ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

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Session Date: Friday, September 23, 2022

Didactic Topic and Presenter:
An Overview of the Most Common Mental Health Conditions in Individuals with SUD

Dean Krahn, MD

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 and Discussion
    - Presenter: Alyssa Bruehlman, MD - *Addiction Medicine Fellow, University of Wisconsin*
- 1 PM: Didactic Presentation
    - Presenter: Dean Krahn, MD
- 1:15 PM End of Session

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON
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Project ECHO
University of Wisconsin

ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2022-2024
An Overview of the Most Common Mental Health Conditions in Individuals with SUD
9/23/2022

Didactic Presenter: Dean Krahn, MD
Case Presenter: Alyssa Bruehlman, MD

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:

1. Summarize the rate of co-occurring substance use and mental health disorders found in studies of general and clinical populations.
2. Explain the mechanisms proposed in the etiology of these co-occurring states.
3. Identify people with the combinations of co-occurring disorders that are particularly important in the development of specific treatment plans.

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Randall Brown	RSS Chair	No relevant financial relationships to disclose	Yes	2/15/2022
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	2/17/2022
Kathleen Maher	RSS Coordinator	No relevant financial relationships to disclose	No	7/14/22
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	2/13/2022
Paul Hutson	Planner	No relevant financial relationships to disclose	Yes	2/15/2022
Susan Mindock	Planner	No relevant financial relationships to disclose	No	2/15/2022
Sheila Weix	Planner	No relevant financial relationships to disclose	No	2/18/2022
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	2/14/2022
Joseph Galey	Planner	No relevant financial relationships to disclose	Yes	5/3/22
Alyssa Bruehlman	Presenter	No relevant financial relationships to disclose	Yes	6/10/2022

Dean Krahn	Presenter	No relevant financial relationships to disclose	No	6/9/2022

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Helping People With SUD's AND MH Disorders

Important Factors in Diagnosis and Treatment

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Overview

- How frequently do people experience co-occurring mental health and substance use disorders?
  - In the general population
  - In clinical populations
- How can we understand the mechanisms of co-occurrence of these disorders?
  - Neurobiological overlap
  - Common risk factors
  - Symptoms triggered by substance use, withdrawal, intoxication and symptoms which patients cope with via substance use
- How does this knowledge allow us to better evaluate and treat people who are experiencing these co-occurring disorders?
- Discussion of your experiences, hypotheses, questions with this group of people.

- There are two major recurring studies of appropriate groups that allow estimates of prevalence of substance use and MH disorders in the US population
  - NESARC and NSDUH
  - NSDUH revealed that in 2018
    - 57.8 million Americans (>18) had a mental disorder and/or SUD
    - 47.6 million (19.1% of Americans over 18) had MH disorder
    - 19.3 million (7.8%) had SUD (of these, 38% had DUD, 74.5% had AUD, and 13% had both AUD and DUD
    - 3.7% of Americans had both SUD and MH Disorder (ie 9.2 million)

- NESARC in 2012-2013 revealed that:
  - 9.9% of adult Americans have lifetime history of DUD and 3.9% have a 12-month history of DUD and 29% have lifetime history of AUD with 13.9% having a 12-month history of AUD.
  - Significant associations of 12-month DUD with several types of MH disorder were found. 12-month DUD was significantly associated with increased rates of Major Depression, dysthymia, bipolar I, PTSD, and antisocial, borderline, and schizotypal personality disorders. Strongest relationships were with bipolar, PTSD, and the personality disorders. Lifetime DUD was also related to GAD, panic, and social phobia.
  - 12 month and lifetime AUD was related most strongly to other SUD's, MDD, bipolar I, and antisocial and borderline personality disorders. DUD's were by far the most strongly related to AUD, while PTSD, antisocial PD, and borderline PD were the most strongly related MH disorders to AUD.

- If one looks at the rate of SUD's in people identified as having a MH disorder, these are the findings:
  - For people with any mood disorder, the ECA revealed a 32% prevalence of a co-occurring SUD
  - But those with a lifetime hx of Major Depression had 16.5% rate of AUD and an 18% rate of DUD (about 25% overall SUD) but those with bipolar d/o had a 56% prevalence of SUD
    - In the National Comorbidity Study, data shows that people with depression were twice as likely to have SUD compared to those without depression, while those people with bipolar disorder were 7X as likely to have an SUD than those w/o bipolar.
    - Note, however, that if one is looking at people presenting for treatment for AUD, you will find a 20-67% rate of depression and a 6-8% with bipolar. Somewhat higher rates of these disorders for those seeking tx for stim d/o's
- Much like mood disorders, there are specific anxiety disorders that are more highly connected to addiction (eg social anxiety, PTSD (not really an anxiety d/o but can present that way))

