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

Agenda

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

Session Date: Friday, July 16, 2021

Didactic Topic and Presenter:
Psychotherapy in MAT

John Ewing MD, AAFP, ASAM, ABPM
Co-Director of NewStart at Meriter-UPH

Content Experts:
Ritu Bhatnagar, MD; Lindsey Peterson, MS, CRC; Sheila M. Weix, MSN, RN, CARN

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation
  - Presenter: Amy E. Parins, MPAS, PA-C - *Faculty, Clinical Assistant Professor, UW Madison*
- 1 PM: Didactic Presentation
  - Presenter: John Ewing MD, AAFP, ASAM, ABPM
- 1:15 PM: End of Session

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON
School of Medicine and Public Health
School of Nursing
School of Pharmacy

Project ECHO®
University of Wisconsin

ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2020-2022
Psychotherapy in MAT
7/16/21

Didactic Presenter: John Ewing MD, AAFP, ASAM, ABPM
Case Presenter: Amy E. Parins, MPAS, PA-C

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

Intended Audience:
Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:
As a result of this educational regularly scheduled series, learners as members of the healthcare team will be able to:
1.Identify the risks of withholding medication treatment of opiate use disorder.

2. Effectively utilize brief psychotherapy techniques in a primary care setting.

3. Identify when to refer patients to psychotherapists.

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Randall Brown	RSS Chair	No relevant financial relationships to disclose	Yes	3/11/21
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	3/11/21
Kathleen Maher	Planner	No relevant financial relationships to disclose	No	3/15/21
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	3/12/21
Paul Hutson	Planner	No relevant financial relationships to disclose	Yes	3/11/21
Susan Mindock	Planner	No relevant financial relationships to disclose	No	3/11/21
Lindsey Peterson	Planner	No relevant financial relationships to disclose	No	3/11/21
Sheila Weix,	Planner	No relevant financial relationships to disclose	No	3/11/21

Kellene Eagen	Planner	No relevant financial relationships to disclose	No	6/23/21
Joseph Galey	Planner	No relevant financial relationships to disclose	Yes	6/23/21
John Ewing	Presenter	No relevant financial relationships to disclose	No	7/3/21
Amy E. Parins	Presenter	No relevant financial relationships to disclose	No	7/14/21

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ACCEPT

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Patient Case Presentation

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

1. Date: Thursday, July 15, 2021
2. Presenter Name: Amy Parins
3. Presenter Organization: UW DFMCH/ UW Hospital
4. ECHO ID: 2603
5. Have you presented this patient during this teleECHO clinic before? ☐ Yes ☒ No

6. Please state your main question for this case:
   How would you best support this patient with severe AUD, housing insecurity, depression, PTSD after he gets out of. 5 Door?

Patient Demographic Information:

7. Age: 32
8. Sex: M
9. Education/Literacy: High School, 1 year MATC
10. Income source: None, housing insecurity/ sleeping unsheltered, panhandles for money
11. Social Factors/History:

HPI: 32 yo man with h/o severe alcohol use disorder, history of prior seizures (unclear historical seizure workup; some seizures have not been in setting of alcohol w/d) portal vein thrombosis (2015) and PE (2018) not currently on therapeutic anticoagulation, tobacco use disorder, and opioid use disorder in remission (on suboxone) who presented to the ED on 5/26/21 after trying to put out a fire and experiencing burns and also felt like he was in alcohol withdrawal. Of note, Mr. *** was previously admitted on 5/10-5/13 and 5/21-5/24. He left AMA on 5/24 b/c he felt his withdrawal symptoms weren't being adequately treated. He left without any of his medications (anticoagulation meds, seizure d/o meds, or suboxone). He thought he probably drank about 6-8 beers in the 2 days he was back at the camp, though his BAC at time of admission was .35. He's had some opioid w/d symptoms since getting back to the camp. He denies other substance use in the 2 days he was out of the hospital.

General: Grew up in small town in WI, parents divorced at a young age. Closer to his father and his brother. Had a turbulent childhood after the divorce. Hx of sexual abuse from babysitter ages 10-11. Came out in high school and was bullied. Has an ex- boyfriend with severe AUD as well.
Living: Currently homeless, unsheltered sleeping in a tent, encampment

Education: Graduated HS. 1 year of college at community collefe -funeral service- didn't finish the program
Work: Used to work at funeral home. A few months was working selling stuff on eBay
History of Violence in Past Six Months: Yes, assaulted by an unknown person prior to admission

12. Substance Use History:

Substance	Use
Nicotine	Smoking- 1 ppd- 2ppd. **Patch.**
Alcohol	1.75 L
Heroin	No,
Opioids	In recovery on suboxone
Benzos	no
Cocaine	no
Methamphetamine	no
Cannabis	Occasionally - once a week
Hallucinogens	no
Synthetic MJ/bath salts/incense	no
IVDU	no

13. Consequences of Substance Use:

- Social/occupational/educational:

Lost his job, homeless, living unsheltered in a tent, unable to stay with family. Currently he is in 5 Door.

- Physical (including evidence of tolerance/withdrawal):

Multiple ED visits to inpatient stay for complicated alcohol withdrawal (May 9, May 20, May 26, June 7).

Complicated withdrawal with history of seizures.

BAC .35

Max CIWA score last hospitalization: 31

Benzodiazepines/barbs administered thus far: 260mg phenobarb; 35mg of lorazepam and 40mg diazepam.

14. Interventions that have been tried:

Acamprosate- no benefit yet, would like to stop it.
Naltrexone not indicated due to buprenorphine
Gabapentin 900 mg TID helpful
Rosecranz residential 2013- helped significantly.
Residential treatment- 5 door. Currently this is where he is.

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15.

