BayCare Behavioral Health
Substance Use Disorders and Medication Assisted Treatment

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Jason Fields MD

Dr. Jason Fields has been practicing addiction medicine for about 15 years. He was a general pediatrician in North Carolina, and started a second career in addictions here in Florida in 2011. Dr. Fields did a fellowship in addiction medicine with the University of Florida Addiction Medicine program from 2011 to 2013 while working at DACCO, a community treatment center in east Hillsborough County. He has been board certified in addiction medicine since 2012. He went on to become the medical director at DACCO and has experience working in both outpatient and residential substance use treatment centers. In 2019 he joined the BayCare Behavioral Health Team to bring best practice addiction medicine to the organization. He enjoys community outreach and does education in the community on best practice medication assisted treatment for opioid use disorder as a peer mentor with both FADAA and DCF. Dr Fields has served as President of the Florida Society of Addiction Medicine and is current serving as Treasurer on this board.

Substance Use and the Brain

- 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".

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

(American Society of Addiction Medicine, 2011)

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Substance use on the brain

Every substance has slightly different effects on the brain, but all addictive drugs produce a pleasurable surge of the neurotransmitter dopamine in the brain. Neurotransmitters are chemicals that transmit messages between nerve cells. This area is responsible for controlling reward and our ability to learn based on rewards. As substance use increases, these circuits adapt. They scale back their sensitivity to dopamine, leading to a reduction in a substance's ability to produce euphoria or the "high" that comes from using it. This is known as *tolerance. A*s a result, users often increase the amount of the substance they take so that they can reach the level of high they are used to. These same circuits control our ability to take pleasure from ordinary rewards like food, sex, and social interaction, and when they are disrupted by substance use, the rest of life can feel less and less enjoyable to the user when they are not using the substance.

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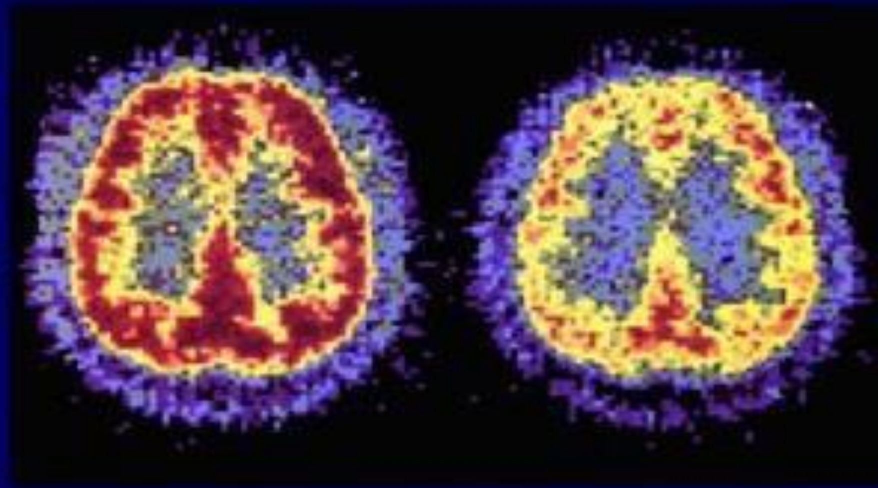
Substance use on the brain



Behaviors associated with addiction

- Besides the risk of overdose and withdrawal, substance use disorders can significantly disrupt a person's life.
- Substance use is often associated with drug-related crimes (possession or distribution of drugs, forgery, burglary, robbery, larceny, and/ or receiving stolen goods).
- People who abuse substances also commonly develop relationship problems with family, friends, and significant others.
- Chronic use of substances can cause a depressed mood and loss of interest in usual activities and relationships.
- Unemployment and difficulty holding a steady job are also common problems with addiction.

Opioids

Natural opioids include morphine and codeine.

Semi-synthetic opioids include oxycodone, hydrocodone, hydromorphone, and oxymorphone.

Methadone is a synthetic opioid that is usually categorized on its own in official data.

Synthetic opioids other than methadone include tramadol and fentanyl.

