



**ACCEPT**  
**Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics**  
**Agenda**

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

**Joining by phone ONLY:** +1 646 558 8656 or +1 669 900 6833 (US Toll)

**Zoom Meeting ID:** 156 261 634

**For attendance, purposes please text the following code:** [FOQMEH](tel:608-260-7097) to [608-260-7097](tel:608-260-7097)

**Session Date:** Friday October 18, 2019

**Didactic Topic and Presenter:**

Interview Advice and Tips Regarding Co-Morbidity Pt. 2

Dean Krahn, MD - Program Director of UW Addiction Psychiatry Fellowship

**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 Presentation & Discussion
    - Presenter: Miranda Behnke MSW, CSW – Prevea Health
  - 1:15 PM: Didactic Presentation
    - Presenter: Dean Krahn, MD - Program Director of UW Addiction Psychiatry Fellowship
  - 1:30 PM End of Session

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JA0000358-9999-19-002-L04-P

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



**ACCEPT**  
**Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics**  
 2018-2020

Interview Advice and Tips Regarding Co-Morbidity Pt. 2

Friday October 18, 2019

Dean Krahn, MD - Program Director of UW Addiction Psychiatry Fellowship

*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.

**Policy on Disclosure**

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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Miranda Behnke MSW,CSW Presenter	No relevant financial relationships to disclose	No
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	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
Lindsey Peterson, MS, CRC, 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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## ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

### Patient Case Presentation

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

1-Date: October 18, 2019

2-Presenter: Miranda Behnke, MSW, CSW, SAC-IT

Presenter Organization:

3-ECHO ID: 6324

4-Have you presented this patient during this teleECHO clinic before? Yes

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Was there anything different to do to help this patient?

#### Demographic Information:

6-Age: 47 (1972)

7-Gender: Female

8-Education/Literacy: High School with some college

9-Income source: Disability

10-Insurance: Care WI

11- HPI:

12-Social History: Divorced Mother (gravida 5, para 3, SAB 2), patient reported agoraphobia

13-Housing: with significant other who is in MAT program

14- Substance Use History: includes, but not limited to marijuana at age 14, heroin, cocaine, alcohol, hallucinogens, fentanyl, hydrocodone, hydromorphone, morphine, oxycodone, 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): Last known, patient had skin lesions throughout body (patient reported parasites), severely underweight (3/19 93 lbs, 5ft 5 in, BMI 15) with cachectic, sickly appearance. Multiple medical issues, such as COPD and PTSD for which she was seeing multiple medical providers. Last known home care service provided in May 2019 with plan to provide skilled services of PT for weight monitor, activity tolerance, and strengthening; no known follow-up.
- Parole ended May 2019

#### 16- Behavioral Health Interventions that have been tried:

Inpatient and outpatient detox/programs x9

Most recent MAT Program was inducted in 4/2017 with buprenorphine-naloxone 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. Last MAT appointment: 5/2/19

Discharged from outpatient therapy on 12/12/18. It was recommended to receive home mental health care due to her physical health challenges - Family care agency did not provide such for patient.

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

4/2017 buprenorphine HCl-naloxone HCl (SUBOXONE) 12-3 MG FILM  
 7/2017 buprenorphine HCl-naloxone HCl (ZUBSOLV) 5.7-1.4 MG SL Tab  
 8/2017 buprenorphine HCl-naloxone HCl (ZUBSOLV) 8.6-2.1 MG SL Tab  
 9/2018 buprenorphine-naloxone (SUBOXONE) 8-2 MG FILM  
 1/2019 buprenorphine-naloxone (SUBOXONE) 4-1 MG FILM  
 4/2019 buprenorphine-naloxone 1.4-0.36 MG SL tablet 3 (three) times daily  
 6/2019 buprenorphine-naloxone 1.4-0.36 MG SL tablet 2 (two) times daily  
 Last Rx: 6/21/19 12 tablets

- buprenorphine HCl-Naloxone HCl Dihydrate 1.4-0.36MG /Tablet Sublingual #12 (6 days) last refilled **6/21/19** per the Wisconsin Prescription Drug Monitoring Program website.
- amphetamine-dextroamphetamine 10MG / Capsule Extended Release 24 Hour #30 (30 days) last refilled **12/15/18** per the Wisconsin Prescription Drug Monitoring Program website.