Current Addiction and Mental Health-related Medications:	Medical/Behavioral Health Diagnosis:
• Buprenorphine-naloxone 8-2 mg TID • Gabapentin 900 mg TID • Pristiq 50 mg QD • Acamprosate 666 mg TID	PTSD, depression, anxiety Hospitalizations: age 20, Suicide attempt by overdose admitted to hospital. 9/2013 was in Rosecrance for 2 months. During that time was started on buprenorphine and has been in recovery from OUD for 7 years.

16.

Patient Strengths/protective factors:	Risk factors:
• He is willing to receive help • Has a new social worker/ community outreach worker Maria Tran	• Homeless, • Jobless, • No support • Isolated

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

	6 5/23/2021 0623	5 5/26/2021 1450	4 5/27/2021 0552	3 6/7/2021 1920	2 6/9/20 0524
GI/LIVER					
ALKALINE PHOSPHATA...	*134*	*110*	*98*	*117*	
ALT/SGPT (UWH)	*101* ▲	*108* ▲	*84* ▲	*64* ▲	
AST/SGOT (UWH)	*63* ▲	*60* ▲	*47* ▲	*56* ▲	
BILIRUBIN, TOTAL (...	*0.5*	*0.3*	*0.3*	*0.3*	
LIPASE (UWH)				*40*	

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	4	3	2	1
	5/21/2021 2124	5/26/2021 1407	5/26/2021 1450	6/7/2(192
DRUGS				
ACETAMINOPHEN (UWH)				
ACETAMINOPHEN (UWHC)				
ACETAMINOPHEN, QUA...				
ALCOHOL (UWH)		*0.35 **▲**		*0.3*
ALCOHOL (UWHC)				
AMPHETAMINE, URINE...	*Not Detected*		*Not Detected*	
AMPHETAMINE, URINE...				
BARBITURATE, URINE...				
BARBITURATE, URINE...	*Screen Positive* !		*Screen Positive* !	
BENZODIAZEPINE, UR...	*Not Detected*		*Not Detected*	
BENZODIAZEPINE, URINE				
COCAINE METABOLITE...	*Not Detected*		*Not Detected*	
COCAINE METABOLITE...				
DETECTED DRUG (UWHC)				
DETECTED DRUG, URI...				
OPIATES, URINE (UWH)	*Not Detected*		*Not Detected*	
OPIATES, URINE (UWHC)				
PHENCYCLIDINE, URI...				
SALICYLATE (UWH)				
TRICYCLIC SCREEN (...				
DRUG SCREEN GC/MS,... !				

18. Patient Goals/Motivations for Treatment:

Wants life “to be easier” feel more secure. Would like to get a job, or go back to school. Wants to repair relationships.

19. Proposed Diagnoses:

Severe AUD

PTSD,

Depression

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20. Proposed Treatment Plan:

By initialing here _AEP_____ 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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Psychotherapy in MAT

John Ewing MD, AAFP, ASAM, ABPM (addiction)
Co-Director of NewStart at Meriter-UPH
Madison, WI

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Project ECHO University of Wisconsin

Overview

- Medication Treatment of Opiate Use Disorder is the primary treatment.
- Patient Education re. mechanism of action of opiates and buprenorphine enhances patient retention.

- Some patients will benefit from Psychotherapy
  - Delivered by Prescriber/Provider
  - Delivered by a Mental Health Professional

- What is Psychotherapy?
- What is the mechanism of action of Psychotherapy?
- What types of Psychotherapy can be delivered by the Prescriber/Provider
- When to refer to a Psychotherapist?

- What is a Psyche? Psyche = breath or bubble
  - Cough
  - Psyche
  - Kaa
  - Qui
  - Chi

Psyche implies mind. Mind = mend, to link together, to remember, to form associations.

(Spiros = sphere or bubble, i.e., breath)

- Therapeutic:

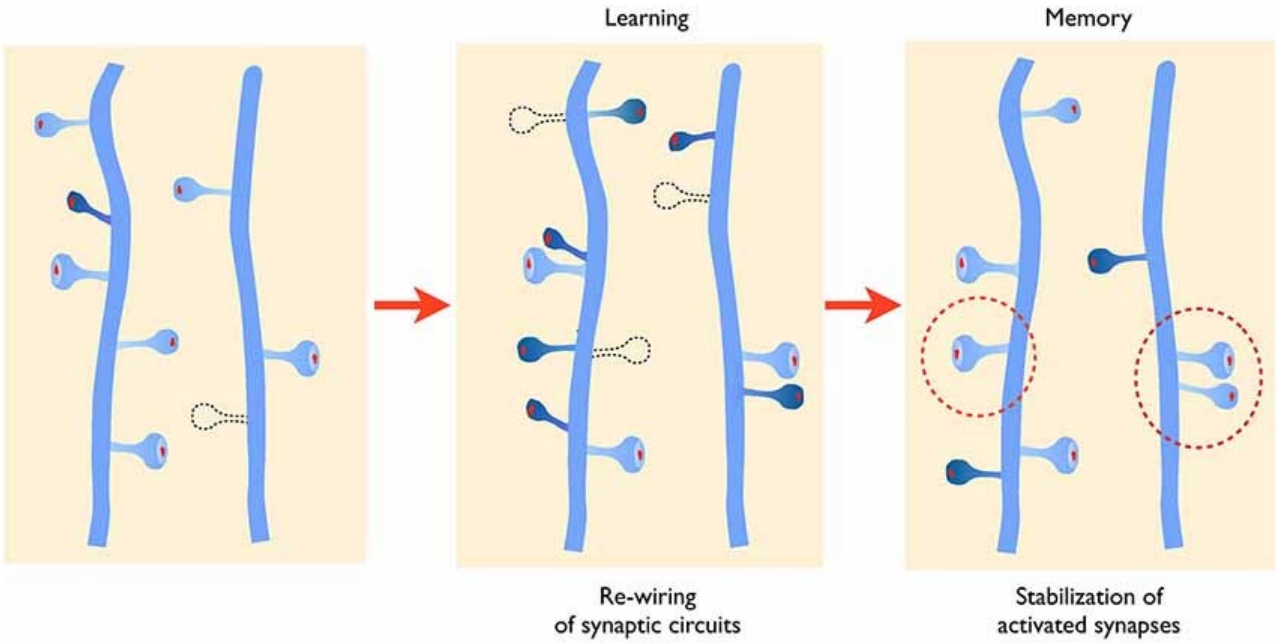
- thera =old
- puton= apprentice
- tic = technique

