OPIOID USE DISORDER AND THE PSYCHIATRIC EMERGENCY ROOM—THE VA CT MODEL

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I have no conflicts of interest or relevant financial disclosures.
LEARNING OBJECTIVES

- To appreciate the magnitude of the opioid use disorder problem
- To understand various levels of care, using VA Connecticut as a model
- To understand the triaging of patients with opioid use disorders
- To understand the initiation of buprenorphine in a psychiatric emergency room setting
HEADLINES

- “Panel approves anti-overdose legislation” – CT Post
- “Heroin-related overdose deaths soar in CT” – Hartford Courant
- “Opioid overdoses spiked again last year” – WTNH Conn News
- “Summit held in New London to address heroin epidemic” – Fox 61 News
- “Rep. Courtney seeking emergency money to fight opioid addiction, overdoses” – CT Mirror
- “Pharmacists working to combat opioid overdose” – Uconn Today
- “Drug overdoses keep rising in CT” – CT Post
- “As opioid epidemic grows, Senator Murphy calls for improved access to buprenorphine treatment” – Stratford Star
- “Senator Blumenthal issues ‘Call to Action’ on opioid addiction” – CT post
OPIOID USE DISORDER

- Every day in the US, 44 people die as a result of prescription opioid overdose
- Drug overdose was the leading cause of injury death in 2013 (more than car accidents)
- 51.8% of overdose deaths involved opioids, 30.6% involved benzos
- In 2011, nearly 1 million ED visits were related to benzo and/or opioid misuse
- In 2013, nearly 2 million Americans either abused or were dependent on opioids
- In 2007, prescription opioid abuse costs were $55.7B

http://www.cdc.gov/drugoverdose/
OPIOID USE DISORDER

- 581 males who met criteria for opioid use disorder were followed for 33 years (mean age 25.4 years)
- By 33 years (mean age 58.4 years), 49% had died, 6% incarcerated, 13% continued to use opioids, 23% were abstinent.
- Common causes of death: Homicide/suicide/accident, accidental overdose, chronic liver disease, cancer, heart disease
- Majority of deaths directly attributable to opioids

OPIOID USE DISORDER

“A key driver of the overdose epidemic is underlying substance-use disorder. Consequently, expanding access to addiction-treatment services is an essential component of a comprehensive response.”

OPIOID USE DISORDER

“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.”

VA CONNECTICUT RESOURCES

- Psychiatric emergency room
- Inpatient Services
  - Inpatient psychiatric unit
  - Contracted detox facility
  - Detox service (ambulatory and inpatient)
  - Local inpatient substance abuse treatment facility
- Outpatient Services
  - Substance abuse day program (PHP)
  - Opioid treatment program (Methadone)
  - Buprenorphine clinic
  - Buprenorphine in primary care
  - Outpatient substance abuse clinic
  - Auricular acupuncture
  - Various groups and therapy options
- AA/NA treatment referral
PSYCHIATRIC EMERGENCY ROOM

- Dedicated and locked unit, 24/7/365
- One of only several nationally at a VA
- 10 beds with ability for extended observation, if necessary
- Patients may present voluntarily or involuntarily
- Most patients are observed overnight while disposition is being considered
- Patients occasionally spend more than one night in the PER when clinically appropriate
- Staffed by >30 MDs, all of whom required to have a buprenorphine waiver
Buprenorphine

- Schedule 3, semi-synthetic opioid, partial agonist at mu-opioid receptor
- Available with or without naloxone
- Partial agonism creates ceiling effect for respiratory depression
- Generally once per day dosing
- Binds to the opioid receptor with high affinity
BUPRENORPHINE

- **Induction Phase**
  - Assess last use of which opioid and how much
  - Assess symptoms of withdrawal using COWS or other scale (COWS > 8)
  - Do not dose with buprenorphine until withdrawal symptoms are present
  - Once present, dose 2mg-4mg once then reassess in 1 hour
  - Ok to redose, not to exceed 8mg on day 1
  - Do not exceed 16mg on day 2, which is usually sufficient
  - Decide whether to maintain or taper/detox
Buprenorphine

- Eighty-nine of 114 patients (78%; 95% CI, 70%-85%) in the buprenorphine group were engaged in treatment at significantly higher rates than the 38 of 102 patients (37%; 95% CI, 28%-47%) in the referral group or 50 of 111 patients (45%; 95% CI, 36%-54%) in the brief intervention group ($P < .001$).