Heroin is an illegally manufactured synthetic opioid made from morphine

THE OPIOID EPIDEMIC BY THE NUMBERS

70,630
people died from drug overdose in 2019[2]

10.1 million
people misused prescription opioids in the past year[1]

1.6 million
people had an opioid use disorder in the past year[1]

2 million
people used methamphetamine in the past year[1]

745,000
people used heroin in the past year[1]

50,000
people used heroin for the first time[1]

1.6 million
people misused prescription pain relievers for the first time[1]

14,480
deaths attributed to overdosing on heroin (in 12-month period ending June 2020)[3]

48,006
deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending June 2020)[3]

SOURCES

1. 2019 National Survey on Drug Use and Health, 2020.
2. NCHS Data Brief No. 394, December 2020.
3. NCHS, National Vital Statistics System. Provisional drug overdose death counts.

HHS.GOV/OPIOIDS

BCBH Overdose Prevention Plan

Purpose: To prevent overdose deaths by educating staff and consumers about the risks of overdose, and by providing information about NARCAN (Naloxone) and its use.

Staff training:
Within six months of hire and at least biennially thereafter, BCBH direct care staff shall receive training about overdose recognition and response, and the risks of overdose, including lower tolerance for opioids if the individual is participating in an abstinence-based treatment program or is being, discharged from a medication-assisted treatment program.
BCBH staff assigned within programs that maintain an emergency overdose prevention kit shall receive training in the prescribed use and availability of the kit during all hours of program operation.

Information about NARCAN:
NARCAN is an FDA approved medication that is safe and effective in reversing opioid overdose. NARCAN does not work on other overdoses (i.e., cocaine, benzodiazepines, etc.)

NARCAN is maintained within designated programs. Staff at those locations are to receive program specific information on where and how to access the NARCAN.

Responding to an Opioid Overdose:
It is rare for an individual to die immediately from an opioid overdose – it usually takes anywhere from a few minutes to a few hours. When people do survive, it's because someone responded.
Rouse and Stimulate
Call 9-1-1
Give NARCAN
Further Resuscitation
Care for the Person

Consumer Education:
Overdose information and information about NARCAN will be shared with individuals upon admission and offered to individuals placed on a waitlist for treatment services. For those in medication-assisted treatment (MAT), individuals will receive education upon admission and discharge from MAT services, regardless of the reason for discharge.

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What is MAT? Harm Reduction

Per SAMSHA- Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery. Learn about many of the substance use disorders that MAT is designed to address.

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Treatment of Opioid Use Disorder

- Methadone

- Buprenorphine

- Naltrexone

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TABLE 1: KEY FEATURES OF MEDICATIONS APPROVED FOR TREATING OPIOID USE DISORDER*

Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Frequency of Administration	Monthly†	Daily	Daily (also alternative dosing regimens)
Route of Administration	Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional.†	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	Oral tablet or film is dissolved under the tongue.
Who May Prescribe or Dispense	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.	SAMHSA-certified OTPs dispense methadone for daily administration either on site or, for stable patients, at home.	Physicians must have board certification in addiction medicine or addiction psychiatry and/or complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.
Pharmacologic Category	Opioid antagonist	Opioid agonist	Opioid partial agonist Buprenorphine's partial agonist effect relieves withdrawal symptoms resulting from cessation of opioids. This same property will induce a syndrome of acute withdrawal in the presence of long-acting opioids or sufficient amounts of receptor-bound full agonists. Naloxone, an opioid antagonist, is sometimes added to buprenorphine to make the product less likely to be abused by injection.

* Table 1 highlights some properties of each medication. It does not provide complete information and is not intended as a substitute for the package inserts or other drug reference sources used by clinicians (see http://www.dailymed.nlm.nih.gov for current package inserts). For patient information about these and other drugs, visit the National Library of Medicine's MedlinePlus (http://www.medlineplus.gov). Whether a medication should be prescribed and in what amount are matters to be discussed between an individual and his or her health care provider. The prescribing information provided here is not a substitute for the clinician's judgment, and the National Institutes of Health and SAMHSA accept no liability or responsibility for use of the information in the care of individual patients.

† Naltrexone hydrochloride tablets (50 mg each) are also available for daily dosing.

