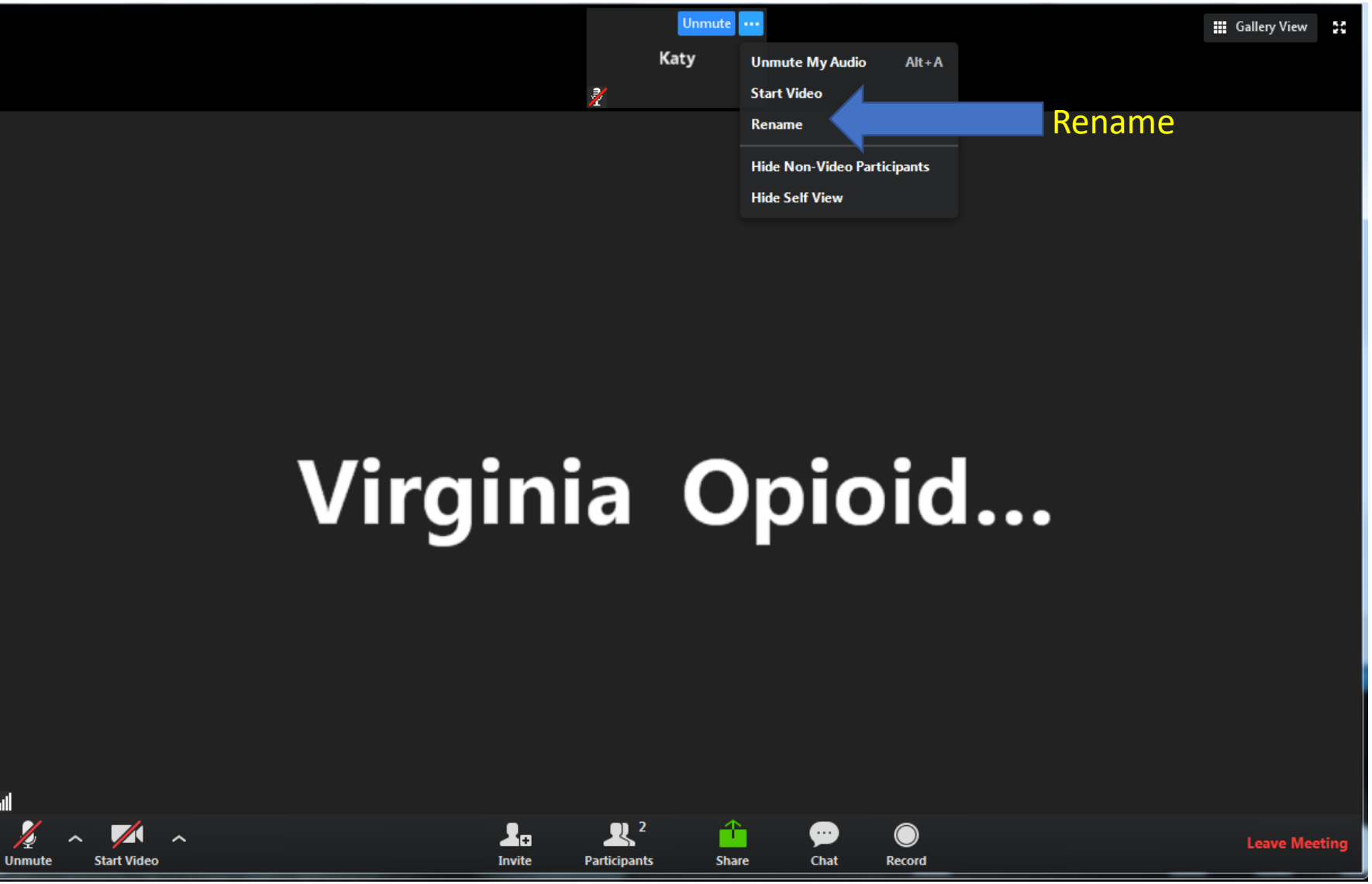
Virginia Opioid Addiction ECHO* Clinic

March 26, 2021

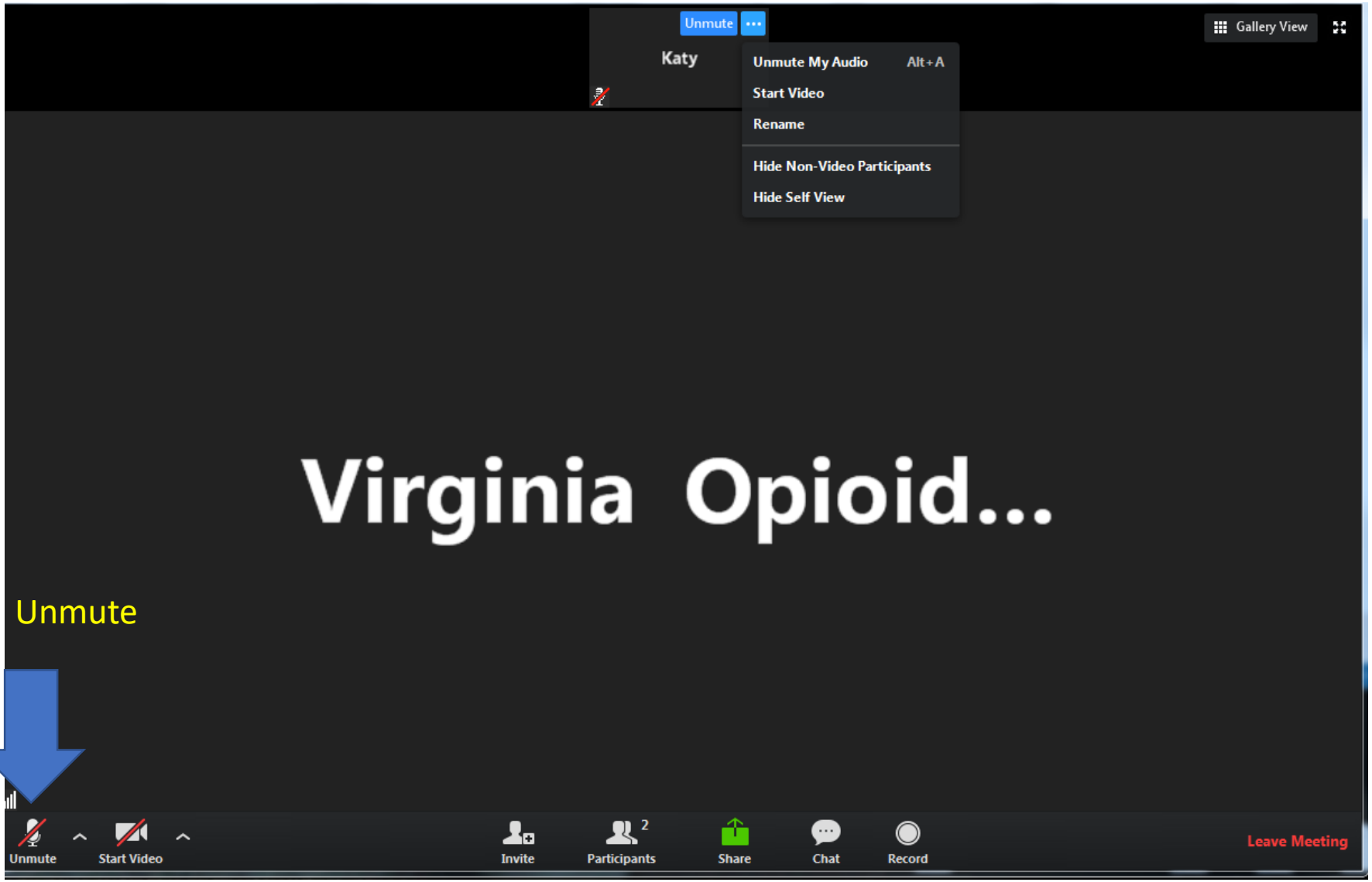
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