- The problem of perspective on these co-occurrences that depends on what kind of clinic setting you work in
  - If you are part of a psychiatric setting, will get more co-occurring disorders
  - If you are part of a long-standing addiction program with hx of being reliant on 12 step treatment, might get less (depending on lots of related variables)
  - ETC!!! Need to learn your own clinical population

- Both MH disorders and Substance Use Disorders involve abnormalities in function of prefrontal cortex, amygdala, and ventral and dorsal basal ganglia.
  - In SUD, see changes in reward systems and "habit" systems in the basal ganglia; see interactions of the stress/anxiety system involving amygdala and use of substances/withdrawal from substances; see changes in prefrontal cortex leading to increased impulsivity and inability to regulate use of substances
  - In MH disorders, see changes in ability to experience pleasure/reward (ie anhedonia) related to basal ganglia dysfunction; see interactions mediated by amygdala between mood/thinking and stress; and see changes in prefrontal cortex leading to difficulty in thinking and in regulating behavior
  - So, it would be surprising if there wasn't co-occurrence and interactions

- Similar genetic and environmental risk factors
  - ACE's
  - Other trauma
  - Social determinants of disorders
  - Genetic vulnerability

- Clinical hints re: treatment
  - Thorough history taking from person who is using drugs and others who know that person is critical
    - Need to understand longitudinal relationships of the clinical syndromes
    - Need to recognize syndromes induced by repeated withdrawals or intoxications
    - Need to identify comorbid MH problems that occur when the person has had a verified extended sobriety or that occurred prior to use/misuse of substances.

- Need to identify disorders that require specific treatment not likely to respond to the “one-size, one-type fits all SSRI”
  - Bipolar might well get worse over time with SSRI even though an early initial response might look very good
  - Social anxiety disorder requires specific psychotherapy and might not require meds at all
  - PTSD clearly requires specific expert psychotherapy in addition to medications and addiction treatment (? Role of prazosin, SSRI’s, etc)
  - ADHD: treatment often helpful but brings up the process of using somewhat “addictive” meds in tx of addiction
    - Important to note that studies support the use of stimulants for people misusing cocaine who have ADHD—but it is hard work and requires lots of education of patient and all other concerned parties in family/friend group

- Treatment must be integrated, not sequential
  - Telling people with PTSD who have often been using substances to cope with aspects of PTSD that they need to stop using for X amount of time prior to getting tx for PTSD is often a reason for treatment drop-out.
    - Might need to be creative in how to work on both issues at once
  - CBT approaches can be worked into the treatment plan of nearly every person with co-occurring disorders as there are forms of CBT for problems with mood, anxiety, alcohol, other substances. Using these skills across problems and across other parts of one's life can be a real boon to recovery/success in life.

- In summary,
  - Co-occurring disorders (SUD + MH) are frequent and all people involved in treatment of people who have problems due to substance use should be able to recognize and arrange or provide integrated treatment for these disorders
  - Some MH disorders are more tightly connected to problems with SUD than others and require greater specificity in treatment planning.
  - People seeking treatment often don't "want" to have multiple diagnoses, but one must become adept at creating hope through the appropriate treatment of all the problems, not just some.
- Thanks/comments and questions???

- References:

- Nunes, EV & Weiss R. Co-occurring Addiction and Affective Disorders in Principles of Addiction Medicine 4th edition, Ch. 84, pages 1151-1181, 2009 (with additional material from Dr Nunes' talk on Antidepressant and Antianxiety Pharmacotherapy with Co-Occurring SUD in the Advanced Addiction Psychopharmacology course 2021
- NESARC data: Grant BF, et al. Epidemiology of DSM-5 Drug Use Disorder: Results from the National Epidemiological Survey on Alcohol and Related Conditions-III; JAMA Psychiatry.2016; 73(1):39-47 and Grant BF, et al. Epidemiology of DSM-5 Alcohol Use Disorder: Results from the National Epidemiological Survey on Alcohol and Related Conditions III, 2016

- References (continued)
- Quello SB et al., Mood Disorders and Substance Use Disorder: A Complex Comorbidities. SciPract Perspective 2005 Dec; 3(1):13-21
- Smith JP et al., Anxiety and Substance Use Disorders: A Review. Psychiatric Times. 2008 October; 25(10):19-23
- Brady KT, Post-traumatic Stress Disorder and Comorbidity:Recognizing the Many Faces of PTSD. J Clin Psychiatry 1997; 58(suppl 9); 12-15
- Zulauf CA et al., The Complicated Relationship Between Attention Deficity/Hyperactivity Disorder and SUD's. Curr Psychiatry Rep. 2014 March; 16(3): 436.