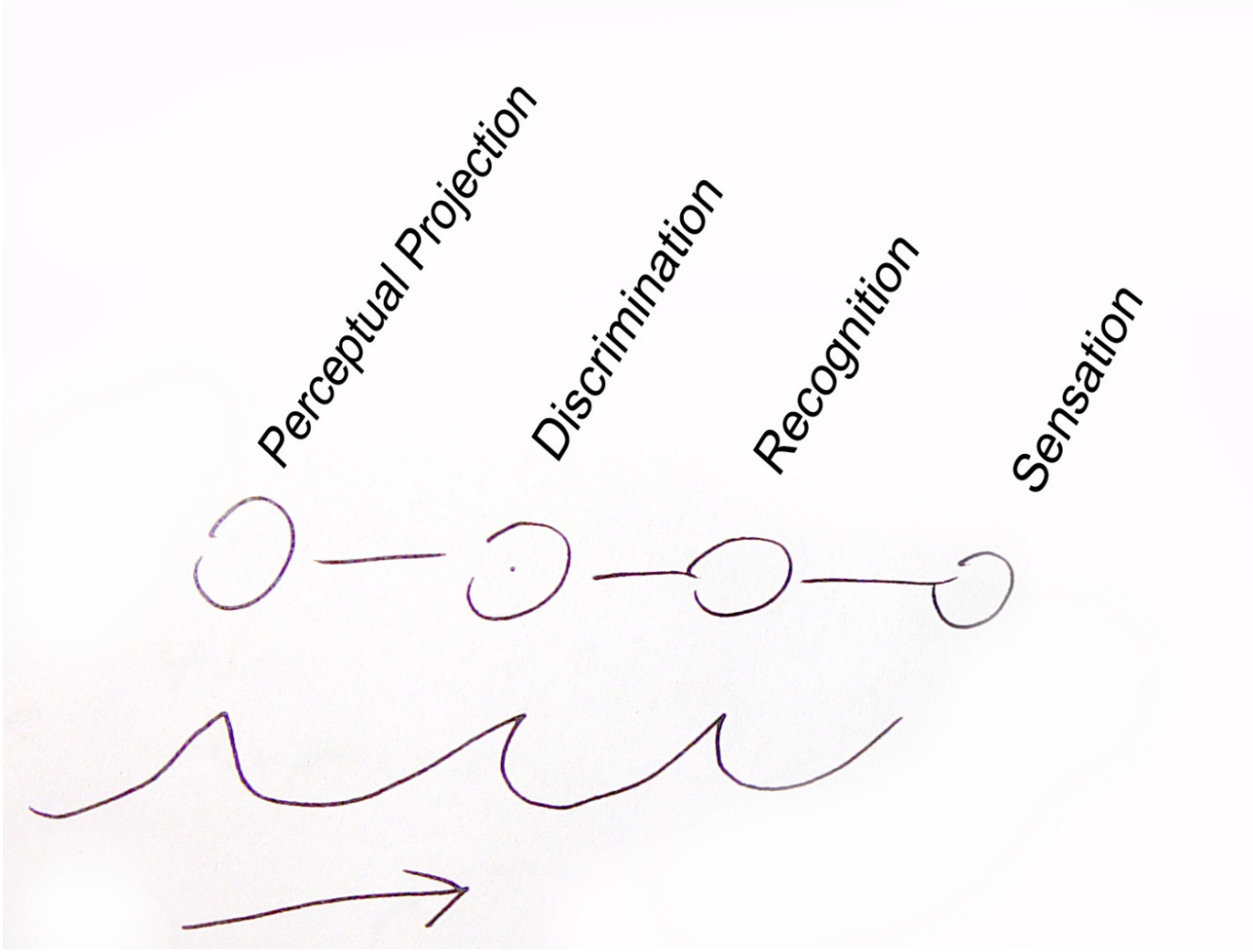
- The application of an established technique

Psychotherapy involves learning

- Psychotherapy is the use of techniques to produce improved function in:
  - Cognitions/ strategies/ self talk (declarative memory)
  - Habits (intrinsic memory) attitudes, trauma, behaviors
  - Arousal Regulation
    - To reduce anxiety, anger, reactivity
    - To increase activation and energy for ADLs and social engagement

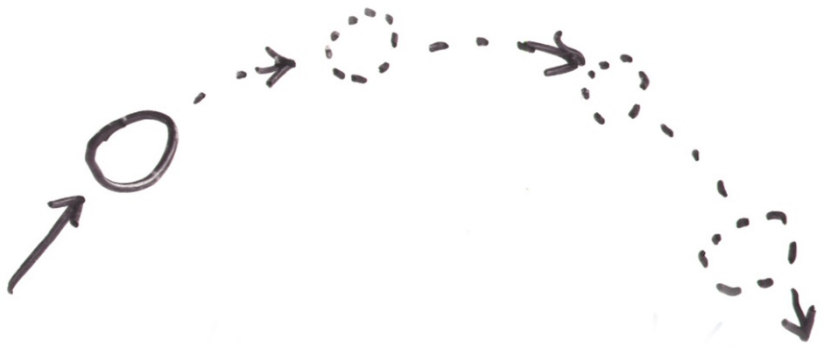
Learning from experiences (and Adaptation to Substance Use)