- Rename your Zoom screen, with your name and organization

Helpful Reminders



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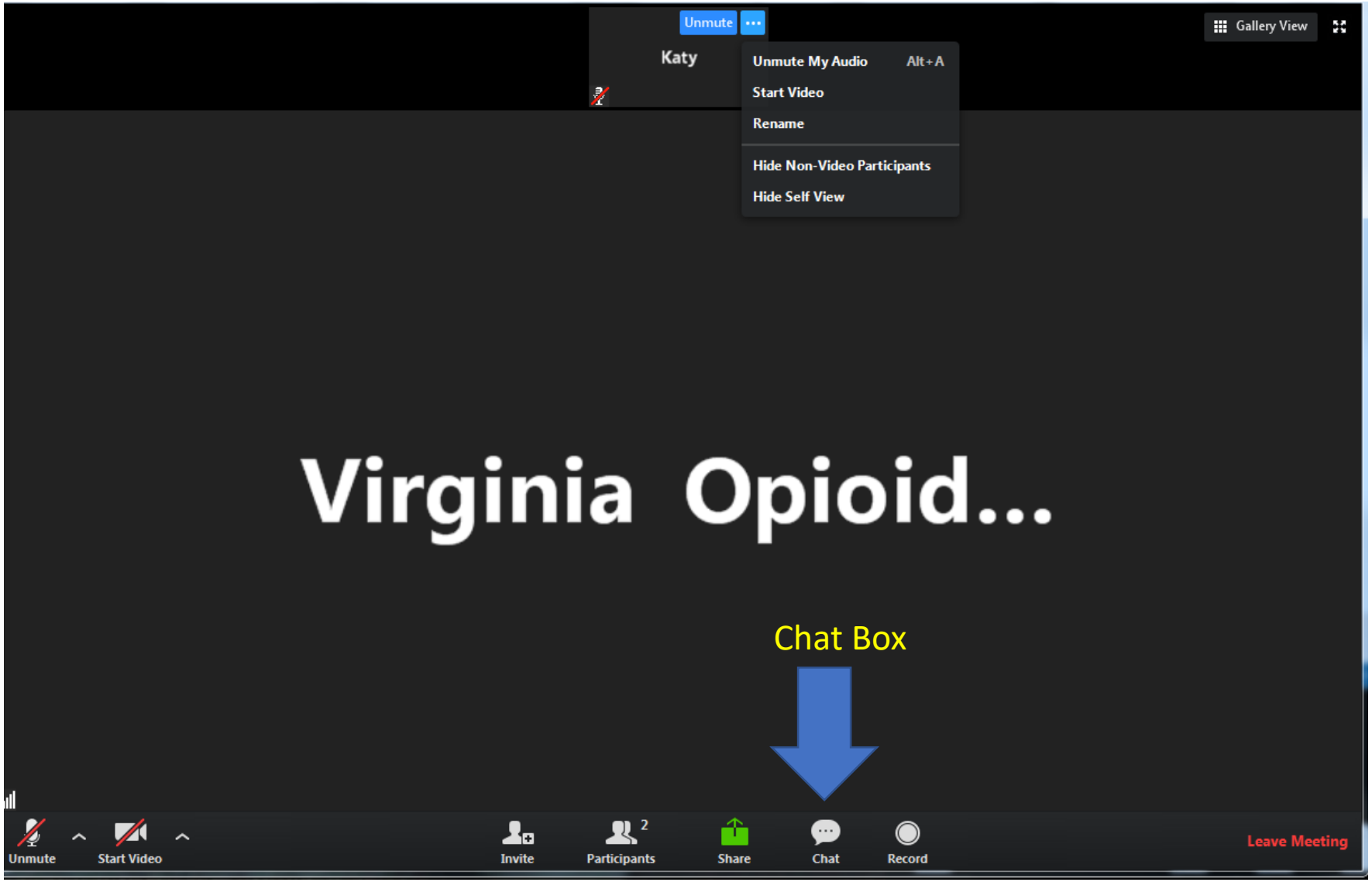
- If joining by telephone audio only, *6 to mute and unmute

Helpful Reminders



- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

VCU Opioid Addiction ECHO Clinics

VCU School of Medicine

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
- Didactic presentations are developed and delivered by inter-professional experts
- Website Link: www.vcuhealth.org/echo

Hub and Participant Introductions

VCU Team	
Clinical Director	Gerard Moeller, MD
Administrative Medical Director ECHO Hub	Vimal Mishra, MD, MMCi
Clinical Experts	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD Megan Lemay, MD Salim Zulfiqar, MD
Didactic Presentation	Gerry Moeller, MD
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

- Name
- Organization

Reminder: Mute and Unmute screen to talk

*6 for phone audio

Use chat function for Introduction

What to Expect

I. Didactic Presentation
   I. **Gerry Moeller, MD**
II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

VCU

C. Kenneth and Dianne Wright Center
for Clinical and Translational Research

Medication for Addiction Treatment Risks of Cognition Effects vs. Benefits of Treatment

F. Gerard Moeller, M.D.

Division Chair for Addictions,

Virginia Commonwealth University

Disclosure

- Grant funding from Indivior
- Consultant for Astellas, AstraZenca, Indivior, Boehringer Ingelheim
- Content of presentation unrelated to grants or consulting

Medication and Substance Use Disorder Treatment: Why Use Medication?

- FDA approved medication for alcohol use disorder (disulfiram, naltrexone (oral and depot), and acamprosate)
- FDA approved medication for opioid use disorder treatment (methadone, buprenorphine (sublingual and depot) and naltrexone (oral and depot), opioid withdrawal symptoms (lofexidine), and overdose (naloxone)
- Unfortunately, no FDA approved medication for cocaine, amphetamine/methamphetamine, or cannabis use disorders

Medication and Alcohol Use Disorder Treatment: **Evidence**

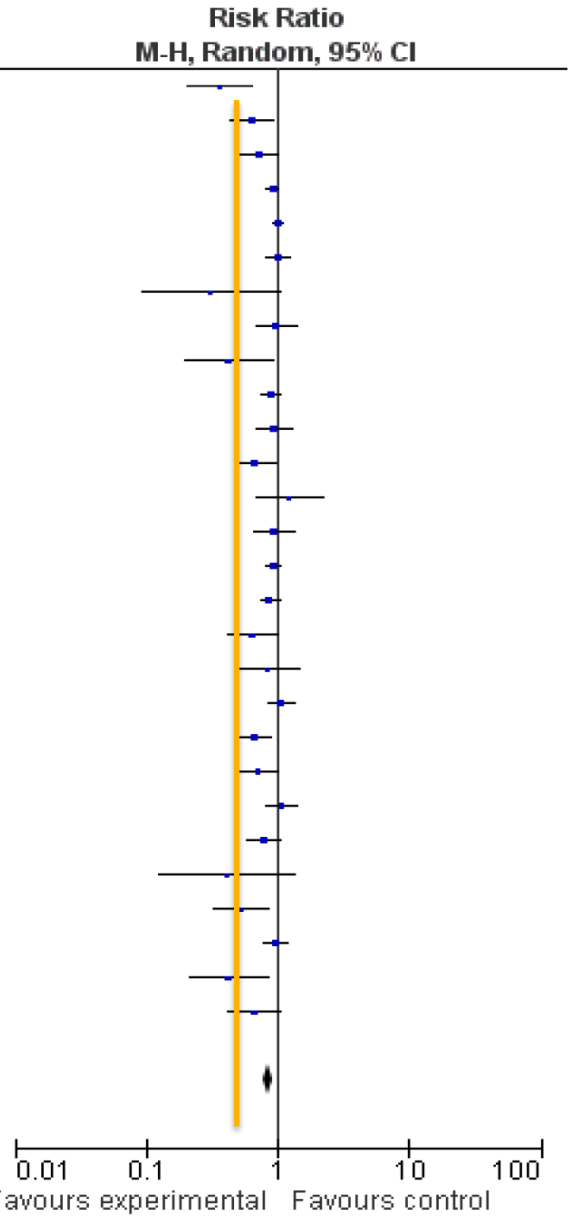
- Naltrexone for alcohol use disorder review Rosner et al., 2010:
  - **50 RCTs with 7793 patients**, naltrexone **reduced the heavy drinking to 83% of the risk in the placebo group and decreased drinking days by about 4%.** Significant effects were also demonstrated for the secondary outcomes of the review including heavy drinking days, consumed amount of alcohol, and gamma-glutamyltransferase, while effects on return to any drinking missed statistical significance.

Figure 5. Forest plot of comparison: 1 NTX versus PBO, outcome: 1.1 Return to heavy drinking.