Source: SAMSHA: Clinical Use of Extended – Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide

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Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide

Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Clinical Uses/Ideal Candidates	Prevention of relapse to opioid use disorder following opioid detoxification; studies suggest benefits for patients who are experiencing increased stress or other relapse risks (e.g., visiting places of previous drug use, loss of spouse, loss of job). Appropriate for patients who have been detoxified from opioids and who are being treated for a co-occurring alcohol use disorder. Extended-release naltrexone should be part of a comprehensive management program that includes psychosocial support. Other good candidates include persons with a short or less severe addiction history or who must demonstrate to professional licensing boards or criminal justice officials that their risk of opioid use is low.	Detoxification and maintenance treatment of opioid addiction. Patients who are motivated to adhere to the treatment plan and who have no contraindications to methadone therapy. Methadone should be part of a comprehensive management program that includes psychosocial support.	Treatment of opioid dependence. Patients who are motivated to adhere to the treatment plan and who have no contraindications to buprenorphine therapy. Buprenorphine should be part of a comprehensive management program that includes psychosocial support.
Contraindications	Contraindicated in patients receiving long-term opioid therapy. Contraindicated in patients who are engaged in current opioid use (as indicated by self-report or a positive urine drug screen) or who are on buprenorphine or methadone maintenance therapy, as well as in those currently undergoing opioid withdrawal. Contraindicated in patients with a history of sensitivity to polylactide-co-glycolide, carboxymethylcellulose, or any components of the diluent. Should not be given to patients whose body mass precludes IM injection with the 2-inch needle provided; inadvertent subcutaneous injection may cause a severe injection site reaction. Should not be given to anyone allergic to naltrexone.	Contraindicated in patients who are hypersensitive to methadone hydrochloride or any other ingredient in methadone hydrochloride tablets, diskettes, powder or liquid concentrate. Contraindicated in patients with respiratory depression (in the absence of resuscitative equipment or in unmonitored settings) and in patients with acute bronchial asthma or hypercarbia. Contraindicated in any patient who has or is suspected of having a paralytic ileus.	Contraindicated in patients who are hypersensitive to buprenorphine or naloxone.

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Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Warnings	Use with caution in patients with active liver disease, moderate to severe renal impairment, and women of childbearing age. Discontinue in the event of symptoms or signs of acute hepatitis. As with any IM injection, extended-release injectable naltrexone should be used with caution in patients with thrombocytopenia or any coagulation disorder (e.g., hemophilia, severe hepatic failure); such patients should be closely monitored for 24 hours after naltrexone is administered. Patients may become sensitive to lower doses of opioids after treatment with extended-release injectable naltrexone. This could result in potentially life-threatening opioid intoxication and overdose if previously tolerated larger doses are administered. Clinicians should warn patients that overdose may result from trying to overcome the opioid blockade effects of naltrexone.	Methadone should be used with caution in elderly and debilitated patients; patients with head injury or increased intracranial pressure; patients who are known to be sensitive to central nervous system depressants, such as those with cardiovascular, pulmonary, renal, or hepatic disease; and patients with comorbid conditions or concomitant medications that may predispose to dysrhythmia or reduced ventilatory drive. Methadone should be administered with caution to patients already at risk for development of prolonged QT interval or serious arrhythmia. The label includes a warning about somnolence that may preclude driving or operating equipment.	Caution is required in prescribing buprenorphine to patients with polysubstance use and those who have severe hepatic impairment, compromised respiratory function, or head injury. Significant respiratory depression and death have occurred in association with buprenorphine, particularly administered intravenously or in combination with benzodiazepines or other central nervous system depressants (including alcohol). Buprenorphine may precipitate withdrawal if initiated before patient is in opioid withdrawal, particularly in patients being transferred from methadone. The label includes a warning about somnolence that may preclude driving or operating equipment.
Use in Pregnant and Postpartum Women	***Pregnancy:*** FDA pregnancy category C‡ ***Nursing:*** Transfer of naltrexone and 6ß-naltrexol into human milk has been reported with oral naltrexone. Because animal studies have shown that naltrexone has a potential for tumorigenicity and other serious adverse reactions in nursing infants, an individualized treatment decision should be made whether a nursing mother will need to discontinue breast feeding or discontinue naltrexone.	***Pregnancy:*** FDA pregnancy category C‡ Methadone has been used during pregnancy to promote healthy pregnancy outcomes for more than 40 years. Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with methadone during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. ***Nursing:*** Mothers maintained on methadone can breastfeed if they are not HIV positive, are not abusing substances, and do not have a disease or infection in which breastfeeding is otherwise contraindicated.	***Pregnancy:*** FDA pregnancy category C‡ Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with buprenorphine during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. ***Nursing:*** Buprenorphine and its metabolite norbuprenorphine are present in low levels in human milk and infant urine. Available data are limited but have not shown adverse reactions in breastfed infants.
Potential for Abuse and Diversion	No	Yes	Yes

SOURCES:[1,26–44]

‡ Animal studies have shown an adverse effect on the fetus and there are no adequate, well-controlled studies in humans, but potential benefits may warrant use of the drug in some pregnant women despite potential risks.