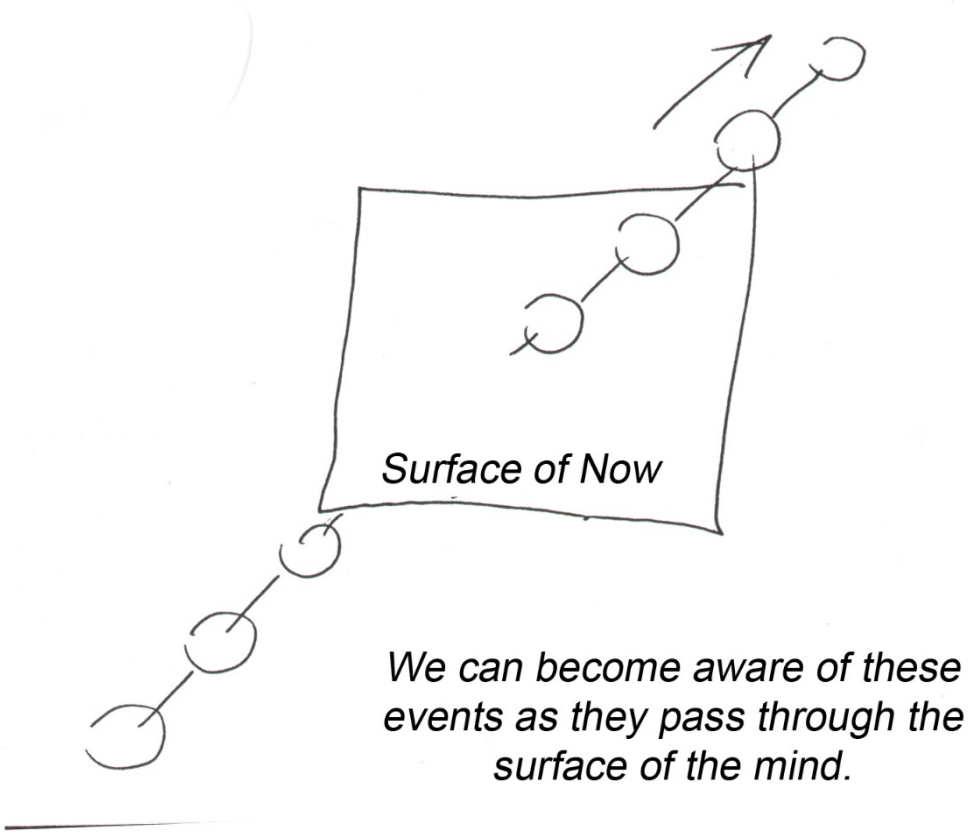
We can perceive where the ball will be

Catch the Ball

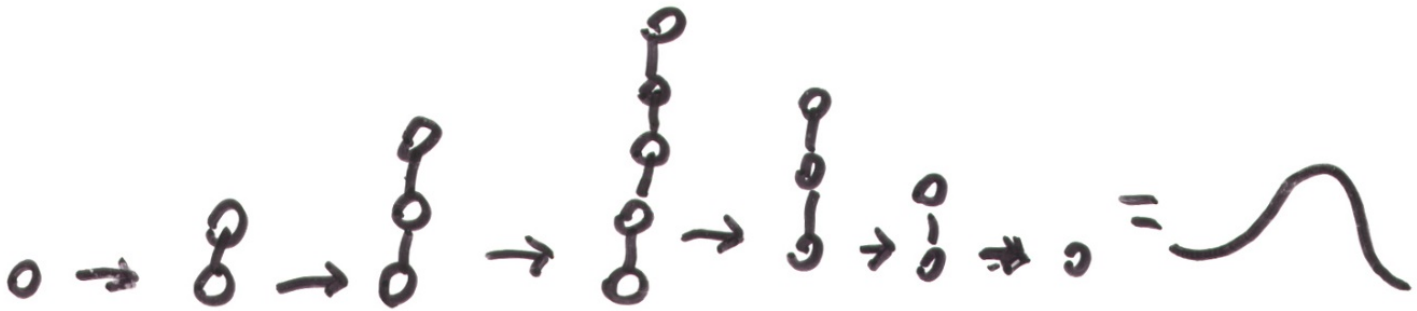


Perceptual projection gives us the illusion of the future

Focusing our attention; future and past

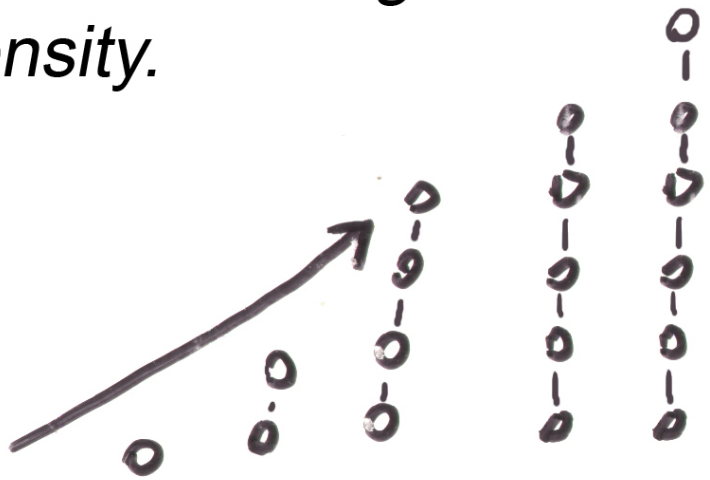


Sensations fade and become memories.