Conclusions

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

Buprenorphine-naloxone in Palliative Care

Alyssa Bruehlman, MD

Addiction Medicine Fellow

UW Department of Family Medicine and Community Health

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Case Introduction

- 60 yo woman with opioid use disorder (OUD) in sustained remission as well as stage IV non-squamous cell lung cancer (NSCLC) with current prescription for fentanyl transdermal patches referred by palliative care MD re: medication safety concerns

- Primary questions for discussion:
  - In what scenarios should we consider buprenorphine for chronic pain?
  - How do you safely transition from transdermal fentanyl patch to buprenorphine-naloxone (BUP-NX)?

Medical & Behavioral Health Diagnosis:	Current Medications:

• Stage IV NSCLC, brain + bone metastasis
• S/p craniotomy and partial resection
• Recurrent falls complicated by chronic subdural hematoma
• Cognitive impairment
• Underweight, BMI 17
• Chronic pain
• OUD in remission
• COPD
• Anxiety/depression
	• Immunotherapy (pembrolizumab)
	• Levetiracetam 500mg BID
	• Additional palliative meds:
	  • Fentanyl 50mcg/hr patch (q72 hrs)
	  • APAP, NAID prn pain
	  • Prochlorperazine prn nausea
	  • Senna-docusate prn constipation
	• Formerly on BUP-NX (2004-2018)
	• Albuterol inhaler prn
	• Escitalopram 20mg daily

Recent Hospitalizations

- 8/2021:
  - Encephalopathy attributed to polypharmacy (lorazepam, morphine IR), wearing 3 fentanyl patches on presentation
- 11/2021:
  - Overdose, respiratory arrest responsive to naloxone, wearing 4 fentanyl patches
  - Complicated by stress-induced cardiomyopathy
- 3/2022:
  - Encephalopathy, seizure-like activity
  - 2 fentanyl patches in place

→ 4/2022:

- Outpatient consult to addiction medicine team

Substance Use

- History:
  - Remote heroin use > 10 years ago (presume IDU, hx HCV Ab+)
  - Hx alcohol misuse
  - Hx daily tobacco use
  - Current daily marijuana use (inhaled)
  - Denies not taking medications as prescribed
    - Concerns for BZD misuse, impulsivity per prior notes
    - Concerns re: cognitive impairment affecting fentanyl patch mgmt
    - Pt shows new label system for fentanyl patches, previously declined HH
- Past treatments:
  - BUP-NX x 14 years (daily dose 8-16mg bup), discontinued around time of cancer diagnosis, concern re: not effective for pain
  - Briefly on methadone, not positive experience (> 15 years ago)

Social History:	Family History:

• Social Factors/History:
  • Husband died by overdose 2003
  • 3 kids (at least 1 in WI), multiple grandkids
  • Roommate also assists as caregiver
• Income source: SSI
• ADLs: independent
	• 3 kids, multiple grandkids
	• Otherwise not asked

Patient strengths & protective factors:	Risk factors:
• Engagement with multidisciplinary care including behavioral health, social work • Sense of humor	• Minimal social support (caregiver overwhelmed per notes) • Cognitive impairment limiting medication adherence • Strained relationship with palliative care provider

Labs

- 4/2022 UDT (LC/MS):
  - + fentanyl, norfentanyl, marijuana

- Previous UDS (immunoassay, no confirmatory testing):
  - + cannabinoids, intermittent + opiates

Patient Goals & Motivations for Treatment

- Pain management
  - *"I'm not looking for anxiety meds or pain meds, I'm just looking to stay on my patch."*
  - *"Where I sit with the suboxone is that…it's not a really good cancer treatment (referencing cancer pain)... I'm not having an addiction issue, I'm not begging for my prescription, I'm not using street drugs, crazy stuff doesn't happen."*

- Avoiding hospitalizations, falls, overdose

Proposed Diagnoses

- OUD in remission
- Chronic pain
- Complex persistent opioid dependence?

In the last 12 months (opioids):	
Larger amounts or longer than than intended	+ (overdose hx, but related to cognitive impairment?)
Persistent desire or attempts to cut down or stop	-
Excessive time using, getting, recovering	-
Craving	-
Failure to fulfill a major role	-
Continued use despite social/interpersonal conflicts	-
Withdrawal from activities	-
Use in physically hazardous situations	-
Use despite knowing its doing harm	N/A
Tolerance	N/A
Withdrawal (if applicable)	N/A

Proposed Treatment Plan

	Fentanyl patch	BUP-NX
Day 1	Apply final patch (remove prior)	1mg BID
Day 2		1mg TID
Day 3		2mg TID
Day 4	Remove patch	2mg TID

- + Naloxone Rx
- Ultimately 2-0.5mg film BID
  - No precipitated or eventual withdrawal
  - Pain controlled
  - Concern for sedation at TID or higher doses

Discussion:

- Primary question:
  - In what scenarios should we consider buprenorphine for chronic pain?
  - How do you safely transition from transdermal fentanyl patch to BUP-NX?

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

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