Me nt:

Study or Subgroup	Naltrexone Events	Total	Placebo Events	Total	Weight	Risk Ratio M-H, Random, 95% CI
Ahmadi 2002	12	58	33	58	1.8%	0.36 [0.21, 0.63]
Anton 1999	26	68	38	63	3.2%	0.63 [0.44, 0.91]
Anton 2005	33	80	46	80	3.6%	0.72 [0.52, 0.99]
Anton 2006	207	309	226	309	7.1%	0.92 [0.83, 1.02]
Balldin 2003	53	56	58	62	7.3%	1.01 [0.92, 1.11]
Chick 2000	57	85	53	79	5.2%	1.00 [0.81, 1.24]
de Goes e Castro 2004	3	35	10	36	0.4%	0.31 [0.09, 1.03]
Gastpar 2002	34	84	36	87	3.2%	0.98 [0.68, 1.40]
Guardia 2002	8	101	19	101	1.0%	0.42 [0.19, 0.92]
Heinälä 2001	49	63	51	58	6.1%	0.88 [0.75, 1.04]
Hersh 1998	22	31	25	33	3.9%	0.94 [0.70, 1.26]
Kiefer 2003	20	40	30	40	3.2%	0.67 [0.47, 0.95]
Killeeen 2004	21	51	12	36	1.7%	1.24 [0.70, 2.18]
Kranzler 2000	29	61	32	63	3.2%	0.94 [0.65, 1.34]
Kranzler 2004	122	158	132	157	7.0%	0.92 [0.82, 1.02]
Krystal 2001	183	418	105	209	5.9%	0.87 [0.73, 1.04]
Latt 2002	19	56	27	51	2.4%	0.64 [0.41, 1.00]
Monti 2001	16	64	19	64	1.7%	0.84 [0.48, 1.49]
Morley 2006	39	53	43	61	5.0%	1.04 [0.83, 1.31]
Morris 2001	28	55	43	56	3.9%	0.66 [0.49, 0.89]
O'Malley 1992	24	52	34	52	3.3%	0.71 [0.50, 1.01]
O'Malley 2007	39	57	32	50	4.3%	1.07 [0.81, 1.40]
O'Malley 2008	22	34	28	34	4.0%	0.79 [0.59, 1.05]
Oslin 1997	3	21	8	23	0.5%	0.41 [0.13, 1.35]
Oslin 2005	13	37	25	37	2.1%	0.52 [0.32, 0.85]
Oslin 2008	73	120	76	120	5.5%	0.96 [0.79, 1.17]
Volpicelli 1992	8	35	19	35	1.3%	0.42 [0.21, 0.83]
Volpicelli 1997	17	48	26	49	2.3%	0.67 [0.42, 1.06]
Total (95% CI)		**2330**		**2103**	**100.0%**	**0.83 [0.76, 0.90]**
Total events	1180		1286			

Heterogeneity: Tau² = 0.02; Chi² = 69.81, df = 27 (P < 0.0001); I² = 61%
Test for overall effect: Z = 4.39 (P < 0.0001)



(From Rosner et al., 2010a)

Medication and Alcohol Use Disorder Treatment: **Evidence**

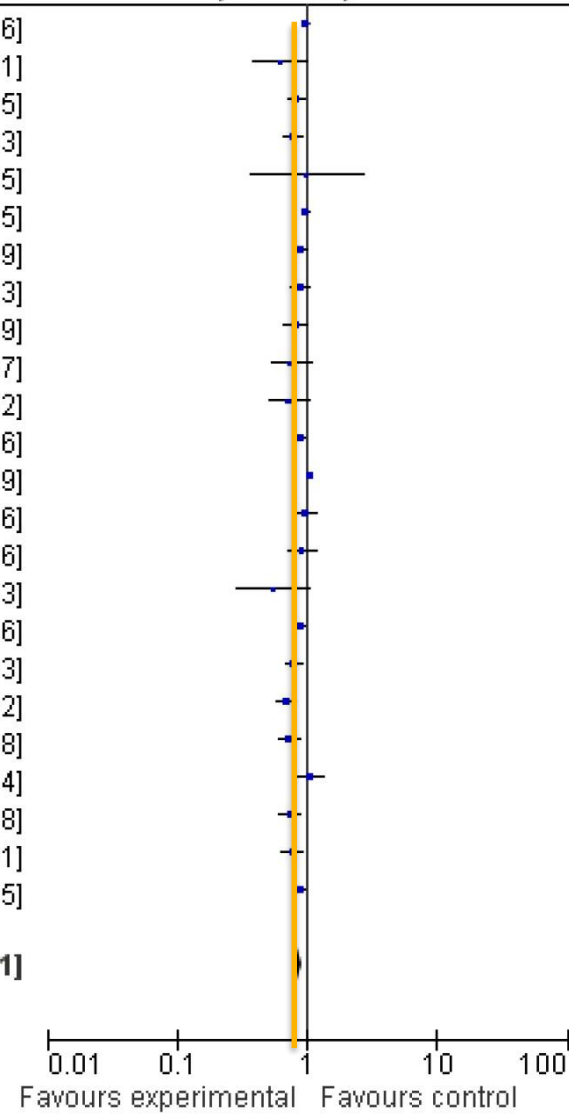
- Acamprosate for alcohol use disorder review Rosner et al., 2010:
  - **24 RCTs with 6915 patients**. Compared to placebo, acamprosate **significantly reduced the risk of any drinking and significantly increased the cumulative abstinence duration**, but secondary outcomes (gamma-glutamyltransferase, heavy drinking) did not reach statistical significance.

Figure 6. Forest plot of comparison: 1 ACAM versus PBO, outcome: 1.1 Return to any drinking.

Study or Subgroup	Acamprosate Events	Acamprosate Total	Placebo Events	Placebo Total	Weight	Risk Ratio M-H, Random, 95% CI
Anton 2006	244	303	254	309	6.3%	0.98 [0.91, 1.06]
Baltieri 2003	15	40	21	35	1.2%	0.63 [0.39, 1.01]
Barrias 1997	98	150	121	152	4.9%	0.82 [0.71, 0.95]
Besson 1998	41	55	52	55	4.4%	0.79 [0.67, 0.93]
Borg 2003	3	5	3	5	0.3%	1.00 [0.36, 2.75]
Chick 2000	254	289	260	292	6.5%	0.99 [0.93, 1.05]
Geerlings 1997	103	128	121	134	5.8%	0.89 [0.80, 0.99]
Gual 2001	92	141	109	147	4.7%	0.88 [0.75, 1.03]
Kiefer 2003	30	40	37	40	3.8%	0.81 [0.66, 0.99]
Ladewig 1993	17	29	25	32	1.9%	0.75 [0.53, 1.07]
Lhuintre 1985	22	42	31	43	2.0%	0.73 [0.52, 1.02]
Lhuintre 1990	208	279	245	291	6.1%	0.89 [0.81, 0.96]
Mason 2006	328	341	240	260	6.8%	1.04 [1.00, 1.09]
Morley 2006	44	55	50	61	4.2%	0.98 [0.82, 1.16]
Namkoong 2003	45	72	48	70	3.2%	0.91 [0.72, 1.16]
Niederhofer 2002	6	13	11	13	0.7%	0.55 [0.29, 1.03]
Paille 1995	294	361	161	177	6.4%	0.90 [0.84, 0.96]
Pelc 1992	42	55	45	47	4.6%	0.80 [0.68, 0.93]
Pelc 1997	74	126	53	62	4.2%	0.69 [0.57, 0.82]
Poldrugo 1997	66	122	92	124	3.9%	0.73 [0.60, 0.88]
Rousseaux 1996	45	63	43	64	3.3%	1.06 [0.84, 1.34]
Sass 1996	75	136	102	136	4.2%	0.74 [0.61, 0.88]
Tempesta 2000	87	164	115	166	4.2%	0.77 [0.64, 0.91]
Whitworth 1996	183	224	208	224	6.3%	0.88 [0.82, 0.95]
Total (95% CI)		**3233**		**2939**	**100.0%**	**0.86 [0.81, 0.91]**
Total events	2416		2447			

Heterogeneity: Tau² = 0.01; Chi² = 110.11, df = 23 (P < 0.00001); I² = 79%

Test for overall effect: Z = 5.07 (P < 0.00001)



(From Rosner et al., 2010b)

Medication and Alcohol Use Disorder Treatment: Evidence

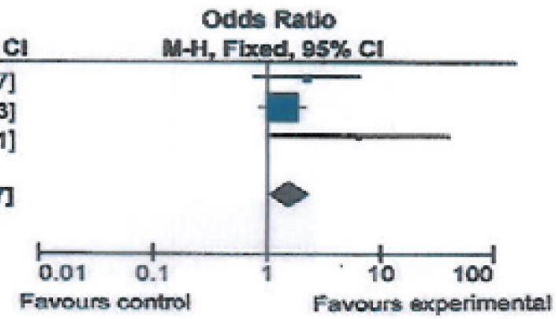
- Disulfiram for alcohol use disorder review Jorgensen et al., 2011
  - **11 randomized controlled trials with a total of 1,527 patients**. Overall, **6 studies reported of a significant better effect on abstinence for patients treated with disulfiram**. Six of 9 studies measuring secondary outcomes reported that patients treated with disulfiram had significantly more days until relapse and fewer drinking days, respectively. **Monitored medication use important. Side effects can be significant**.