**18-**

Current Medications:	Medical/Behavioral Health Diagnosis:
Oxygen, continuous saccharomyces boulardii (Florastor) cholecalciferol (Vitamin D) omega-3 fatty acids (Fish Oil) ascorbic acid (Vitamin C) guaifenesin (Mucinex) aspirin metoprolol (Lopressor) duloxetine (Cymbalta) cetirizine (Zyrtec) tea tree oil vitamin E skin oil turmeric garlic ginger albuterol (Proair HFA) mupirocin (Bactroban) ointment gabapentin (Neurontin) polyethylene glycol (Miralax) albuterol (Ventolin) vitamin D voltaren gel amphetamine-dextroamphetamine (Adderall XR) fluticasone (Flonase) nystatin (Mycostatin)	Irritable bowel syndrome Drug-induced constipation Esophageal dysphagia Debility: muscle loss, weight loss Coronary artery disease Possible NSTEMI Vitamin D deficiency Chronic respiratory failure with hypoxia COPD Mucopurulent chronic bronchitis Maxillary sinusitis, chronic Environmental allergies Major depressive disorder, recurrent episode, mild Fibromyalgia Arthralgia of multiple sites Lung nodules Generalized anxiety disorder Borderline personality disorder PTSD Antisocial personality disorder Anxiety Polysubstance abuse HTN Chronic pain Hyperlipidemia

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hydroxyzine (Atarax) bisacodyl (Dulcolax) polyethylene glycol-electrolytes daliresp Symbicort Spiriva Handihaler	
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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, gang rape at age 13, abuse, incarceration for seven years for selling drugs, and an overdose death of her son (2016 at age 23). She also has two daughters, one is her caretaker. One of her daughters has significant medical, emotional, and substance abuse issues, related to childhood and adult trauma experiences. Current significant other had nude photos of her adult daughter on his phone.

**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.):**

Patient has unresolved grief over the death of her son due to overdose – patient had belief that she may have supplied her son with the substance causing his death. Anniversary of his death is November.

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

5/2/19 Last UDS: positive for buprenorphine

**22-Prescription Monitoring Program Pertinent Findings:**

Patient showed signs that were detrimental. For the last several months of her participation in MAT Program, patient had not been taking Suboxone as prescribed. She stated 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 continued to not show up for scheduled appointments.

**23-Proposed Diagnoses:**

Narcotic Addiction, Noncompliance, Depression, Anxiety, Failure to Thrive, therapist in 2018 questioned Anorexia/Bulimia diagnosis though no formal diagnosis was given.

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## **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:**

Last MAT appointment: 5/2/19

Last Therapy session in December 2018 – therapist moved to Madison, and patient refused to schedule with another provider – patient was offered multiple times

Patient was recommended for inpatient mental health and substance use treatment multiple times, and refused treatment outside of her home.

**By initialing here \_\_\_\_MB\_\_ 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.**

## **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

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

# PART I

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# GOALS OF INITIAL ASSESSMENT

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- 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???

# INTERVIEWING STYLES

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- 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?

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- 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

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- 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?

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- 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

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- Calendar approach for last few weeks/months (last Christmas, last 4<sup>th</sup> 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

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- 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)

# PART II

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# COMORBIDITY IS THE RULE

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- 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

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- Epidemiology
- Diagnosis

# OVERVIEW

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- 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

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- 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 intoxication, withdrawal criteria)

# PREVALENCE OF COMORBIDITY: CLINICAL SAMPLES

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- 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

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- 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

	<b>Alcohol</b>	<b>Drug</b>
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

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- 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

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- 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

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

# COMORBIDITY

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- 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

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- 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

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- 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

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



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

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- 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)

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- 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.