Wisconsin Opioid Project ECHO
Agenda

Zoom link to join from PC, Mac, iOS or Android**:** https://echo.zoom.us/j/156261634

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Zoom Meeting ID: 156 261 634

For attendance purposes please text the following code: BECQAZ to 608-260-7097

Session Date: Friday January 18, 2019

Didactic Topic and Presenter: Anxiety and Depression and Opioid Use Disorder by Dean Krahn, MD

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case #1 & discussion
    - Presenter: Miranda Behnke, MSW, CSW
- 1:00 PM: Case #2 & discussion
    - Presenter: Eun Ha Kim, MD
- 1:15 PM Didactic Presentation
- 1:30 PM: End of Session

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Detailed disclosures will be available prior to the start of the activity.

Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: December 17, 2018

2-Presenter: Miranda Behnke, MSW, CSW

3-ECHO ID:

4-Have you presented this patient during this teleECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

Demographic Information:

6-Age: 46

7-Gender: Female

8-Education/Literacy: High School with some college

9-Income source: Disability

10-Insurance: Family Care Organization

11- HPI:

12-Social History: Divorced Mother

13-Housing: with significant other whom is also in MAT program

14- Substance Use History: includes, but not limited to Marijuana at age 14, heroin, cocaine, alcohol, hallucinogens, and dealing drugs.

15- Consequences of Substance Use:

- Social/occupational/educational: patient is isolated, unemployed, with increased stress, anxiety, and agitation.
- Physical (including evidence of tolerance/withdrawal): Physically, patient has skin lesions throughout body, BMI of 15.8 (underweight category) with Ht of 5’5” and Wt 95lbs, and multiple medical issues, such as COPD, chronic constipation, and PTSD for which she is seeing multiple medical providers. She is currently receiving in home physical therapy for deteriorating condition.

16- Behavioral Health Interventions that have been tried:

MAT was inducted on 4/13/2017 with Suboxone along with mental health and AODA counseling. Behavioral therapy, cognitive therapy, supportive psychotherapy, and trauma counseling have also been a part of patients past health interventions.

17-Medications Tried for Relapse Prevention? (Specify):
Zubsolv and she is currently on Suboxone 8-2mg film daily.

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
acetaminophen 500 MG tablet ADDERALL XR 20 MG 24 hr capsule albuterol (2.5 MG/3ML) 0.083% nebulizer solution albuterol sulfate HFA 108 (90 BASE) MCG/ACT inhaler aspirin 81 MG tablet atorvastatin 40 MG tablet Bisacodyl (DULCOLAX OR) buprenorphine-naloxone 8-2 MG FILM mupirocin 2 % ointment cephALEXin 500 MG capsule Cholecalciferol (VITAMIN D) 2000 units Tab diclofenac sodium 1 % gel vitamin C 500 MG tablet duloxetine 60 MG capsule Fish Oil 1000 MG Cap fluticasone propionate 50 MCG/ACT nasal spray fluticasone-salmeterol 500-50 MCG/DOSE inhaler gabapentin 800 MG tablet guaifenesin 12 hr 600 MG 12 hr tablet Levocetirizine Dihydrochloride 5 MG Tab metoprolol tartrate 25 MG tablet nystatin 100000 UNIT/ML suspension	includes, but not limited to, PTSD, opioid use disorder, COPD, traumatic grief, anxiety, depression, ADD, and borderline personality disorder.

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Patient strengths include verbalizing the will to live and the need to stay alive for her family, and her current relationships with them.	Patient has a history significant for abandonment by father, abduction, suicide attempts, rape, abuse, incarceration for seven years for selling drugs, and an overdose death of her son. She also has a strained relationship with her mother and her two daughters. One of her daughters has significant medical, emotional, and substance abuse issues, related to childhood and adult trauma experiences, that she is currently in therapy for.

20- <u>Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):</u>

None

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21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

Recent UDS have been positive for Amphetamines, for which she is prescribed d/t ADD, and Buprenorphine, for which she is prescribed through MAT. Past UDS tests, on 1/11/18, have included methamphetamine, but were believed to be false positive due to all the medications patient takes.

