Addressing Medical and Psychiatric Needs in Substance Abuse Treatment

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Interface of substance abuse treatment and primary care

Case Study -LJ 50 year-old woman

- HIV (last CD4 count 200, viral load not known)
- Chronic mental illness
- Opioid dependence
- Alcohol abuse
- Nicotine dependence

Case Study -LJ, cont.

- Referred for methadone maintenance therapy
- 5 prior treatment episodes, never more than 5 months
- Last treatment was 4 months ago
  - Discharged for continued drug and alcohol abuse.

Case Study -LJ, cont.

- Past community mental health
  - Diagnosed and treated for schizophrenia
  - Discharged by CMH about 2 years ago for continued drug use.

Case Study -LJ, cont.

- At the time of intake, the patient reported chronic leg pain since a gunshot wound to the thigh 6 years earlier. The assessing physician suspected that this pain was "neuropathic".

Case Study -LJ, cont.

- The patient agreed to a trial of amitriptyline for the leg pain and agreed to limit alcohol use per contract. She was linked to a primary care physician who was affiliated with the methadone program.

Case Study -LJ, cont.

- Evaluation by psychology suggested schizoaffective disorder. Primary care began olanzapine at the suggestion of the methadone treatment team.

Case Study -LJ, cont.

- The patient was abstinent of heroin and alcohol after about 6 months of treatment. Antiviral medications were restarted and she was re-enrolled in HIV treatment in the infectious disease clinic at the university.

Case Study -LJ, cont.

- After a lapse of many years, she re-established contact with her daughter.

Case Study -LJ, cont.

- She remained in methadone treatment and free of illicit drugs until her death from lung cancer two years after enrolling in treatment.

Primary care physician’s role

- Relapse prevention
- Monitoring adherence to treatment
- Promoting entry into treatment

Treatment program's role

- Awareness of emerging medical problems as treatment progresses

Dual obligations

- Communication

Major Medical Issues Encountered

Chronic Viral Illness

- HIV
- Hep C

Regular and Stable Methadone Attendance Was Primary Predictor of HAART Acceptance

- Clarke S, Delamere S, McCullough L, Hopkins S, Bergin C, Mulcahy F. Assessing limiting factors to the acceptance of antiretroviral therapy in a large cohort of injecting drug users. HIV Med 2003;4(1):33-7.

Chronic Medical Illness

- Diabetes
- Hypertension
- Asthma and chronic lung disease

Moderate Supplemental Support for Methadone Clients More Cost Effective than Minimal

- Kraft MK, Rothbard AB, Hadley TR, McLellan AT, Asch DA. Are supplementary services provided during methadone maintenance really cost-effective? Am J Psychiatry 1997;154(9):1214-9.

Chronic pain

- Musculoskeletal
- Chronic venous insufficiency
- Neuropathic

High Prevalence of Severe Chronic Pain Among Patients in Recovery

- Rosenblum A, Joseph H, Fong C, Kipnis S, Cleland C, Portenoy RK. Prevalence and characteristics of chronic pain among chemically dependent patients in methadone maintenance and residential treatment facilities. JAMA 2003;289(18):2370-8.

Acute medical problems

- Skin and soft tissue infections
- Pneumonia
- Drug intoxication

Medical and Drug Treatment Associated with Less Hospitalization

- Laine C, Hauck WW, Gourevitch MN, Rothman J, Cohen A, Turner BJ. Regular outpatient medical and drug abuse care and subsequent hospitalization of persons who use illicit drugs. JAMA 2001;285(18):2355-62.

Tobacco dependence

Patients Treated for Addiction Have Later Excess Mortality Due to Tobacco

- Hurt RD, Offord KP, Croghan IT, et al. Mortality following inpatient addictions treatment. Role of tobacco use in a community-based cohort. JAMA 1996;275(14):1097-103.