LEVELS OF CARE

- Hold in psych ER
- Admit to the VA inpatient/detox service
- Transfer to contracted detox bed
- Refer to inpatient substance abuse treatment
- Refer to substance abuse day program
- Refer to opioid treatment program
- Refer to ambulatory detox team
- Refer to buprenorphine clinic
- Refer to outpatient clinic
- Refer to 90 in 90, sponsor, step work
25yo veteran presents to the PER seeking assistance with opioid use and sleep. He has no significant history of psychiatric or substance abuse treatment. Pt reports that 6 months ago he was prescribed an opioid for a shoulder injury. He realized that he started using the opioids to help him sleep and to get high. He started buying oxycodone on the street when he could no longer obtain prescriptions. He recently tried snorting though has never injected. He is currently using 1-2 times per week as that is all he can afford. He drinks alcohol occasionally. He wants to stop using opioids and is help-seeking.
LEVELS OF CARE

- Hold in psych ER
- Admit to the VA inpatient service
- Transfer to contracted detox bed
- Refer to inpatient substance abuse treatment
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CASE #2

40yo male presents to the PER at the request of the buprenorphine clinic for continued opioid use. Pt reports that he has been on buprenorphine for 2 years and it has been very helpful. He admits to using occasional heroin off and on while on buprenorphine. He wishes to stay on buprenorphine. Pt has never been on methadone. He has been off buprenorphine for 2 weeks and last used IV heroin 5 days ago. Collateral from buprenorphine clinic reveals that they do not feel they can safely prescribe buprenorphine any longer.
LEVELS OF CARE

- Hold in psych ER
- Admit to the VA inpatient service
- Transfer to contracted detox bed
- Refer to inpatient substance abuse treatment
- Refer to substance abuse day program
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- Refer to buprenorphine clinic
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CASE #3

27yo veteran with a 5 year history of opioid use disorder. He presents to the psych ER seeking opioid detox. He has been injecting approximately 10 bags of heroin daily with his last use being yesterday morning. He has also been using xanax 1-2mg daily and drinking sporadically. He denies medical problems. His parents have threatened to evict him if he does not stop using. He is interested in detox but not treatment because he does not want to miss work. He denied psychiatric complaints.
Levels of Care

- Hold in psych ER
- Admit to the VA inpatient service
- Transfer to contracted detox bed
- Refer to inpatient substance abuse treatment
- Refer to substance abuse day program
- Refer to opioid treatment program
- Refer to ambulatory detox team
- Refer to buprenorphine clinic
- Refer to outpatient clinic
- Refer to 90 in 90, sponsor, step work
CASE #4

31yo presents to the PER seeking assistance with opioid use and suicidal thoughts. He has a history of 3 recent suicide attempts, one involving crashing his car into a tree. He also has a history of IV heroin use with multiple near overdoses, some intentional, some unintentional. He has been through the day program and the inpatient substance use program in the past. He has several inpatient psychiatric admissions as well. He has no medical problems. He is willing to be admitted for stabilization.
Levels of Care

- Hold in psych ER
- Admit to the VA inpatient service
- Transfer to contracted detox bed
- Refer to inpatient substance abuse treatment
- Refer to substance abuse day program
- Refer to opioid treatment program
- Refer to ambulatory detox team
- Refer to buprenorphine clinic
- Refer to outpatient clinic
- Refer to 90 in 90, sponsor, step work
CONCLUSION

- Psychiatric emergency rooms are often the point of entry for many opioid use disorder patients and serve as a referral source to various levels of care
- Community physicians should be aware of the resources available to their patients and be able to refer for proper treatment

References:

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