Sensations and perceptions fade into the background of cortical activity, becoming memories.

Some sensations grow in intensity.



Increasing sensations can evoke longer trains of thought and can result in desire formation.

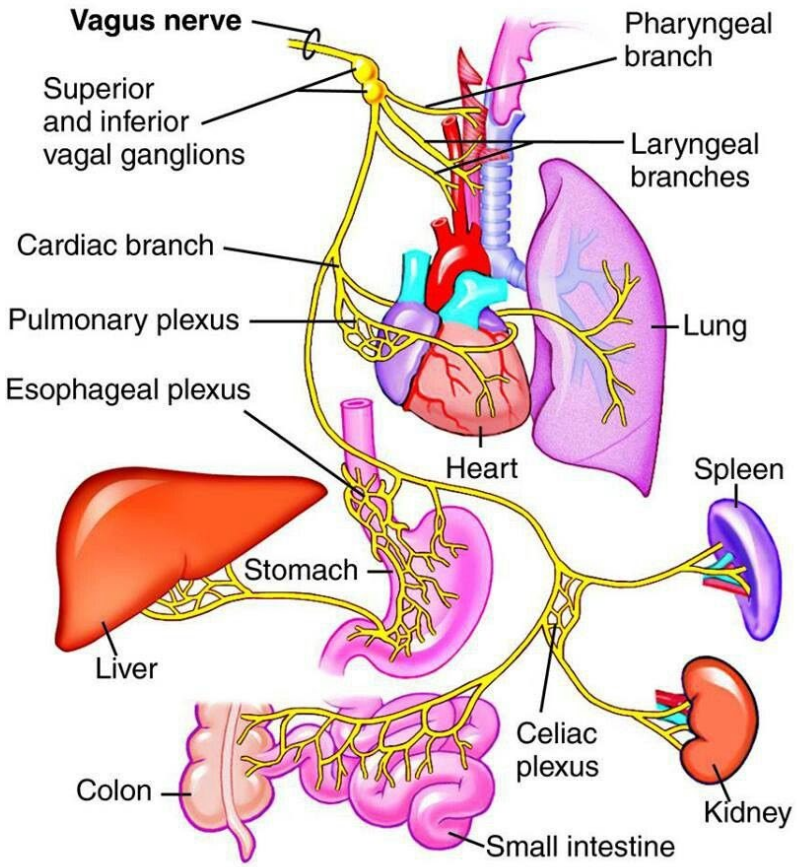
Desire activates the formation of ideas and plans

Fantasys consist of sequences of ideas

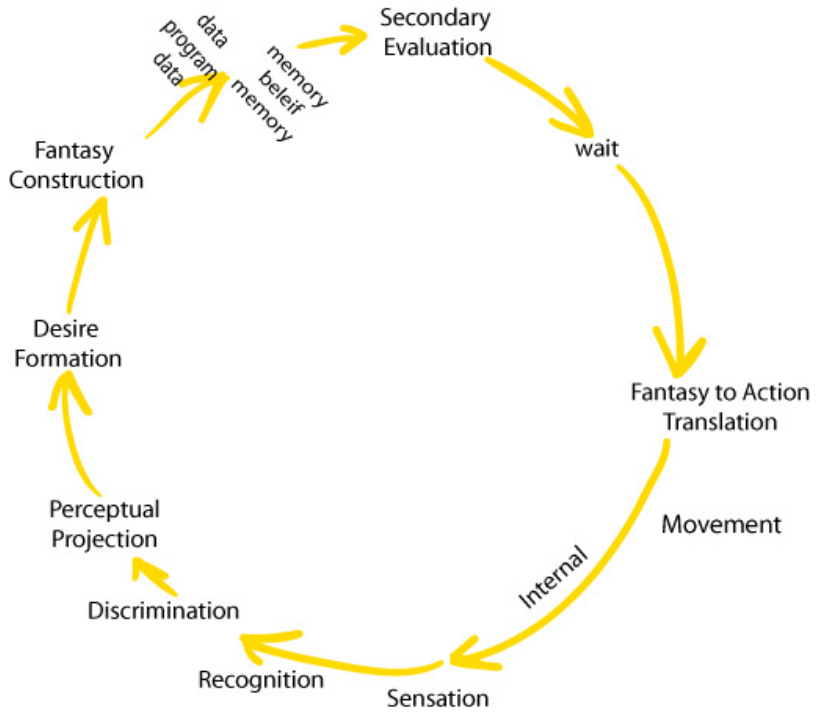
Memory=data
Belief=program

The vagus nerve (vagrant= wanderer)
Active in anticipation and emotion
Angst; to squeeze – Anger and Anxiety

