ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

Agenda

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Zoom Meeting ID: 156 261 634

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

Session Date: Friday June 21, 2019

Didactic Topic and Presenter:
Tips for a Good Initial Interview regarding SUD's and Some Pointers regarding Comorbidity
by Dean D. Krahn, MD, MS – Program Director, UW Addiction Psychiatry Fellowship Program

Content Experts:
Ritu Bhatnagar, MD and Susan Mindock, CSAC; and Sheila Weix, MSN, RN, CARN

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case #1 & discussion
  - Presenter: Eun Ha Kim, MD – Addiction Psychiatry Fellow—UW Addiction Psychiatry Fellowship
- 1:15 PM: Didactic Presentation
  - Presenter: Dean Krahn, MD
- 1:30 PM End of Session

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Interprofessional Continuing Education Partnership

WISCONSIN DEPARTMENT of HEALTH SERVICES

ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

2018-2020

Tips for a Good Initial Interview regarding SUD's and Some Pointers regarding Comorbidity

Friday June 21, 2019

Dean D. Krahn, MD, MS

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 substance use disorders.
3. Seek, with greater frequency, overdose prevention education.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of substance use disorders.

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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	Yes
Paul Hutson, Content Expert, Pharmacy	Consultant for Projections Research Inc.	Yes
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
Eun Ha Kim, Content Expert	No relevant financial relationships to disclose	No
Dean Krahn, Content Expert	No relevant financial relationships to disclose	Yes
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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CONTINUING EUDCATION INFORMATION:

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2019 Universal Activity Number (UAN)
JA0000358-9999-19-002-L04-P
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Patient Case Presentation

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

1. Date: 6/21/19
2. Presenter Name: Eun Ha Kim, MD
3. Presenter Organization:
4. ECHO ID: 2397
5. Have you presented this patient during this teleECHO clinic before?
6. PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Drug of choice is stimulant, but regular opioid use "speedball", required inpatient detox. Will suboxone treatment help her addiction?

Patient Demographic Information:

7. Age: 27
8. Sex: F
9. Education/Literacy:
10. Income source: she had a full time job, recently lost after legal issue. Lives on saving.
11. Social Factors/History: she was adopted when she was 4 months old, her parents got divorced when she was 4-5 y/o, both parents shared custody, raised by parents and their new spouse (live same school district, spend 50:50 time both house). She started seeing a counselor after she was molested by her brother (he was adopted by her parents). She dx with ADHD 7th grade, reported no conduct behavior, mostly easily distracted, hyperactivity were issue. No learning disability. Finished high school without issue. Having a full time job. Never married, no child. Still maintain good relationship with parents, step father, step siblings.

12. **Substance Use History:**

First alcohol use at age 17, first heroin use age 19. Alcohol drinking became problems age 20, daily drinking (1/2 liter) until she got first DUI age 21. She finished IOP, got sober, but she had used cocaine, heroin intermittently with friends. Age 25/6 had a new boyfriend, who was heroin user. She used using heroin (IV) daily 1.5-2gram daily and some cocaine use. They broke up and he moved to other state. She self-referred to program to get help "can't function at work without heroin". Started IOP and methadone therapy. She remained abstinence while she was in IOP, but quickly relapsed on amphetamine after completed IOP. She struggled with methadone therapy due to not consistent attendance, and repeated no show her scheduled appointment with this writer. She was recommended AODA residential treatment, and starting IOP while waiting for bed. She failed to show up for first IOP, no showed for MD appointment. Seeing her again while she was hospitalized for burn/ skin graft. She fell asleep on boiling pot of water

while making spaghetti: Combination of crash coming off of stimulant and intoxicating effects of heroin. She wanted back to treatment, wanted to go residential AODA treatment. She was hesitant to Suboxone, since current her drug of choice is stimulants (methamphetamine and cocaine), also worried about withdrawal.

13. Consequences of Substance Use:

- Social/occupational/educational:
    - Beginning of April, she and her boyfriend were pulled over by pursing police, who arrested them for possession of meth and heroin and paraphernalia. She spent 3 days in jail after detox, pending court date for initial hearing. Subsequently, she was fired from her job for non-attendance. Her mother sold her car (the title was in mom's name). She got eviction notice due to fail to pay rent.

- Physical (including evidence of tolerance/withdrawal):
    - Patient sent 4 days at Rogers detox unit for opioid withdrawal
    - Patient was hospitalized for burn on trunk and upper and lower extremities. She fell asleep on boiling pot of water while making spaghetti: Combination of crash coming off of stimulant and intoxicating effects of heroin.
    - New dx of hep C from IV drug use

14. Interventions that have been tried:

Outpatient counseling for alcohol use in 2010. She completed IOP twice in 2012 (alcohol use d/o), 2019 (opioid use d/o). She quickly relapsed after finishing IOP. Recommended AODA residential treatment, and while waiting for bed, recommended do IOP, but she failed to attend. She was on methadone from November, 2018-March, 2019. Max dose of 75 mg. unable to try higher dose due to inconsistent attendance, also consisting positive for cocaine, meth on UDS. She stopped attend methadone clinic due to continuous drug use.