4 Unsupervised disulfiram versus other or no treatment

4.1 Alcohol abstinence

Study or Subgroup	Disulfiram Events	Total	Other or no treatment Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Fuller et al. 1979	20	86	5	42	12.8%	2.24 [0.78, 6.47]
Fuller et al. 1986	84	406	32	199	84.9%	1.36 [0.87, 2.13]
Niederhofer et al. 2003	7	13	2	13	2.3%	6.42 [1.00, 41.21]
Total (95% CI)		**505**		**254**	**100.0%**	**1.59 [1.07, 2.37]**
Total events	111		39			

Heterogeneity: Chi² = 3.03, df = 2 (P = 0.22); I² = 34%
Test for overall effect: Z = 2.27 (P = 0.02)

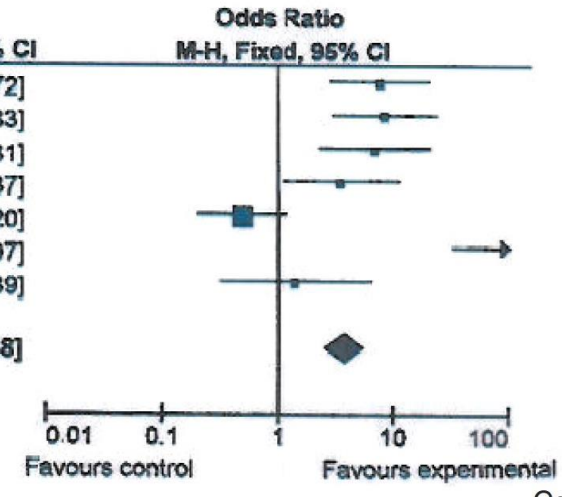


3 Supervised disulfiram versus other or no treatment

3.1 Alcohol abstinence

Study or Subgroup	Disulfiram Events	Total	Other or no treament Events	Total	Weight	Odds Ratio M-H, Fixed, 95% CI
De Sousa 2004	43	50	22	50	10.9%	7.82 [2.95, 20.72]
De Sousa 2005	44	50	23	50	9.7%	8.61 [3.11, 23.83]
De Sousa 2008a	45	50	28	50	9.9%	7.07 [2.40, 20.81]
De Sousa 2008b	23	29	15	29	11.0%	3.58 [1.13, 11.37]
Nava et al. 2006	12	31	31	55	48.4%	0.49 [0.20, 1.20]
Tønnesen et al. 1999	20	20	0	21	0.0%	1763.00 [33.40, 93070.97]
Ulrichsen 2010	5	19	4	20	10.1%	1.43 [0.32, 6.39]
Total (95% CI)		**249**		**275**	**100.0%**	**3.89 [2.66, 5.68]**
Total events	192		123			

Heterogeneity: Chi² = 36.84, df = 6 (P < 0.00001); I² = 84%
Test for overall effect: Z = 7.00 (P < 0.00001)



(From Jorgensen et al., 2011)

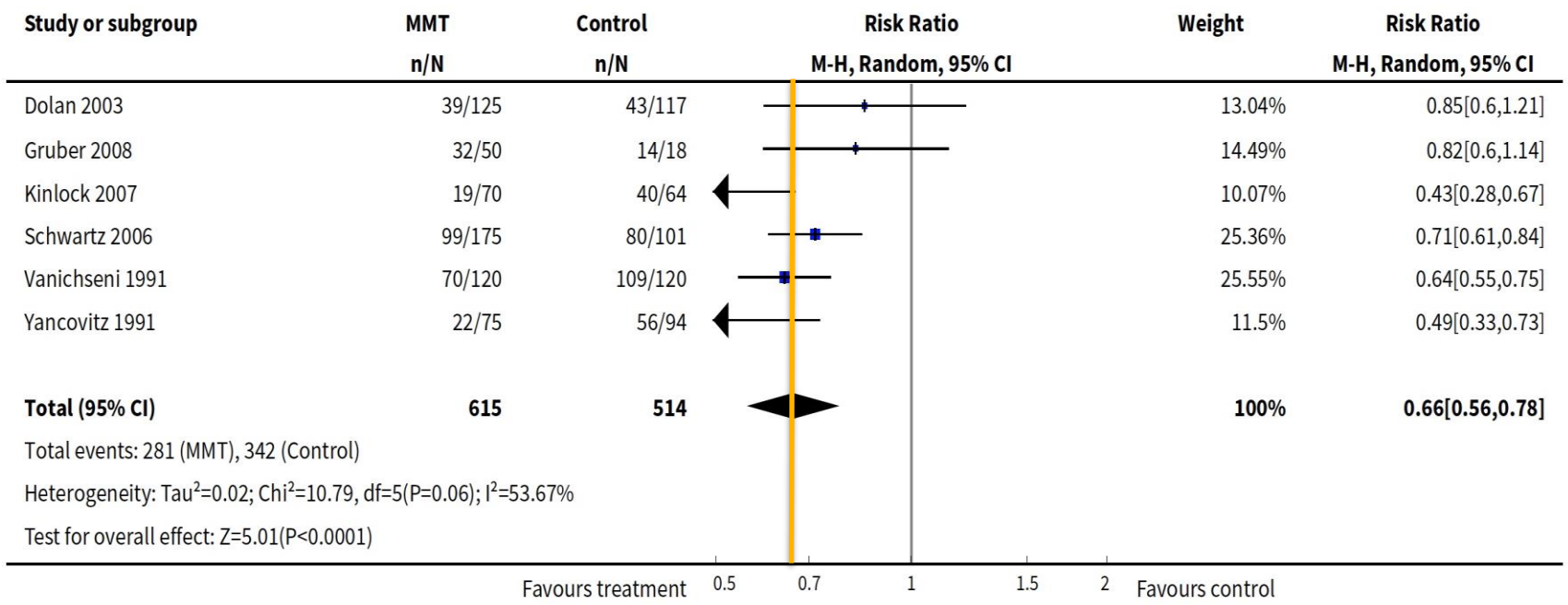
Medication and Alcohol Use Disorder Treatment: Evidence

- **Overall, evidence supports medication treatment for alcohol use disorder, Naltrexone reduces heavy drinking, acamprosate reduces relapse to drinking after abstinence, disulfiram may have use but may require monitoring and side effects significant.**

Medication and Opioid Use Disorder Treatment: **Evidence**

- Methadone for opioid use disorder vs. no medication review Mattick et al., 2009:
  - **11 studies with 1969 patients**. Methadone appeared statistically **significantly more effective than non-pharmacological approaches in retaining patients in treatment and in the suppression of heroin use** as measured by self report and urine/hair analysis, but not statistically different in criminal activity or mortality.

Analysis 1.2. Comparison 1 Methadone maintenance treatment vs No methadone maintenance treatment, Outcome 2 Morphine positive urine or hair analysis.



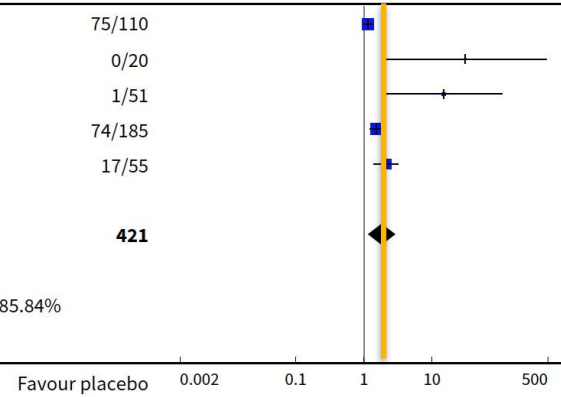
(From Mattick et al., 2009)

Medication and Opioid Use Disorder Treatment: **Evidence**

- Buprenorphine for opioid use disorder vs. no medication or methadone review Mattick et al., 2014:
  - **31 studies with 5430 patients**. High quality of evidence that **buprenorphine superior to placebo in retention of participants in treatment at all doses examined**. However, there is moderate quality of evidence that only high-dose buprenorphine (≥ 16 mg) was more effective than placebo in suppressing illicit opioid use measured by urinalysis in the trials. No difference between high-dose buprenorphine (≥ 16 mg) and high-dose methadone (≥ 85 mg) in retention or suppression of self-reported heroin use (1 study, 134 participants).

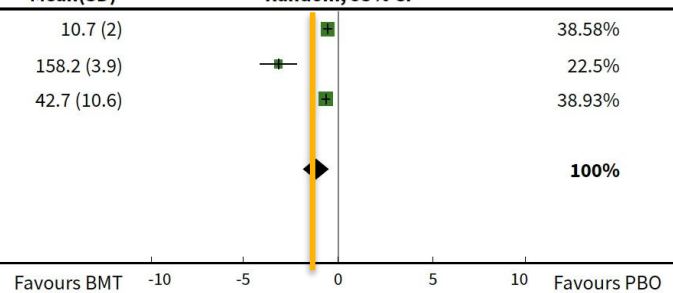
Analysis 7.1. Comparison 7 High-dose buprenorphine versus placebo, Outcome 1 Retention in treatment.