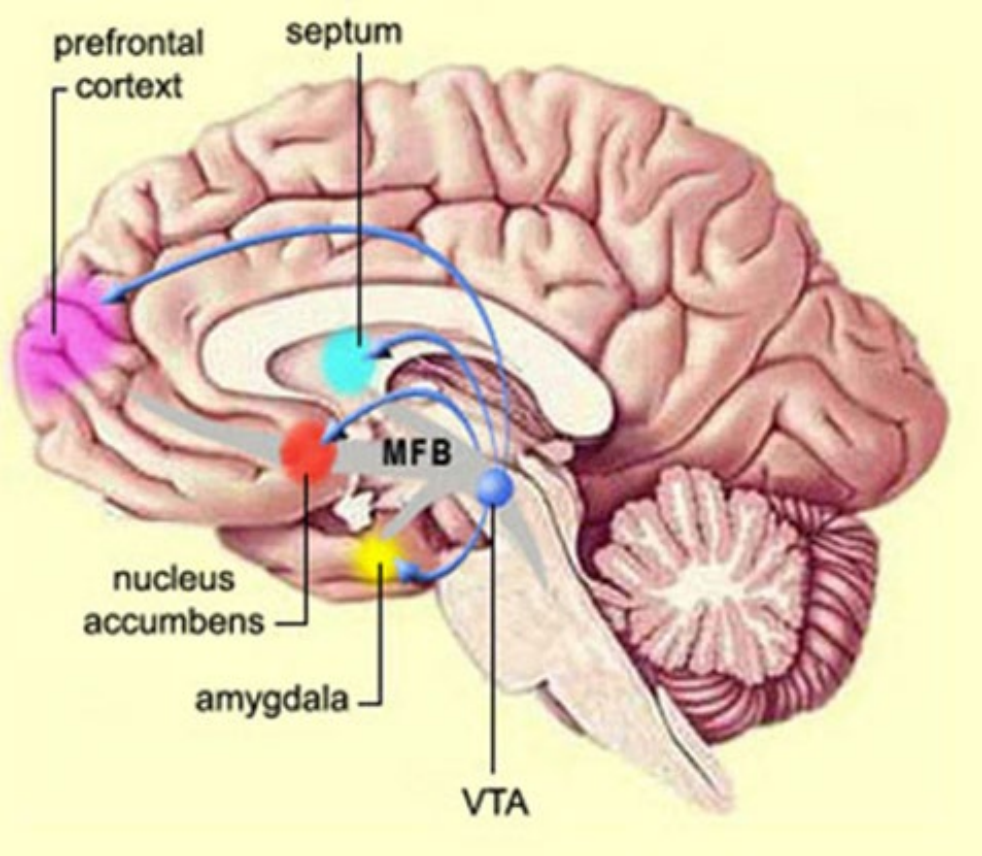
Is the seat of the mind
The brain?
Or the heart?



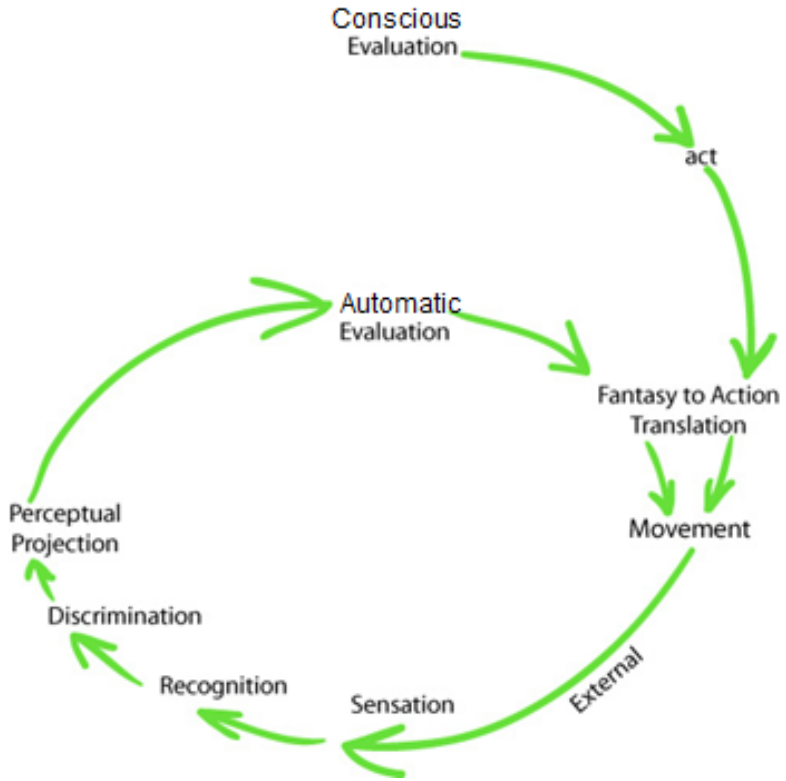
The Wait Loop: Anticipation with Internal Tension, leads to the sensations and thoughts of an Emotion



The Septum (striatum/basal ganglia) facilitates intrinsic memory and habit

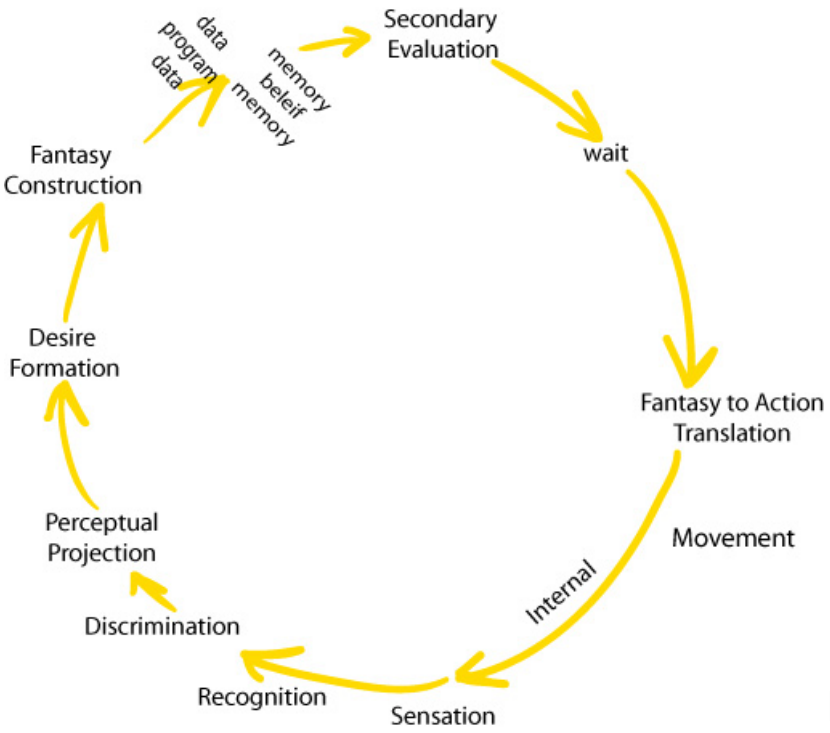


Habit; The Act/React Loop (attitudes and trauma lives here) (autopilot)



