpatient Care → Community Based Care

High risk of fractured care at multiple transition points
Patient admitted with cellulitis due to injection drug use

Medical team pages Psychiatry Consult Liaison service

Consult service develops inpatient management plan. Patient referred to outpatient SUD treatment program.

Patient presents to the ED a week later with heart failure and fever

No appt made, PCP/health center not involved, patient does not follow through

Patient given phone numbers of other programs to call

Transportation, financial issues interfere

Discharge
Patient admitted with cellulitis due to injection drug use

Prevent readmit, M/M

Community Partners / Educated PCPs

Recovery (Peer) Coaches

Low Threshold Bridge Clinic

Dedicated addiction team

Expert social worker

Interrupting the “Traditional” Model of SUD Care
Addiction Consult Services: care, connect, coordinate

"It’s been an Experience, a Life Learning Experience": A Qualitative Study of Hospitalized Patients with Substance Use Disorders

Christine M. Velez, MSW1,2, Christina Nicolaidis, MD, MPH2,3, P. Todd Korthuis, MD, MPH3, and Honora Englander, MD1,4

1Clinical Integration, Oregon Health & Science University, Portland, OR, USA; 2School of Social Work, Portland State University, Portland, OR, USA; 3Division of General Internal Medicine, Oregon Health & Science University, Portland, OR, USA; 4Division of Hospital Medicine, Oregon Health & Science University, Portland, OR, USA.

BACKGROUND: Individuals with substance use disorders (SUD) have high rates of chronic illness and readmission, yet few are engaged in addiction treatment. Hospitalization may be a reachable moment for initiating and coordinating addiction care, but little is known about motivation for change in the inpatient setting.

OBJECTIVE: To explore the experiences of hospitalized adults with SUD and to better understand patient and system level factors impacting readiness for change.

INTRODUCTION

Individuals with substance use disorders (SUD) have high rates of chronic illness, hospitalization, and readmission.1-5 Despite frequent contact with healthcare systems, many people are not engaged in addiction treatment.6-8 This study addresses gaps in our knowledge.
Addiction Consult Services: care, connect, coordinate

Inpatient Addiction Consultation for Hospitalized Patients Increases Post-Discharge Abstinence and Reduces Addiction Severity

Sarah E. Wakeman, MD1,2, Joshua P. Metlay, MD, PhD1,2, Yuchiao Chang, PhD1,2, Grace E. Herman, BA1, and Nancy A. Rigotti, MD1,2

1Division of General Internal Medicine, Massachusetts General Hospital, Boston, MA, USA; 2Harvard Medical School, Boston, of Psychiatry, Massachusetts General Hospital, Boston, MA, USA.

BACKGROUND: Alcohol and drug use results in substantial morbidity, mortality, and cost. Individuals with alcohol and drug use disorders are overrepresented in general medical settings. Hospital-based interventions offer an opportunity to engage with a vulnerable population that may not otherwise seek treatment.

OBJECTIVE: To determine whether inpatient addiction consultation improves substance use outcomes 1 month after discharge.

DESIGN: Prospective quasi-experimental evaluation comparing 30-day post-discharge outcomes between participants who were and were not seen by an addiction consult team during hospitalization at an urban academic hospital.

PARTICIPANTS: Three hundred ninety-nine hospitalized adults who screened as high risk for having an alcohol or drug use disorder.

INTRODUCTION

B Background:

Substance use disorders (SUDs) are common medical conditions that affect up to 20% of the US population and are associated with significant morbidity and mortality (Hedrick et al, 2010). Treatment for SUDs, including medications, is often underutilized in hospital settings (Robertson et al, 2015). However, hospital-based interventions can improve substance use outcomes (DeRubeis et al, 2017).

METHODS: We conducted a prospective quasi-experimental evaluation comparing 30-day post-discharge outcomes between participants who were and were not seen by an addiction consult team during hospitalization at an urban academic hospital. Participants were recruited from the emergency department or hospital admission, and those with alcohol or drug use disorders were eligible for the study. The intervention involved consultation with a trained addiction consultant who provided education, referral to treatment resources, and follow-up care. The control group received routine care. Outcome measures included abstinence from alcohol or drugs, as well as return visits or readmissions related to SUDs. Statistical analysis involved multivariable logistic regression to adjust for confounders.