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Benefits of providing MAT

MAT has proven to be clinically effective and to significantly reduce the need for inpatient detoxification services for these individuals. MAT provides a more comprehensive, individually tailored program of medication and behavioral therapy that address the needs of most patients.

The goal of MAT is full recovery, including the ability to live a self-directed life.
This treatment approach has been shown to:

- Improve patient survival
- Increase retention in treatment
- Decrease illicit opiate use and other criminal activity among people with substance use disorders
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders and are pregnant

Research also shows that these medications and therapies can contribute to lowering a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse.

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Marchman Act

- ***Who is the Marchman Act designed to help?***
- The act is meant to provide a way for concerned loved ones to get help for someone who desperately needs, but won't accept, substance abuse treatment. Criteria for an appropriate referral includes:
- The individual cannot control or stop his or her drug/alcohol use AND is either:
  - Unable to make rational decisions regarding treatment OR
  - Has inflicted or attempted to inflict self-harm or harm to others
- It should be noted that a judge may find that an individual's refusal to seek treatment may not constitute an inability to make a rational decision regarding such treatment.
- ***Steps to initiate an evaluation and potential involuntary commitment under the Marchman Act***

1. The petition can be filed by a spouse, relative, or guardian, or by three concerned unrelated individuals who have witnessed the uncontrollable drug/alcohol use. Emergency petitions can also be filed by a physician, therapist or law enforcement officer.
2. It may be helpful to enlist the help of an attorney who understands the Marchman Act. There are attorneys who work with families to get the petition filed correctly and will continue to assist throughout the process.
3. The petition paperwork must be filed with the clerk of the court in the county where the person who is uncontrollably using drugs/alcohol lives or is staying. The person completing the paperwork must swear to its veracity, then the petition is notarized and sent to a judge for review.

- https://marchmanactflorida.com/faq

- https://www.myflfamilies.com/service-programs/samh/crisis-services/marchman-act.shtml

Integrated Stabilization Unit

Intake: 727-841-6430

- The Integrated Stabilization Unit (ISU) is a 30 bed crisis stabilization unit (CSU) and Adult Addictions Receiving Facility (AARF). ISU is a locked secured facility which services individuals 18 years of age or older with serious and acute mental illness and/or substance abuse impairment.

Insurance:

- Commercial insurance Blue Cross Blue Shield, Cigna, Humana and more
- Managed Medicaid – Wellcare, Sunshine Health, Beacon, New Directions…etc…
- Managed Medicare – Wellcare, Beacon, etc…
- VA insurance
-
- We don't take the following:
- Florida MEDICAID
  - Florida MEDICARE
  - SHARE OF COST
  - Tricare
  - Ambetter
- ***We do take uninsured clients.

- **Medical Criteria:** We cannot take clients who need medical care, are incontinent, require medical equipment on the unit (such as CPAPs, walkers, crutches, cane or hospital beds) or who cannot perform ADLs independently. We can take patients who need a wheelchair for stability.
- We will send patients out for medical clearance for:
- Glucose <74 or >300
- Unstable vital signs
- Lethargic or unresponsive
- Blood alcohol level >300
- Wounds with extensive treatment
- Patients with ostomies, PEG tubes or stomas
- Pregnant patients in any trimester.

- NOTE: BayCare ISU does not provide Detox for the following substances.
- Marijuana (THC)
- Crack Cocaine
- Cocaine
- Methadone over 60 MG dosage
- Methamphetamine / Amphetamine

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Community Recovery Center

Residential Facility

- New Port Richey

Individuals 18+ with substance use disorders and co-existing disorders that have significant deficits in independent living skills and need extensive support and supervision. The program provides assessment, treatment, rehabilitation and support services utilizing a structured rehabilitation-oriented approach.

State funded facility. If an individual has a residential benefit with health plan, will not cover.

727-841-4475 between 8 & 4pm Mon – Fri to be screened

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Crisis Intervention Resources

BayCare's Mobile Response Teams:
Pasco 727-372-4357
Hernando 352-467-6529

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THANK YOU!