22-Prescription Monitoring Program Pertinent Findings:

Patient shows signs that are detrimental to her MAT program. For the past 4 months patient has not been taking Suboxone as prescribed. She states to staff, "I take pieces of the strip. A corner here, half there, sometimes I sleep all day and don't take it at all." Along with this, patient continues to not show up for scheduled appointments. She is due for a prescription refill, but has been consistently missing appointments, showing up a week late.

23-Proposed Diagnoses:

Narcotic Addiction, Noncompliance, Depression, Anxiety, Failure to Thrive

24-Patient Goals for Treatment:

As stated by her MAT physician and behavioral counselor, patient's goals for treatment are long-term remission, repair of family relationships, develop honesty, decrease symptoms and increase functioning.

25- Proposed Treatment Plan:

Vivitrol, as patient verbalizes wanting to get off Suboxone, and continued supportive counseling by current providers.

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DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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Opioid & Addiction Treatment ECHO Patient Case Presentation

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1-Date: 8/17/18

2-Presenter: Eun Ha Kim, MD addiction psychiatry fellow

3-ECHO ID: 6436

4-Have you presented this patient during this teleECHO clinic before? no

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Using suboxone for patient with polysubstance use, opioid is not currently primary drug of choice. What is an appropriate target dose or dosing strategy? What other options for treatment would help make treatment successful?

Demographic Information:

6-Age: 57

7-Gender: M

8-Education/Literacy: associate degree.

9-Income source: working at VA thru VA TSES (therapeutic supported employment service), ex-girlfriend has been giving money when he asked for living expenses.

10-Insurance: VA patient

11- HPI:

- Patient is a 57-year-old Caucasian male with long history of opioid, alcohol and cocaine use disorder.
- Patient was referred from psychiatric inpatient unit for possible opioid maintenance therapy.
- He was brought into the hospital by his ex-girlfriend, requested detox from alcohol and crack cocaine, also endorsed depressed mood, low energy, poor sleep, decreased appetite with significant weight loss (20+ Ibs since May), and hopelessness.
- He reported that he's been drinking a fifth of vodka daily since March this year, crack cocaine "almost every day" past 2-3 months, he spent about 100 dollars per each time. He was using heroin when it was available, most of time someone offered him "couple times a week", not regular using, last use was beginning of July. Also, he smoking cigarette 1ppd past 3 months and chewing tobacco prior. Last drinking was earlier day of admission; he was in psychiatric inpatient unit for 4 days.
- During inpatient treatment, he asked to restart Suboxone because when he was on Suboxone, he was "feeling good enough not to use other drugs". He was offered naltrexone, but he declined as he "failed" in the past. He accepted trial on Acamprosate.

12-Social History:

- Currently unemployed, Divorced, no child, worked as a housekeeper at VA hospital, split up from long term partner last fall due to his drug use, but ex-girlfriend is still main support system.
- Consistent work history; worked at VA as a housekeeper 2001-2013
- Since, short stint at UW health or VA in housekeeping or labor as part of TSES.

13-Housing:

- Living alone with a dog, apartment which his friend owned, he's supposed to help out him to managing apartment facility.

14- **<u>Substance Use History:</u>**

- Started using cannabis at age 13, then speed, acid, PCP and alcohol. Consistent thru high school year. Drinking became prominent since joining the military at age 18. Started Crack cocaine age 25, and heroin 30 or 31 years old, using was intermittent mostly due to incarceration. He started using heroin again in 2000 (age 39). He overdosed on heroin and cocaine in 2003, "accidental overdose".
- He reported he started Suboxone treatment in 2000 at VA hospital in MN, transferred his care to Madison VA in 2004. He's been on Suboxone, highest dose of 24mg / day until 2010. It seems he was compliant with medication between 2003-2008. From 2008, He's used extra dose of Suboxone daily, ran out medication early, had experienced withdrawal between appointment or used other opioid to avoid withdrawal. Also continuously used cannabis and chewing tobacco while in treatment. Treatment ended in 2010 as patient requested "sick of having withdrawal".
- Since 2010, he has been using alcohol, crack cocaine, heroin and cannabis, several hospital visit for detox. Since 2017, he visited hospital three times for detox.

15- <u>Consequences of Substance Use:</u>

- Social/occupational/educational:
  - Hit and run and OWI last year, prison time September 2017, currently on probation until October, 2018
  - Numerous DUI/DWI; 7-8 times per records. 7months of prison for DWI 2015-2016.