RESULTS: Among the 399 participants, those who received consultation were more likely to achieve abstinence and had lower rates of return visits or readmissions related to SUDs compared to those who did not receive consultation. The intervention was particularly effective among patients with co-occurring psychiatric disorders.

CONCLUSIONS: In a non-randomized study, inpatient addiction consultation was significantly associated with improved substance use outcomes 1 month after discharge. Future research should focus on developing strategies to increase the reach and effectiveness of hospital-based interventions for SUDs.

Vanderbilt Model: VISTA

• mid 17th century: from Italian, literally ‘view’, from visto ‘seen’, past participle of vedere ‘see’, from Latin videre.

1. a pleasing view, especially one seen through a long, narrow opening

2. Vanderbilt Integrated Services for the Treatment of Addiction

<table>
<thead>
<tr>
<th>Emergency Department and Psych ED</th>
<th>Addiction Consult Service</th>
<th>Bridge Clinic</th>
<th>Outpatient Addiction Clinic</th>
<th>Inpatient Dual Unit</th>
<th>IOP</th>
<th>ECHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine-waivered physicians and SUD-focused social worker can triage patients with SUD in the ED and provide assessment, MAT initiation and referral.</td>
<td>Dedicated consultation service within Vanderbilt University Hospital (general hospital) to evaluate, assess, manage and refer any patient with SUD in adult hospital</td>
<td>Three-month multi-specialty outpatient transitional clinic to stabilize appropriate patients with SUD discharging from Vanderbilt Adult Hospital and ED/Psych ED</td>
<td>Outpatient services ranging from MAT and psychiatric care to counseling, case management, group, family and individual therapy. Clinic will eventually have capacity to receive a steady flow of patients from within our system</td>
<td>Inpatient team including psychiatrist, social worker and additional staff providing stabilization, evaluation and management services on a contained unit to complex patients with SUD and co-occurring psychiatric issues</td>
<td>Professional clinic team offering multiple extended outpatient group therapy and psychoeducation visits per week for patients with SUD and co-occurring psychiatric issues</td>
<td>Tele-education platform leveraging the expertise of VUMC faculty to assist statewide efforts to expand addiction treatment capacity</td>
</tr>
</tbody>
</table>
Vanderbilt Bridge Clinic Clinical Services

Psychiatry assessment/follow-up for co-occurring diagnoses

- MOUD
- Psychosocial assessment
- Behavioral interventions
- Recovery Coaching
- Screening for hepatitis, HIV
- Vaccination for HAV/HBV
- Case management
- Social work support

Pain Medicine Consultation for management of acute and chronic pain conditions

ID care for treatment of acute infection; initiation of HCV treatment

Primary Care for post-acute medical issues and linkage to care*

*Referral for Women’s Health Services when needed
The Treatment Team: Wrap-Around Support

• Primary providers
  • Addiction Psychiatry, Internal Medicine, ID, Pain Management
• Intensive Case Management
• Social Work/Brief Interventions
• Peer Recovery Coaches

• Warm handovers at each transition in care
• Encourage patients to engage in recovery community
What is a Certified Peer Recovery Specialist?

A Certified Peer Recovery Specialist (CPRS) is someone who has self-identified as being in recovery from mental illness, substance abuse, or co-occurring disorders of both mental illness and substance use disorder. To become certified, a CPRS has completed specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to provide peer recovery services based on the principles of recovery and resiliency.

Certified Peer Recovery Specialists can provide support to others with mental illness, substance abuse, or co-occurring disorder and help them achieve their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment inherent in self-directed recovery.
The Treatment Team: Wrap-Around Support

Southeastern states with Peer Recovery Specialist certification programs
Working with Patients in the Outpatient Setting

“…immediate abstinence may not be a realistic goal for patients early in treatment.”

“In the event that a patient’s self-reported substance use differs from the results of a drug test, the provider should use the discrepancy as a springboard for therapeutic discussions.”

2017 ASAM Consensus Statement
Working with Patients in the Outpatient Setting

ASAM Levels of Care

Cyclical Reassessment

Figure 30.1. Individualized, outcome-driven treatment.
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All of our patients