Intervention Points in the process of Emotion

Cognitions and
Self talk



Internal tension
Mindfulness
Smooth
Breathing

Types of Psychotherapy in Primary Care

- Reflective Listening (taking a history) and Motivational Interviewing to elicit patient goals and strategies.
- CBT (Cognitive Behavioral Therapy) becoming aware of ideals, beliefs, and learning to edit self talk
- Mindfulness Training: using smooth breathing, meditation techniques

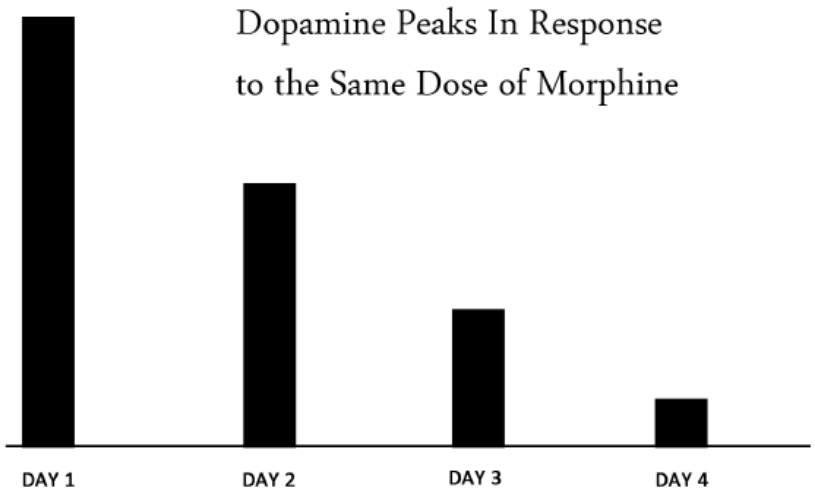
Medication first; to prepare the patient for learning and psychotherapy

- When to Refer to a Psychotherapist

- Sexual trauma
- Personality Disorder
- Psychosis
- Ongoing distress or dysfunction despite your efforts

Therapeutic Neuroscience Education:

We can use animals to measure the dopamine release from euphorigenic drugs. **The dopamine surge corresponds to the high provided by the drug.**



As the body adapts to a chemically induced high, it begins to take more of the drug to have the same effect. The low that follows gets worse.

If we take the same dose, the effect is less and less until we don't get that high any more.

No matter the dose, **the high always goes away.**

The Opponent Process Model of Addiction, by Dr. Solomon et al 1973

The Dynorphin Hypothesis is that Elevated Dopamine results in compensatory increases in dynorphin (Dr. David Mysels 2009).

The elevated dynorphin inhibits dopamine release.

Prochaska Stages of Change/ Motivational Interviewing

Precontemplation: provide information

Contemplation: provide information

Preparation: Explore Strategies

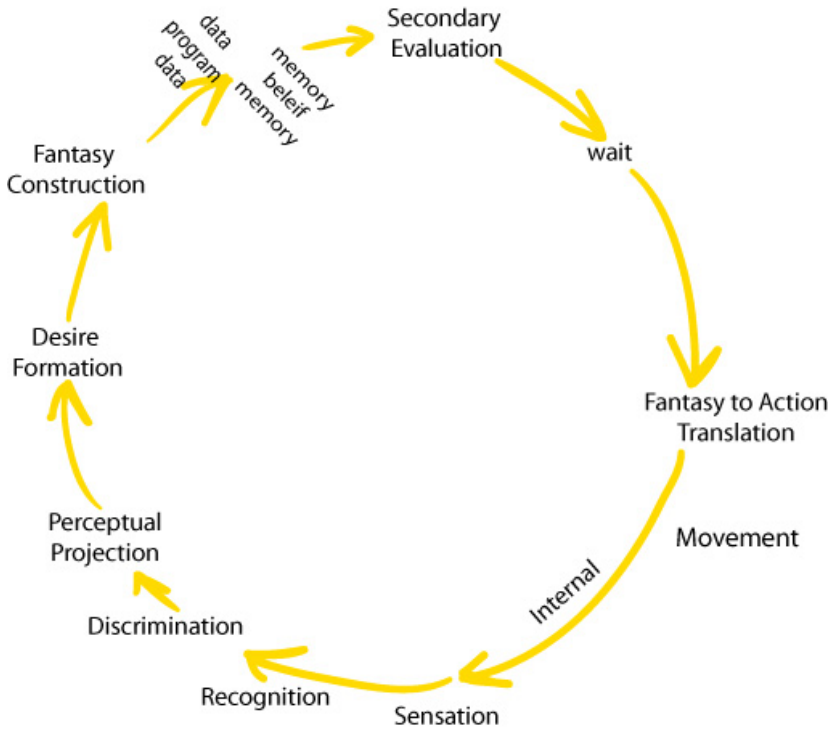
Action: provide encouragement

Maintenance: provide encouragement

Relapse/Precontemplation: provide information

Intervention Points in the process of Emotion Cognitive Behavioral Therapy (CBT)

Cognitions and
Self talk



Internal tension
Mindfulness
Smooth
Breathing

Emotional Scripts can be analyzed

Sample journal sheet:

What Happened:

I went out to go to work

And the Car would not start

What a camera would see:

The car would not start

What I said to myself about it:

1. Piece of crud car. Come on darn it.
2. Oh, no. this is terrible
3. Now I'll never get to work
4. I am so fired
5. I am such a loser
6. I am doomed
7. I'm going to lose everything
8. I might as well go live under the bridge
9. Argghh

Updated Self Talk:

1. This is not what I expected
2. This is highly inconvenient
3. I may be late for work
4. I will look better if I call in
5. How can I avoid this inconvenience
6. This is a little setback
7. I may have to delay getting stuff
8. Let's see, what are my options
9. Hmm

How I felt:
Despair, Rage, Fear

Updated Feeling:
Mildly disappointed

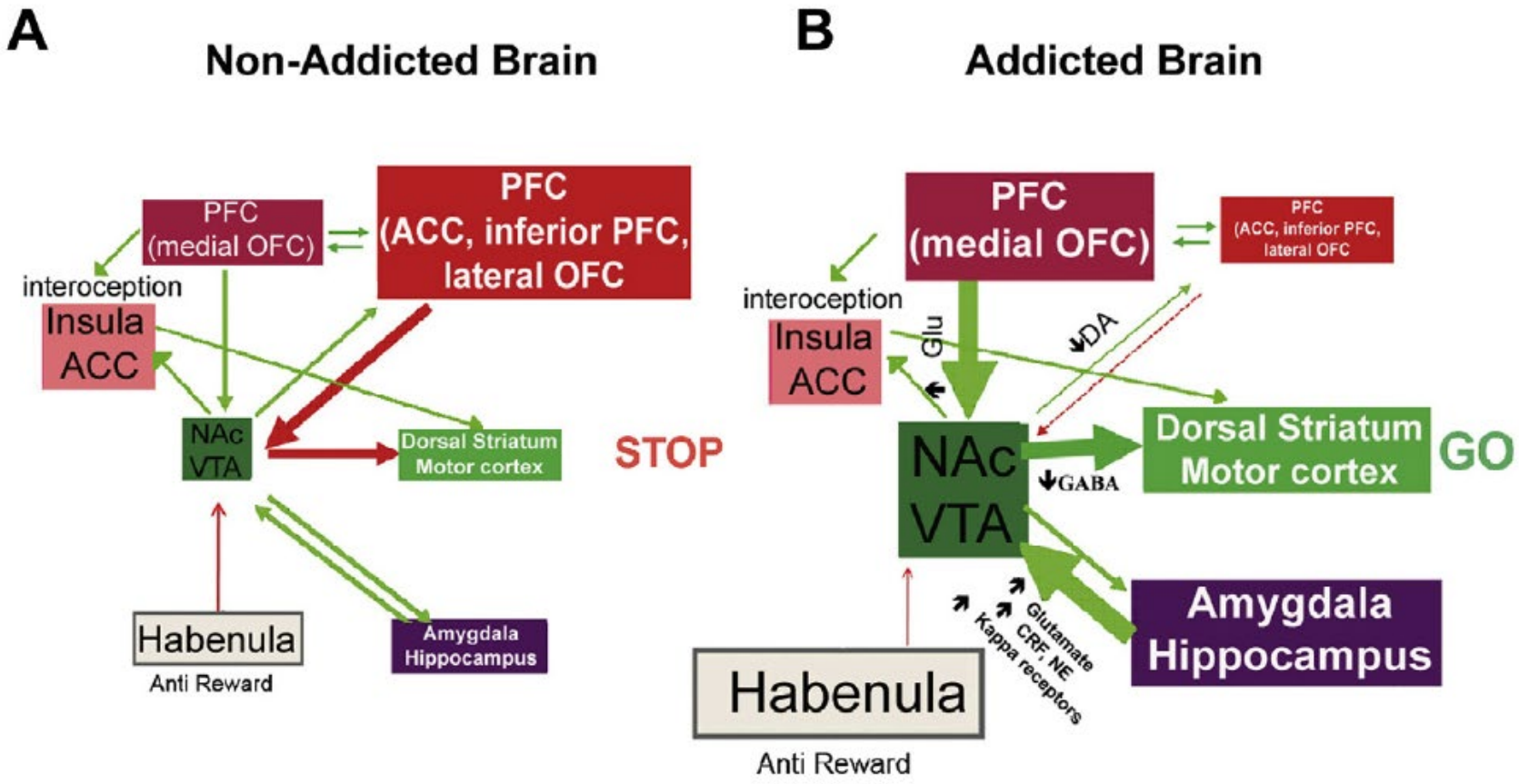
Modulating Inner Tensions

Mindfulness Interventions

- Smooth breathing
  - Suffocation Alarm Hypothesis of Panic disorder (CO_2 triggers suffocation alarm and adrenaline release) Yawn or sigh, then breathe smoothly.
  - Belly breathing
- Deciding to not decide
- Shaking it off
- Stretching
- Walking or exercise
- Distraction: engaging in an alternative activity

Conclusions

- Medication is the primary treatment of opiate use disorder
- Provider facilitated Psychotherapy and therapeutic neuroscience education can enhance retention in treatment
- Psychotherapists can assist when
  - The patient is struggling
  - Personality Disorders
  - Severe PTSD and Sexual Trauma


A
Non-Addicted Brain
PFC
(medial OFC)
PFC
(ACC, inferior PFC,
lateral OFC
interoception
Insula
ACC
NAc
VTA
Dorsal Striatum
Motor cortex
STOP
Habenula
Anti Reward
Amygdala
Hippocampus
B
Addicted Brain
PFC
(medial OFC)
PFC
(ACC, inferior PFC,
lateral OFC
interoception
Insula
ACC
Glu
DA
NAc
VTA
GABA
Dorsal Striatum
Motor cortex
GO
Glutamate
CRF, NE
Kappa receptors
Amygdala
Hippocampus
Habenula
Anti Reward

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