- Physical (including evidence of tolerance/withdrawal):
  - Per records, CIWA score never above 4 during inpatient detox. No history of withdrawal seizure or DT.

16- <u>Behavioral Health Interventions that have been tried:</u>

- He is currently in IOP at VA ADTP.
- He has history of multiple inpatient and outpatient drug rehab, residential at building 5 for 2 years in 2013-14. Most recent inpatient drug rehab was November – December, 2017.
- He had 12 weeks of treatment at Meriter in 2009,
- Individual counseling at VA and outside of VA.

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17-Medications Tried for Relapse Prevention? (Specify):

- Suboxone 8mg/2mg TID for 10 years
- Naltrexone 2010- 2011 discontinued due to noncompliance, continuous drinking.
- Gabapentin tried while and after suboxone 2000-2010

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Acamprosate 666mg tid Trazodone 100mg hs Lexapro 10mg qd Gabapentin 600mg tid	Depressive disorder, unspecified Personality disorder, Cluster B

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Have place to stay Ex-girlfriend still supportive for his recovery	Legal issue Isolation unemployment Personality trait

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

- Blood alcohol on admission; 248 mg/dl
- UDS negative for all tested 3rd hospital day; amphetamine, barbiturates, benzodiazepine, opiates, cannabinoids, methadone, ETOH, Cocaine

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22-Prescription Monitoring Program Pertinent Findings:

23-Proposed Diagnoses:

- Alcohol use disorder
- Cocaine use disorder
- Opioid use disorder
- Tobacco use disorder
- Depressive disorder, Unspecified

24-Patient Goals for Treatment:

- Being sober
- Employed
- Restore relationship with ex-girlfriend

25- Proposed Treatment Plan:

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The Comorbidity of Depression, Anxiety, and Opioid Use Disorders

Dean Krahn, M.D., M.S.
Director, UW Addiction Psychiatry Fellowship
Staff Psychiatrist, VA-Madison

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Overview

- Because this learning session is aimed at clinicians who are dealing with patients who are misusing opioid substances, we will focus on the prevalence of mood and anxiety disorders in subjects with opioid disorders as well as how that changes treatment and treatment outcome. We will cover:
- 1) Epidemiology of mood/anx d/o's in s's w/opioid d/o's
- 2) How to diagnose comorbid mood and anxiety disorders as opposed to substance-induced disorders, intoxication, or withdrawal
- 3) Describe available evidence about treatment and

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- NESARC, NCS, ECA: Odds Ratios of Association between Alcohol or Drug Dependence & Other Disorders

	Alcohol	Drug
Major Depress.	1.6 to 4	2.0 to 9.0
Dysthymia (PDD)	2.3 to 3.8	1.3 to 11.3
Bipolar D/O	4.6 to 8.0	8.3 to 13.9
Panic with Agor.	2.6 to 3.6	4.4 to 10.5
Social Phobia	1.6 to 2.5	2.2 to 5.4

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- Conclusions from Community Surveys
  - Comorbidity is the rule
  - Lots of variability across studies based on differences in instruments and methods
  - Associations of MH D/O’s are stronger with drug use disorders than with alcohol use disorders
  - Associations for depressive disorders are smaller than for the other disorders we listed
  - When you see depression in an addict, think about anxiety disorders, bipolar, PTSD, etc as they might be more critical to treat.

- Arch Gen Psychiatry. 1982 Feb;39(2):151-6.
- **Diagnosis and symptoms of depression in opiate addicts. Course and relationship to treatment outcome.**
- Rounsaville BJ, Weissman MM, Crits-Christoph K, Wilber C, Kleber H.
- **Abstract**
- Evaluations of diagnosis and symptoms of depression were undertaken in 157 opiate addicts at entrance to a multimodality drug treatment program and six months later. While 17% were having an episode of major depression (defined by Research Diagnostic Criteria) and 60% had at least mildly elevated depressive symptoms at entrance to treatment, substantial improvement was noted at the six-month reevaluation, with the rates of major depression and elevated symptoms dropping to 12% and 31%, respectively. Starting treatment during a major or minor depressive episode was predictive of poorer outcome in the areas of illicit drug use and psychological symptoms.

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Arch Gen Psychiatry. 1997 Jan;54(1):71-80.