15.

Current Addiction and Mental Health-related Medications:	Medical/Behavioral Health Diagnosis:
• Fluoxetine • Guanfacine	• ADHD • Anxiety disorder

16.

Patient Strengths/protective factors:	Risk factors:
• She was able to maintain full time job • Enjoyed coaching gymnastics for youth • Future oriented • Supportive family	• ADHD • Anxiety disorder • Family history of addiction • Childhood sexual trauma • Boyfriend who also has SUD

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17. Labs (as indicated), include summary of urine testing or last urine drug screen results:

Positive for methadone, methamphetamine, amphetamine, ecstasy on last clinic visit

18. Patient Goals/Motivations for Treatment:

legal issue (pending charge of drug possession

financial reason

“want her life back” (job, coaching, independent living and relationship)

19. Proposed Diagnoses:

Stimulant use disorder

Opioid use disorder

Cannabis use disorder

Alcohol use disorder

Tobacco use disorder

ADHD

GAD

20. Proposed Treatment Plan:

By initialing here __EHK__ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

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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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TIPS FOR A GOOD INITIAL INTERVIEW RE SUD'S AND SOME POINTERS RE COMORBIDITY

- Dean Krahn, MD, MS
  - Director, University of Wisconsin Addiction Psychiatry Fellowship
  - Board-certified addiction psychiatrist practicing at VA-Madison Rockford Clinic

GOALS OF INITIAL ASSESSMENT

- Identify presence of substance-related disorder and/or harmful/hazardous substance use
- Make an accurate diagnosis and relate it to comorbid med/psych conditions
- Identify barriers to treatment as well as strengths/supports
- Assess patient's motivation to change
- Formulate and help initiate evidence-based treatments

- How is it different from a later assessment??? (maybe not that much)

INTERVIEWING STYLES

- Open-ended questions (to start, not forever)
- Honest, respectful, empathic, matter-of-fact (Columbo) questions
  - "Some people…….";"can you help me understand your pattern/etc?"
- Be honest about why you are there, and, at this point it is to understand and see if you can work together on some common goals
- These are difficult interviews
  - Patients often believe you will not understand or will want them to do something they don't want to do
- Remember, you represent an organization, a profession, sometimes a gender or ethnic group the patient has a history with—don't take offense, try to understand it (So you don't necessarily like a lot of folks who are addiction docs; what is it that got you feeling that way?

HOW DO PATIENT CHARACTERISTICS AFFECT INTERVIEW?

- Age (don’t try too hard to be younger than you are)
- Gender (abuse factor in women addiction pts is very high)
- Partner/marital status (women alcohol dependent pts married to males who are drinking have harder time quitting)
- Legal status (example of probation pt from last week!)
- Employment status (can help or hinder—can’t come to treatment because I need to go to work/can come because I have insurance; also professionals’ issues)
- Culture/ethnicity (construction workers; Irish vs Jewish, etc)

PSYCHOLOGIC AND MEDICAL ISSUES AFFECTING INTERVIEW

- Level of insight/denial (13 DUI example)
- Personal explanation (anybody with my pain and PTSD would drink)
- Psych/med comorbidities (bipolar, soc anxiety, pain)
- Stage in addiction/recovery (the crash of the addiction counselor (AVE)
- Current state (intox, withdrawal, etc)—sometimes need to wait
- Readiness for change (often doesn't match stage of illness/disorder—example of doctors readiness)

WHAT NEEDS TO BE TREATED?

- Intoxication or overdose
- Withdrawal/detox
- Recovery-focused treatment (often wider and longer than pt wants)

GETTING A LONGITUDINAL HISTORY OF LIFE, SUBSTANCE USE, PSYCH ISSUES, MED ISSUES

- Calendar approach for last few weeks/months (last Christmas, last 4th of July, last Super Bowl, last ?????)
- Life Stages: often by stage in school, by when married, when divorced, where and when employed, etc
- Try to relate onset of psych/med issues and onset of substance use/overuse; try to relate stoppage of substance use/overuse to stoppage or aggravation of psych/med issues

TRY TO GET A STRUCTURED LONGITUDINAL HISTORY OF THE USE OF EACH CATEGORY OF DRUGS

- First time use
- First time intoxication
- First time it caused a problem
- When used regularly (weekly or more often)
- Period of max use (how did life go?) (also routes of use)
- Period of no use (how did life go)

COMORBIDITY IS THE RULE

- But which caused which and, at some point, does it matter?
  - Even if it doesn't matter in treatment, it still often matters to pt
- Resistance to comorbidity
  - I drink (or use), I am not crazy
  - I have bipolar (dep/anx), I am not an addict
  - I cannot have more diagnoses
  - I have to take drugs for my mood/etc
  - "Depression is an excuse, not a disorder"—old AA rhetoric
- The value of corroborative history (with consent unless severe emergency)