Study or subgroup	Very high dose BMT n/N	Placebo n/N	Risk Ratio M-H, Random, 95% CI	Weight	Risk Ratio M-H, Random, 95% CI
Fudala 2003	168/216	75/110		33.43%	1.14[0.99,1.32]
Kakko 2003	15/20	0/20		2.62%	31[1.98,485.13]
Krook 2002	16/55	1/51		4.71%	14.84[2.04,107.89]
Ling 1998	110/181	74/185		32.25%	1.52[1.23,1.88]
Ling 2010	71/108	17/55		26.99%	2.13[1.4,3.23]
Total (95% CI)	**580**	**421**		**100%**	**1.82[1.15,2.9]**
Total events: 380 (Very high dose BMT), 167 (Placebo)					
Heterogeneity: Tau^2=0.16; Chi^2=28.24, df=4(P<0.0001); I^2=85.84%					
Test for overall effect: Z=2.54(P=0.01)					



Analysis 7.2. Comparison 7 High-dose buprenorphine versus placebo, Outcome 2 Morphine-positive urines.

Study or subgroup	Very high dose BMT N	Very high dose BMT Mean(SD)	Placebo N	Placebo Mean(SD)	Std. Mean Difference Random, 95% CI	Weight	Std. Mean Difference Random, 95% CI
Fudala 2003	214	9.1 (3.3)	109	10.7 (2)		38.58%	-0.55[-0.78,-0.32]
Kakko 2003	20	45.7 (49.4)	20	158.2 (3.9)		22.5%	-3.15[-4.1,-2.19]
Ling 1998	181	34.1 (15.4)	185	42.7 (10.6)		38.93%	-0.65[-0.86,-0.44]
Total ***	**415**		**314**			**100%**	**-1.17[-1.85,-0.49]**
Heterogeneity: Tau^2=0.3; Chi^2=26.88, df=2(P<0.0001); I^2=92.56%							
Test for overall effect: Z=3.38(P=0)							



"High" dose = 16mg or more daily

(From Mattick et al., 2014)

Medication and Opioid Use Disorder Treatment: **Evidence**

- **Naltrexone for opioid use disorder**.
- **Oral naltrexone** review Minozzi et al., 2011:
  - **13 studies with 1158 patients**. Comparing naltrexone versus placebo or no pharmacological treatments, **no statistically significant difference were noted for all the primary outcomes considered.** The only outcome statistically significant in favor of naltrexone was re incarceration, but results come only from two studies.
- Compliance is a major issue with oral naltrexone for opioid use disorder (28% retention in studies reviewed).

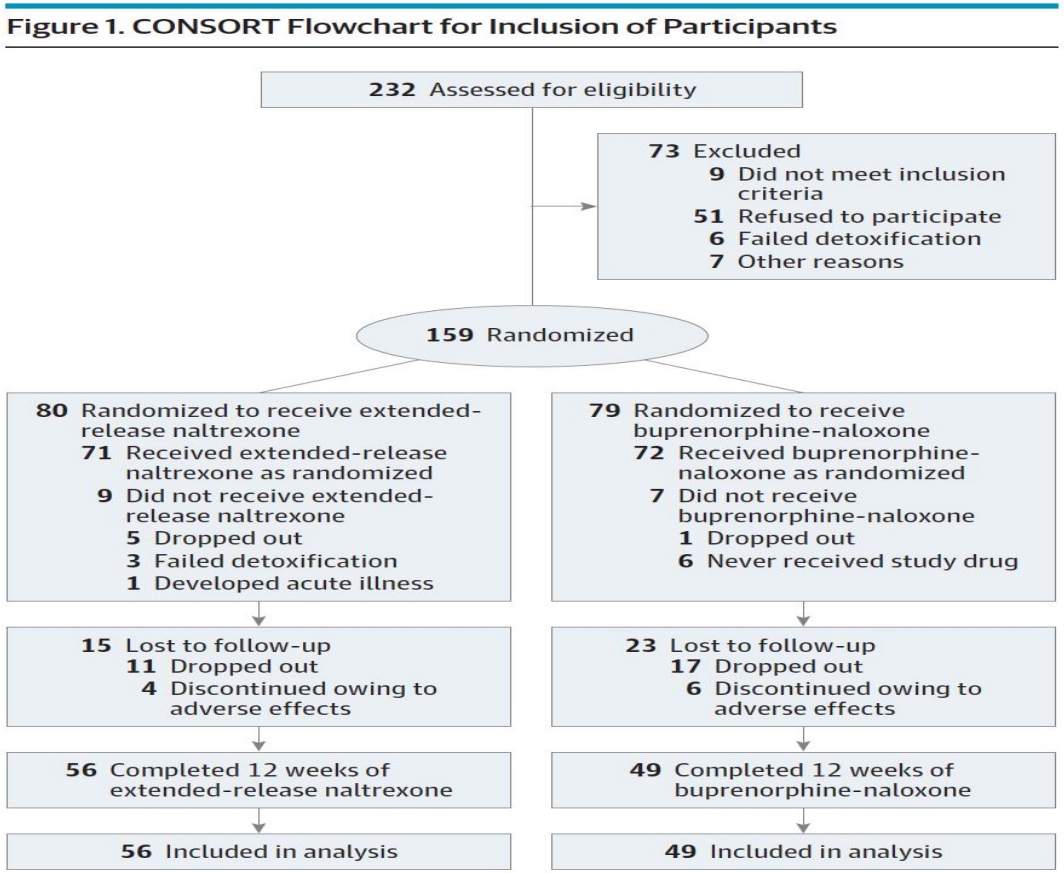
Medication and Opioid Use Disorder Treatment: **Evidence**

- **Naltrexone for opioid use disorder**.
  - **Sustained release implant naltrexone** Krupitsky et al., 2011a:
    - **306 patients** in Russia. Comparing sustained release naltrexone, oral naltrexone, and placebo. **Sustained release naltrexone significantly better treatment retention and negative urine drug screens at 6 months.**
  - Sustained release injectable naltrexone Krupitsky et al., 2011b:
    - 250 patients in Russia. **Significantly greater retention and opioid free days in depot naltrexone group.**

    Sustained release naltrexone effective. Wound infections more common in implants, though not serious if treated

Medication and Opioid Use Disorder Treatment: **Evidence**

Tanum et al., Buprenorphine vs. Depot Naltrexone



From Tanum et al., 2017

Medication and Opioid Use Disorder Treatment: **Evidence**

Buprenorphine vs. Depot Injectable Naltrexone for opioid use disorder Tanum et al., 2017:

- **232 patients** in Norway. Comparing sustained release 380mg naltrexone, vs. oral buprenorphine/naloxone 4-24mg. **Retention and opioid negative urines in the extended-release naltrexone group were noninferior to the buprenorphine-naloxone group, Lower illicit opioid use in the naltrexone group.**
- **Patients that can undergo detox and receive depot naltrexone do as well as buprenorphine treated patients**

Medication and Alcohol Use Disorder Treatment: **Cognitive Effects**

- **Naltrexone for Alcohol Use Disorder**
  - In non-alcohol-dependent overweight men, high-dose naltrexone (300 mg/day) does not cause cognitive impairment and does not alter subjects' mood compared to placebo (Hatsukami et al., 1986).
  - Double blind study in which 19 non-alcohol dependent subjects were given either 50 mg of naltrexone or placebo in combination with either a glass of alcohol or a soft drink. Naltrexone does not alter the psychomotor performance of those who do not consume alcohol (Swift et al., 1994)
  - Naltrexone may reduce cue reactivity in alcohol dependent subjects (Ciccocioppo et al., 2003, 2002; Monti and Rohsenow, 1999;Rohsenow et al., 2000).

From Pujols 2018

Medication and Alcohol Use Disorder Treatment: **Cognitive Effects**

- **Acamprosate for Alcohol Use Disorder**
  - In non-alcohol-dependent young volunteers, acamprosate may reduce long term memory recall but not working memory (Schneider et al., 1999).
  - In alcohol-dependent abstinent patients moderate improvement in psychomotor performance with acamprosate (Soyka et al., 1998)
  - Schizophrenic patients with comorbid alcohol dependence no improvement in cognitive function with acamprosate (Ralevski et al., 2011).