Psychiatric and substance use comorbidity among treatment-seeking opioid abusers**.**

Brooner RK[1], King VL, Kidorf M, Schmidt CW Jr, Bigelow GE.

Previous studies were published more than a decade ago and reported on few women and few substance use diagnoses.

Psychiatric and substance use comorbidity was assessed in 716 opioid abusers seeking methadone maintenance. Assessments conducted 1 month after admission. Psychiatric comorbidity was documented in 47% of the sample (47% women and 48% men).

Antisocial personality disorder (25.1%) and major depression (15.8%) were the most common diagnoses.

Psychiatric comorbidity, especially personality and mood disorder, was common in men and women.

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- Prognostic Implications of Comorbidity
  - Major depression, for example, is associated with greater overall severity of addiction and worse addiction and other outcomes, but only in the situation where the subject/patient has a full blown disorder (at least in the case of depression). Scoring high on a rating scale for depression without meeting criteria for the disorder is not associated with worse outcome.
    - So one must be careful in applying diagnostic criteria appropriately. We don’t know for sure if that is also the case for anxiety disorders, but, in my judgement (based on no data), it probably is.
    - Other problems with comorbidity: high rates of polypharmacy

- Other important issues:
  - To make these diagnoses well, one must take longitudinal histories of both the anxiety or depressive disorder and all substance use disorders that are or have been active in the patient's life AND
  - One needs a reliable corroborative historian
  - Often not achievable—but you have to make your best guess anyway

- Treatment
- Hassan AN et al Management of Mood and Anxiety Disorders in Patients Receiving Opioid Agonist Therapy: Review and Meta-analysis. Amer Jl on Addictions, 26: 551-563, 2017
- Found 22 RCT's of which 8 were eligible for the meta-analysis
  - 7 studies started antidepressants well after methadone/bup started//2 studies reported stat sig + effect of IMI or doxepin over placebo for symptoms of depression
  - 7 studies started antidepressants close in time to start of methadone/bup//2 studies reported stat sig + effect of doxepin over placebo.
  - Total of 4 studies, all with TCA's, showed more drop out in active drug group

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- Treatment (continued)
  - Meta-analysis of TCA’s vs placebo studies showed sig advantage for active drug
  - Meta-analysis of the very few SSRI vs placebo studies showed no significant difference

  3 RCT’s compared buprenorphine and methadone for effects on mood. One showed an advantage for buprenorphine when both buprenorphine and methadone were paired with carbamazepine

- Psychotherapies: 4 randomized studies (and 2 small pilots) of effect of psychotherapies on depression and in methadone-treated patients; 2 studies of depression in methadone treated 2 mothers and infants used Relational Psychotherapy Mother's Group protocol and both had positive results on depression symptoms. An RCT of Behavioral Therapy for Depression in Drug Dependence was negative. An RCT of ACT in patients with MMT showed + results for depression but – results for anxiety. Finally, a small RCT of CBT vs non-directive group showed + results on both depression and anxiety in MMT patients

Conclusions

- Comorbid depressive disorders, as opposed to symptoms only, are associated with worse outcomes in subjects with opioid use disorder
- Need to do careful interviewing of subject and corroborative historian to effectively diagnose
- Few treatment studies exist. Psychotherapy probably is the most consistently beneficial approach to depression in patients with opioid use disorders. TCA's are more effective but have far more se's than SSRI's which have yet to have a positive impact in early studies. No studies with SNRI's or atypical antipsychotics exist. Also too early to say if buprenorphine and methadone effects on depression differ. Far more and larger studies are needed.

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

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WI Opioid Project ECHO 2018-2020

Anxiety and Depression and OUD
Friday January 18, 2019
Dean Krahn, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:

1. Review appropriate opioid prescribing and monitoring practices
2. Participate in office-based management of opioid use disorders
3. Seek overdose prevention education with greater frequency.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of OUD

Policy on Disclosure
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Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair	No relevant financial relationships to disclose	Yes
Chris Nicholas, Content Expert, Psychology-SUD/Mental Health Counselor	No relevant financial relationships to disclose	No
Elizabeth Collier, Content Expert, Social Worker	No relevant financial relationships to disclose	No
Paul Hutson, Content Expert, Pharmacy	No relevant financial relationships to disclose	No
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse	No relevant financial relationships to disclose	No
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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