Confronting the New Epidemic: Integrated Care for Opioid Use Disorders

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The inaugural Collaborative Family Health Care (CFHA) regional conference took place March 17, 2017, in St. Louis, Missouri. The conference theme was opioid use disorders and the potential of medication-assisted treatment using team-based care to address this epidemic. The conference ended with an emphasis on the importance of and strategies for self-care among caregivers working with this population and their families. This intensive meeting was crafted as a proof in concept for CFHA; however, the content was timely with regard to its importance in health care as well as compelling in the opportunity for collaborative care to offer an effective approach. In the following sections we highlight five important topics.

Opioid Use Disorders Should Be Addressed in Primary Care

Prescription opioid abuse and heroin use has increased dramatically in the past decade, and the consequent addiction, overdoses, and deaths have reached epidemic proportions (Cicero, Ellis, Surratt, & Kurtz, 2014; Kolodny et al., 2015). In a growing number of communities, a large proportion of these deaths involve a highly lethal, illegally produced version of fentanyl, cut into heroin or sold on its own. Opioid use disorders (OUD) are chronic, lethal, and highly stigmatized, and treatment is vastly underfunded. The latter characteristics make treatment difficult to access and sustain. While there is a small portion of patients whose OUD is best treated in a specialty substance abuse treatment setting, the vast majority are better served in primary care. Epidemics must be managed by a public health and primary care response. Specialty models cannot be sufficiently scaled to address this crisis, and the chronicity of the disorder does not fit well in a specialty care model. This is particularly true in rural communities in which specialty addiction services are unavailable. It is, and perhaps well should be, the work and service of primary care with access, care coordination, continuity, and comprehensiveness as core tenets.

A Team Is Essential

Successful identification, treatment, and care of patients with OUD requires a well-coordinated team—for patients, their families, and for the sustainability of clinicians. Patients with OUD frequently have complex comorbid medical and behavioral needs, best addressed by multidisciplinary teams. Care coordination and intervisit contact is also a key feature of this care—work that is best supported by a care manager with behavioral health training.

Harm Reduction

While abstinence from all high-risk substance use is our hope for patients, the chronic course of substance use disorders and the functional role of substances means that most patients who enter treatment will continue to have intermittent use. Training in harm reduction, as a philosophy and clinical skill set, is therefore an essential ingredient for successfully managing OUDs within primary care. A harm reduction approach means shifting the focus toward treatment engagement and reducing the risk of harm from substance use. Herein lies the para-
An individual can **at the same time** have the desire for treatment and use substances. Harm reduction approaches recognize the complexity and nuance of human behavior and meet the patient where they are with regard to motivation and ability to change (Denning & Little, 2012). Success is not bound to abstinence, but is any step in the right direction (Marlatt, Larimer, & Witkiewitz, 2012). When abstinence-only goals and methods are not effective, desired, and/or realistic for certain patients, harm reduction offers providers an alternative approach to care (Marlatt, Blume, & Parks, 2001; Tatarsky, 2007).

**Medication-Assisted Treatment**

Despite evidence that buprenorphine reduces morbidity and mortality, too few clinicians are licensed or willing to treat patients with OUD with this medication (Jones, Campopiano, Baldwin, & McCance-Katz, 2015). Buprenorphine may occasionally be shared among users; however, it is also true that this sharing may be a gateway drug to treatment. Patients who have had prior exposure to buprenorphine before accessing care have a better response to treatment (Monico et al., 2015). Many primary care physicians (PCPs) are reluctant to prescribe buprenorphine unless a patient commits to attending counseling, and yet the evidence does not support counseling as a necessary ingredient to successful recovery (Friedmann & Schwartz, 2012; Schwartz, 2016). In fact, requiring counseling might limit access and continuity with patients. Those who engage in counseling at some point during their recovery are likely to benefit substantially more than someone being forced to attend. The PCP can provide counseling around changing habits, friend groups, cell phones, and so forth. PCPs often encounter patients using other nonopioid substances and their associated health risks. It is important to remember that treatments specific to OUD do not address other forms of substance use. Holding patients to a standard of abstinence from all other substances risks serious harm to them, which is why the American Society of Addiction Medicine (2015) advises that “the use of marijuana, stimulants, or other addictive drugs should not be a reason to suspend opioid use disorder treatment (p. 5).”

**Sustaining Self Through Mindful Practice and Self-Compassion**

Primary care providers and integrated behavioral health providers have varying levels of experience and interest in the care of patients with substance use disorders, yet are being called upon to meet the demand for treatment. Recognition of the need for training and support for primary care team members was a critical message for the audience in St. Louis. Participants explored reasons why this work is challenging for the health care team, such as personal life experiences with the devastating effects of addiction, implicit and explicit biases, lack of knowledge and training in addiction care, and concerns about challenging patient behaviors.

The unease felt by primary care providers and integrated behavioral health providers is fueled by two factors: (a) there is no clear, one-size-fits-all approach to intermittent opioid use while receiving medication assisted treatment, and (b) it only takes one poorly administered dose of an illicit opioid to be lethal. As providers, we must learn how to “tread the ambiguity” when caring for patients with a chronic, lethal, and relapsing disease such as OUD. Providing continued access to medication-assisted treatment and the support of a primary care team, despite intensity of use, is akin to keeping the life raft within arm’s reach, so that the opportunity for change and recovery is never out of reach. It is not our job to stop patients from using substances. The primary care team provides access to life-saving treatment, compassion, support, and resources, offering patients hope and motivation to move toward sustained abstinence. The difference between emotional empathy (when you physiologically feel along with another person) and compassion (when you strive to understand and help another’s predicament without emotionally fusing with them) were discussed. Recent findings suggest identifying too deeply with patients’ suffering can be a risk factor for clinician burnout (Bloom, 2017; Singer & Klimecki, 2014). However, when empathy is paired with compassion, this can remove the expectation to fix another person. Several resiliency strategies in support of this model were discussed and practiced during the conference, such as gratitude, mindful moments, and self-compassion.
There is a Japanese proverb, “Fall seven times. Stand up eight.” This is how it feels to overcome opioid addiction. This is how it feels to love someone who is overcoming opioid addiction. This is how it feels to take care of someone seeking treatment for opioid addiction. Often, team members tire or become frustrated in the care process. The criticality of having a collaborative team is most evident when one member of the team can help another member stand up again after falling. The work can be hard. And the reward can be just as sweet.

References


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