From Pujols 2018

Medication and Alcohol Use Disorder Treatment: **Cognitive Effects**

- **Disulfiram for Alcohol Use Disorder**
  - In non-alcohol-dependent healthy subjects, no effect of 2 weeks of disulfiram on neuropsych testing battery or EEG variables (Peeke et al., 1979).
  - In alcohol-dependent patients two case reports of encephalopathy and EEG abnormalities after disulfiram (Hotson and Langston et al., 1976)
  - No effect of disulfiram on executive function, attention, or intelligence in 11 severe alcohol dependent subjects (Gilman et al., 1996).

From Pujols 2018

Medication and Alcohol Use Disorder Treatment: **Cognitive Effects**

- **Overall findings:**
  - **Very few studies examining effects of medications on cognition in alcohol dependent patients.**
  - **No evidence of negative effects on cognition other than case reports with disulfiram**

From Pujols 2018

Medication and Opioid Use Disorder Treatment: **Cognitive Effects**

- **Opioid use disorder patients have mild, generalized cognitive dysfunction including effects on the complex psychomotor domain, attention, working memory, memory, visuospatial ability, verbal fluency, and executive functioning** (Wollman et al., 2018)
- **Improvement in cognition is seen after medication treatment, but questions remain about effects of medication on cognition** (Maglione et al., 2018)

Medication and Opioid Use Disorder Treatment: **Cognitive Effects**

- **Improvement in cognitive function after treatment with methadone** (Bracken et al., 2012; Gruber et al., 2006; Soyka et al., 2008, 2010).
- **Negative effects of methadone on working memory and psychomotor performance 90-120 minutes after dose, some (n-back) worse at higher doses** (Rass et al., 2014)

Medication and Opioid Use Disorder Treatment: **Cognitive Effects**

- **Buprenorphine impairs cognition in non-opioid using volunteers, but patients under treatment with buprenorphine perform same as healthy volunteers on battery of tests related to driving motor vehicle** (Reviewed in Pujol et al., 2018)
- **Small study showed treatment with naltrexone in abstinent heroin abusers may result in less impairment of cognitive functions compared to treatment with buprenorphine** (Messinis et al., 2009)

Medication and Opioid Use Disorder Treatment: **Cognitive Effects**

- **Study transitioning patients from buprenorphine to depot naltrexone showed improvement in several cognitive tests, but post hoc analysis showed improvement greater in *low dose* buprenorphine treated patients** (Kosten et al., 2020)

Medication and Opioid Use Disorder Treatment: **Cognitive Effects**

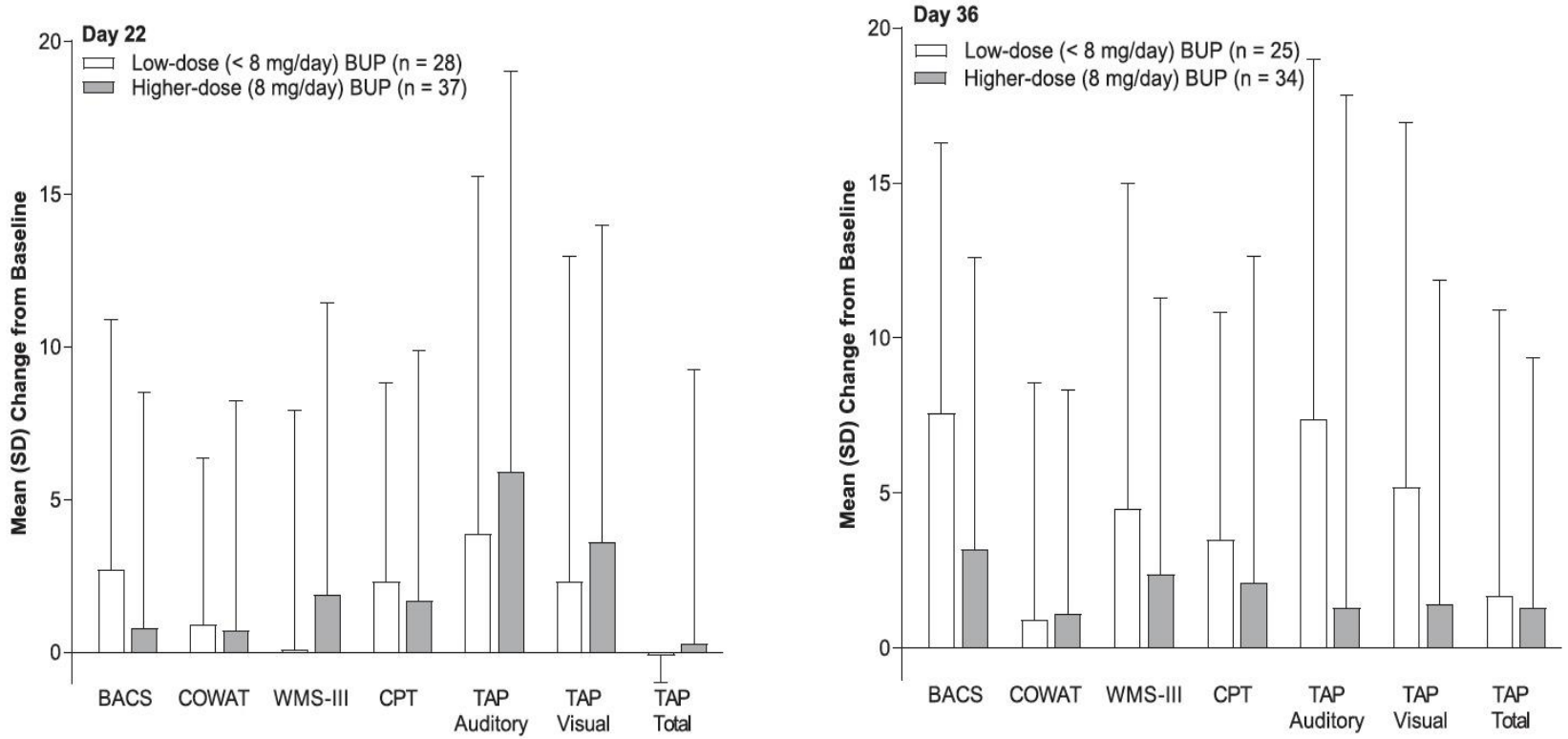


Fig. 1. Mean changes from baseline in cognitive outcome standardized T scores at Day 22 and Day 36 by BUP dose group at study entry. BACS = Brief Assessment of Cognition Symbol Coding test; BUP = buprenorphine; COWAT = Controlled Oral Word Association Task; CPT = Continuous Performance Test; SD, = standard deviation; TAP = Test of Attentional Performance; WMS-III = Wechsler Memory Scale-III Spatial Span test.

Kosten et al., 2020

Medication and Opioid Use Disorder Treatment:
Cognitive Effects

- **Cognitive function improves with treatment**
- **Patients on buprenorphine no different from controls on driving measures**
- **Some evidence naltrexone > buprenorphine > methadone related to cognitive outcomes but no definitive data**
- **Overall, medication treatment leading to abstinence better than no treatment on cognition, if can tolerate abstinence with depot naltrexone *may* be better**

Medication and Stimulant/Cannabis Use Disorder Treatment: **Evidence**

- **Several placebo-controlled trials have shown benefit of various medications for stimulant and cannabis use disorder**
- **None of these studies have been replicated with phase III clinical trial leading to FDA approval**
- **May be beneficial for individual patients but side effects and costs (may not be covered by insurance) need to be considered**
- **Behavioral treatments continue to be mainstay for these disorders**

Summary

- FDA approved medication for substance use disorders is available for alcohol and opioid use disorder
- Evidence clearly supports use of medications for these disorders
- No evidence of cognitive effects for naltrexone, acamprosate for alcohol use disorder
- Patients with opioid use disorder on treatment have improved cognition compared to active use

Summary

- Some evidence that naltrexone may have less cognitive effects than buprenorphine which may have less effects than methadone
- If can achieve abstinence by whatever method likely to have greatest effect on cognition in opioid use disorder

Questions?