COMORBIDITY IN PEOPLE WITH ADDICTIONS

- Epidemiology
- Diagnosis

OVERVIEW

- Mood disorders
  - Depressive, bipolar
- Anxiety disorder
  - Ptsd
  - Soc anxiety, GAD, other
- ADHD
- Cluster B
- Schizophrenia

- *From ASAM Principles of Addiction Med/Chapters 85-92*
- *From Nunes et al Substance and Co-occurring Psychiatric Disorders, Civic Research Institute (2010)*
- *DSM V sections of Substance induced disorders*

DSM IV APPROACH TO COMORBIDITY

- Primary (aka Independent) depression:
  - Temporally independent: preceded drug abuse or persisted in abstinence (preferably current and observed)
- Substance-induced depression
  - Not temporally independent
  - Exceeds what would be expected from usual toxic or w/d effects of substance
  - What are usual effects (look at intox, w/d criteria)

PREVALENCE OF COMORBIDITY: CLINICAL SAMPLES

- Patients entering tx for SUD
  - 20-50% lifetime major depression
  - PTSD common, esp in females
  - ADHD 10-30%
- Patients with schizophrenia
  - 70+ % have nicotine dependence
  - Alcohol and cannabis frequent
- Clinician's illusion (Berkson's bias)

COMMUNITY SURVEYS TO AVOID BIAS

- ECA (Epidemiologic Catchment Area Studies) in 80's
- National Comorbidity Study 90's
- NESARC National Epidemiological Study of Alcoholism and Related Conditions 2000's

NESARC, NCS, ECA: ODDS RATIOS OF ASSOC BETWEEN DRUG/ETOH DEP AND OTHER DISORDERS

	Alcohol	**Drug**
Major Depression	1.6-4	2.0-9.0
Dysthymia	2.3-3.8	1.3 – 11.3
Bipolar	4.6 – 8.0	8.3 – 13.9
Panic with Agoraphobia	2.6-3.6	4.4-10.5
Social Phobia	1.6-2.5	2.2-5.4
PTSD	3.4	3.8
ADHD	2.8	7.9
ASP	8.3-118.54.7	15.6-

CONCLUSIONS FROM COMMUNITY SURVEYS

- Comorbidity is the rule
- Varies across studies (different methods, mostly)
- Odds ratios higher for drug disorders vs alcohol disorders
- Odds ratios smaller for depression than other disorders
- Depression might be a good signal to look for another disorder with a more specific treatment

PROGNOSTIC IMPLICATIONS OF COMORBIDITY

- More comorbidity is assoc with greater severity and worse outcome
- Need to be careful in dx: full blown MDD is assoc with worse prognosis in alc dep; but just sx severity without full syndrome has much less effect

LOTS OF POSSIBLE ETIOLOGIC RELATIONSHIPS

- Complex relationships between disorders
- Role of stress and trauma
- Avoid being simplistic
- Some examples of relationships

COMORBIDITY

- Complex and important
- Probably important to include both disorders in treatment plan
- Current thinking is that fairly contemporaneous treatment is better than sequential—should be able to make a story that connects the two disorders well
- Sometimes makes treatment mildly more complex

MEDICAL COMORBIDITIES

- Huge numbers assoc with each substance abused
- But besides for looking at the number of medical disorders that a given substance specifically causes, need to look at all the neglected health behaviors and med/dental care that is now clearly needed
- “I quit drinking and now my back hurts”

FAMILY HISTORY

- Increased risk of addiction if family has addictions
  - Remember, none of the disorders we treat in MH are more heritable than addictions
  - (70%)Coke, nicotine, alcohol, opiates(40%)from most to least heritable
  - Usually, one's problems are due to nature AND nurture! Not one or another!

SOCIAL/DEVELOPMENTAL HISTORY

- Abuse of all sorts
- Spouse/partner/friends (relationships)
- Education
- Vocations
- Military
- Parenting

DON'T LEAVE WITHOUT GIVING SOME PRESENTATION OF YOUR THOUGHTS/FINDINGS/OPINION

- And further steps to make a more final opinion
  - Labs, biomarkers, etc
- Remember my intro—used to try to keep myself appropriately humble
  - "You have 2 problems now: it is 2019 and I am your doctor"
  - We know what we know in 2019 and I know some of that—
    - We will do our best to use the evidence to identify what your problems are and how to help you and I will try to keep up with the evidence.
    - If you decide to go "off the evidence-supported approach", I will ask you to reconsider but I will always be rooting for you to make a success out of your course of action.

AND DON'T LEAVE WITHOUT MAKING A COMMITMENT TO A NEXT STEP(S)

- What are the patient's goals?
- How would they like to get there?
- Would they like your opinion on the goals and how to get there?
  - It is hard to change habits in general and substance use in particular
  - However, it is important to change if (health, mortality, family, job, etc) are important to you
  - Here is what I think of your plan
  - Here is what I would hope I would do if I were in your position – but it is your life
  - Let's talk more and agree on goals and a plan to get there.