Case Presentation #1
Diane Boyer, DNP

- 12:35-12:55 [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Main Question

Fragile therapeutic relationship within Medication Management- Concerns for Recovery from ECO placed by psychiatric medical provider

Demographic Information

26 yo man , Caucasian, High School Graduate, had been working cutting grass and other maintenance on golf course. Oxford house, Father Aunt and Uncle live nearby and are strong social support

Background Information

A 26yo person with psychiatric history of IVDU including amphetamine use disorder, amphetamine-induced psychosis, opioid (heroine) use disorder, unspecified psychosis,
Auditory hallucinations, disturbing repetitions of family members repeating thoughts and putting chips in eye.
Decompensating after heavy Methamphetamine use over a week, stopped taking prescribed Suboxone or Latuda

Past history of psychiatric hospitalizations, Last psych hospitalization May 2020
-Rehab, Oxford house, half way houses
Family hx of bipolar d/o, alcohol use disorder,

ECO a day after his virtual OBOT appt. - Day of appt had discussed with emergency services team if I had enough evidence for ECO - they said no
Shared Concerns with Family who live nearby who went to check on him that evening and found him in severe disarray.
Called me and I had enough evidence to obtain ECO- to local ED - due to worsening, increased disorganization, not going to work, difficulty caring self. Not eating or bathing

Seen and evaluated in the ED by the psychiatry consult team.
Tested positive for COVID -19

Background Information

Had a methamphetamine positive UDS and there was concern for substance induced psychosis. Per the patient and family member the patient had AH at baseline for the last 2.5 years making a primary thought disorder more likely. Possibly abusing Methamphetamine during that time

Initially started on Zyprexa 10 mg daily and Zyprexa 2.5 mg PRN q6hrs
Refused Zyprexa stated it did not work for him in the past (although it was documented that it worked well for him)
Concern because past hx of acute dystonia previously from Haldol and Risperdal.
Started on Seroquel 150 mg nightly and Seroquel 25 mg q4hrs PRN for anxiety
Seroquel titrated up to 300qhs.
Developed behavioral outburst and admitted to persistent AH .
Switched over to Zyprexa 10mg BID and loaded him with Depakote 20mg/kg (1250mg total) then started him on Depakote 500mg BID.

While in SPU -required a number of PRN Ativan for agitation.
Perseverated on his discharge throughout his time on the SPU.
Behavioral Emergency Response Team (BERT) called 2 days in a row for agitation for asking to leave.
Ativan increased to 2mg BID both for agitation and akithisia prevention.
Agitation again on 1/30 after demanding to leave despite security at his bedside.
Required an extra 3mg of PO lorazepam on 1/30.

The patient continued to perseverate on AH and delusions involving family at the end of 10 isolation due to COVID-19
Required transfer to psych unit
- Treatment Team begin to discuss a disease process of schizophrenia and finding better medications for him to deal with them.
- Discussed further therapy on psych unit and transfer over. There was disagreement and request for release to manage own life

Background Information

-Patient initially hesitant eventually agreeing once back in a more familiar setting (prior hospitalizations in this unit)
-Began transition off of Zyprexa 10mg BID to Abilify 20mg which was completed by 2/5. Patient agreed (with AR parent's permission) to take Abilify Maintenna 400mg.
-Marked improvement
- Patient reported Suboxone had helped with his cravings for Meth and Opioids.
- Discussed he be followed by for his Suboxone therapy through hospital's Psych Suboxone clinic as patient has hard time with virtual appointments

Schizophrenia with paranoid features
- Continue Abilify 20mg PO for 7 days
- Continue Depakote 500mg in the morning and 1000mg at night
- Recommended to Diane Boyer that patient get repeat Maintena injection in timely fashion

Opioid Use disorder:
- Suboxone 4mg BID
Discharged without a place to stay - Father refusing to support housing due to patient not consenting for ASAM and not wanting to go to residential treatment
Travels to stay with family member over the mountain with access to Meth

5 days later Returns to ED
ADMISSION DIAGNOSES:
Schizophrenia, multiple episodes, currently in acute episode
Amphetamine use disorder, severe
Opioid use disorder, on maintenance therapy

Had not taken po medication Positive for high level of Amphetamines (349)

Protected from more Meth use, Stabilized. Transferred to Dual Diagnoses Residential Rehab.

Discharged to halfway house. Father helping with transition. Suboxone from UVA OBOT
Monthly Abilify Maintena

Previous Interventions

Communication with family and hospital treatment team

Plans for Future Treatment/ Patient's Goal

Continue medication management for psychiatric medications

Consultation with Hospital OBOT Team

Reminder: Main Question

Fragile therapeutic relationship within Medication Management- Concerns for Recovery from ECO placed by psychiatric medical provider

Case Presentation
Jordan Siebert, Peer

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
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Use chat function for questions

Main Question:

How can a peer best support a participant who displays very intense borderline personality symptoms?

Demographics

32 yo cisgender heterosexual female. Unemployed, living with boyfriend who she dated for a couple of months before moving in with May 2020. She does not use any support for her recovery other than our program. Does want psychiatric services. Sees a urologist for bladder issues and pain.

Background Information

Opioid Use Disorder, Depression and generalized anxiety.
Currently on suboxone, and has rx for Narcan.
Resistant to group therapy, attended a couple of virtual sessions after she started with us in May of 2020, but decided that she just wanted to continue seeing her clinician individually, and seeing the peer individually.
Tried to engage in another mat program before, but struggled with their guidelines.
Before that she has had mental health treatment off and on since she was of adolescent age.
Started using opioids about three years prior to coming into our program, before that used cocaine, and alcohol, and THC, and bezos.
She struggles with identifying herself as an addict. She feels that she is addicted because her ex-husband made her an addict by giving her her first "taste" of opioids.

Previous Interventions

Speaking from the perspective of the peer I have encouraged her to use community supports in the way of meetings/groups. Trying to find solutions for support "outside of the box".
She does not see her benzo use as problematic, and struggles with wanting to continue this prescription that she gets from another provider even when we do not allow this in our program. Because of this, I encouraged her to try other programs that do not have this boundary. She gets upset when I suggest that there are programs that may be better for her goals than we are. Because of this, I am very mindful when I suggest things like this.
She displays traits of borderline personality disorder (as stated by clinical professional, not myself). She struggles with boundaries, and accepting responsibility.
This is also evident when she speaks about previous providers in both medical setting and behavioral health setting. She is very upset with previous providers for not fixing what is "wrong" with her.

Future Treatment / Patient Goal

I planned on continuing to support her and making myself as available as possible as she navigates her recovery. Unfortunately, I was recently fired from her service when I offered to make myself available to show her how to navigate the GRTC system. She struggles getting places because she says that the buses are stressful. She demonstrated a lack of knowledge about this system, and I asked if I could offer feedback, when she agreed I said that one of the things I have done in the past is walking people through the bus system in person. I explained that the information she had about getting to VCU Health main hospital was incorrect (she said that it takes three buses from where she lives, and it should only take two-or one depending on the bus she takes).
She became very upset, and said that I was treating her like a "kid". I apologized for the way that came across, and explained that I did not mean to come across like that. She cursed at me and hung up.
I have processed with the team, as I wanted to make sure that I do not come across in a condescending manner.
I made myself available in an effort to show her that positive regard despite this outburst.
If anyone has any suggestions that would be great. We do have a DBT Skills group, but she is resistant to any group.

Other Information

Getting support and resources from the peer in our program is voluntary, and so she is not required to use my service.
She said that it was very helpful before, but that was before I upset her. Whether she really felt it was helpful, or it was just the beginning of the relationship I cannot know.

Reminder: Main Question

How can a peer best support a participant who displays very intense borderline personality symptoms?

Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
  - Earn **$100** for presenting

Telehealth

About Telehealth at VCU Health +

For Patients +

For Providers +

Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- **Ademola Adetunji**, NP from Fairfax County CSB
- **Michael Bohan, MD** from Meridian Psychotherapy
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, MD** from VCU Health
- **Kayla Brandt, B.S.** from Crossroads Community Service Board
- **Susan Cecere, LPN** from Hampton Newport News
- **Michael Fox, DO** from VCU Health
- **Shannon Garrett, FNP** from West Grace Health Center
- **Sharon Hardy, BSW, CSAC** from Hampton-Newport News CSB
- **Sunny Kim, NP** from VCU Health
- **Thokozeni Lipato, MD** from VCU Health
- **Caitlin Martin, MD** from VCU Health
- **Maureen Murphy-Ryan, MD** from AppleGate Recovery
- **Faisal Mohsin, MD** from Hampton-Newport News CSB
- **Stephanie Osler, LCSW** from Children's Hospital of the King's Daughters
- **Jennifer Phelps, BS, LPN** from Horizons Behavioral Health
- **Crystal Phillips, PharmD** from Appalachian College of Pharmacy
- **Tierra Ruffin, LPC** from Hampton-Newport News CSB
- **Manhal Saleeby, MD** from VCU Health Community Memorial Hospital
- **Jenny Sear-Cockram, NP** from Chesterfield County Mental Health Support Services
- **Daniel Spencer, MD** from Children's Hospital of the King's Daughters
- **Cynthia Straub, FNP-C, ACHPN** from Memorial Regional Medical Center
- **Saba Suhail**, MD from Ballad Health
- **Barbara Trandel, MD** from Colonial Behavioral Health
- **Bill Trost, MD** from Danville-Pittsylvania Community Service
- **Art Van Zee, MD** from Stone Mountain Health Services
- **Ashley Wilson, MD** from VCU Health
- **Sarah Woodhouse, MD** from Chesterfield Mental Health

Claim Your CME and Provide Feedback

- www.vcuhealth.org/echo

- To claim CME credit for today's session
- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

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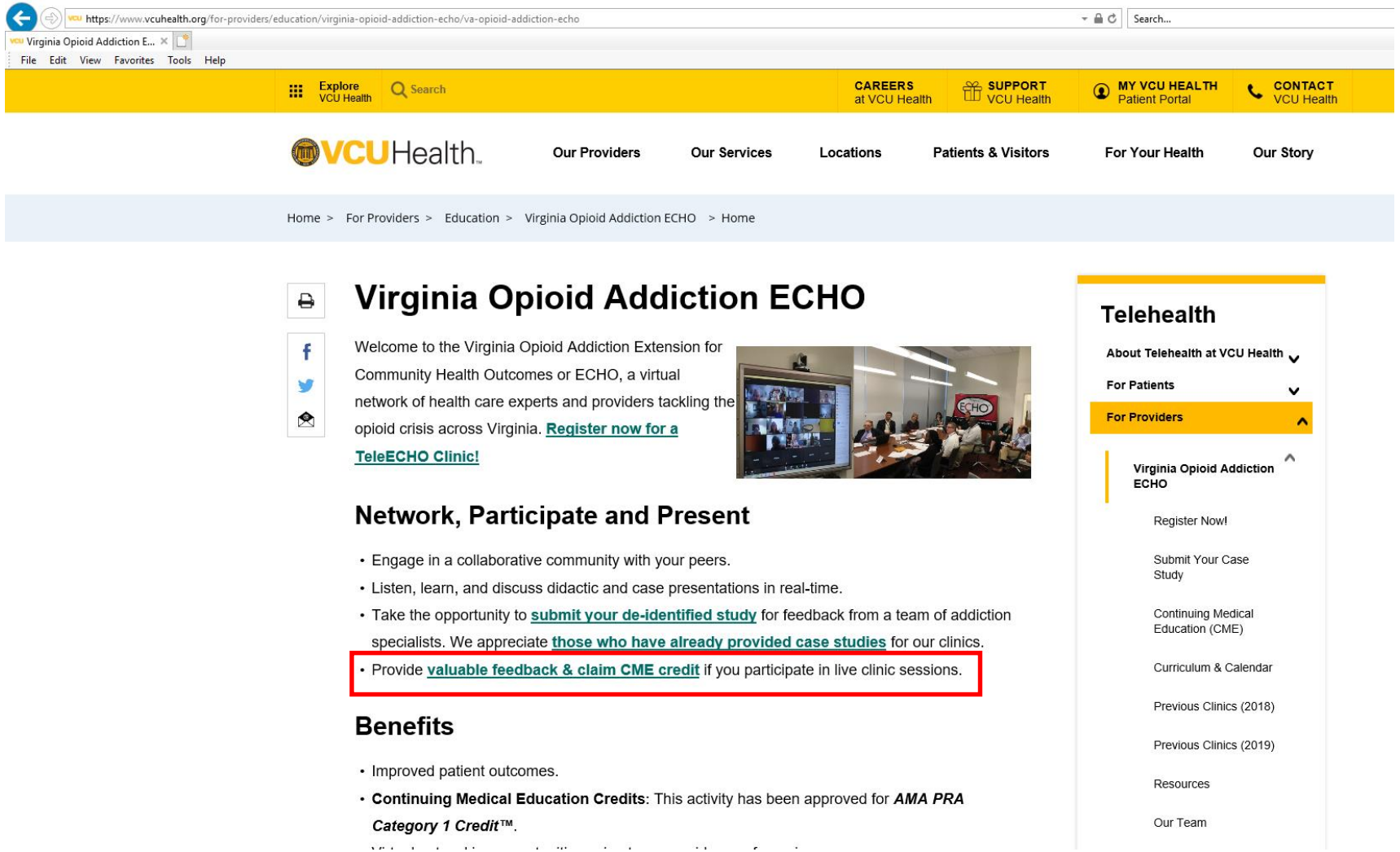

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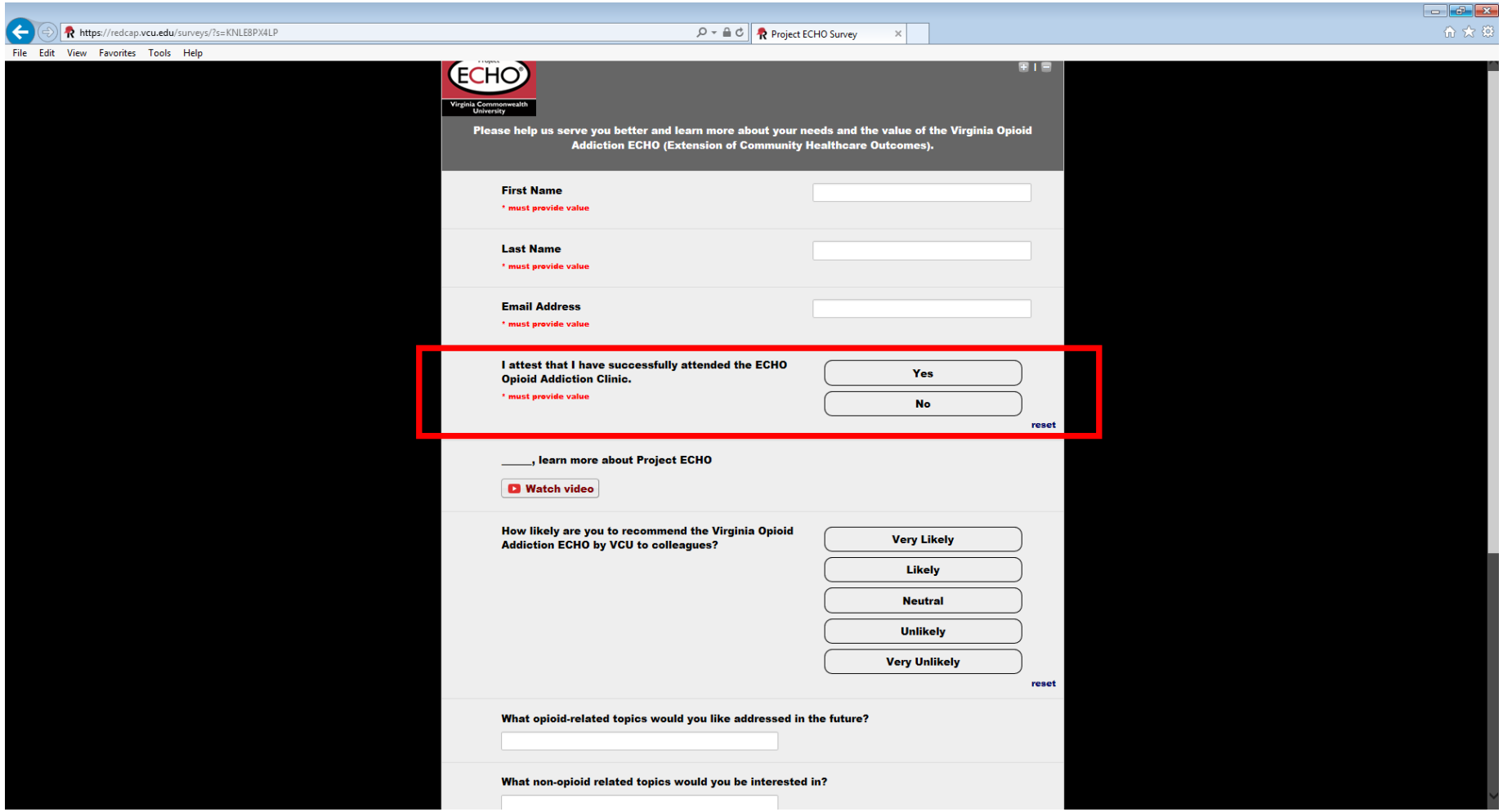

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- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME

Telehealth

- About Telehealth at VCU Health +
- For Patients +
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  - **Opioid Addiction ECHO** –
    - Register Now!
    - Submit Your Case Study
    - Continuing Medical Education (CME)
    - Curriculum & Calendar
    - Previous Clinics (2018)
    - Previous Clinics (2019)
    - Previous Clinics (2020)

Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes or ECHO, a virtual network of health care experts and providers tackling the opioid crisis across Virginia. Register now for a TeleECHO Clinic!

Network, Participate and Present

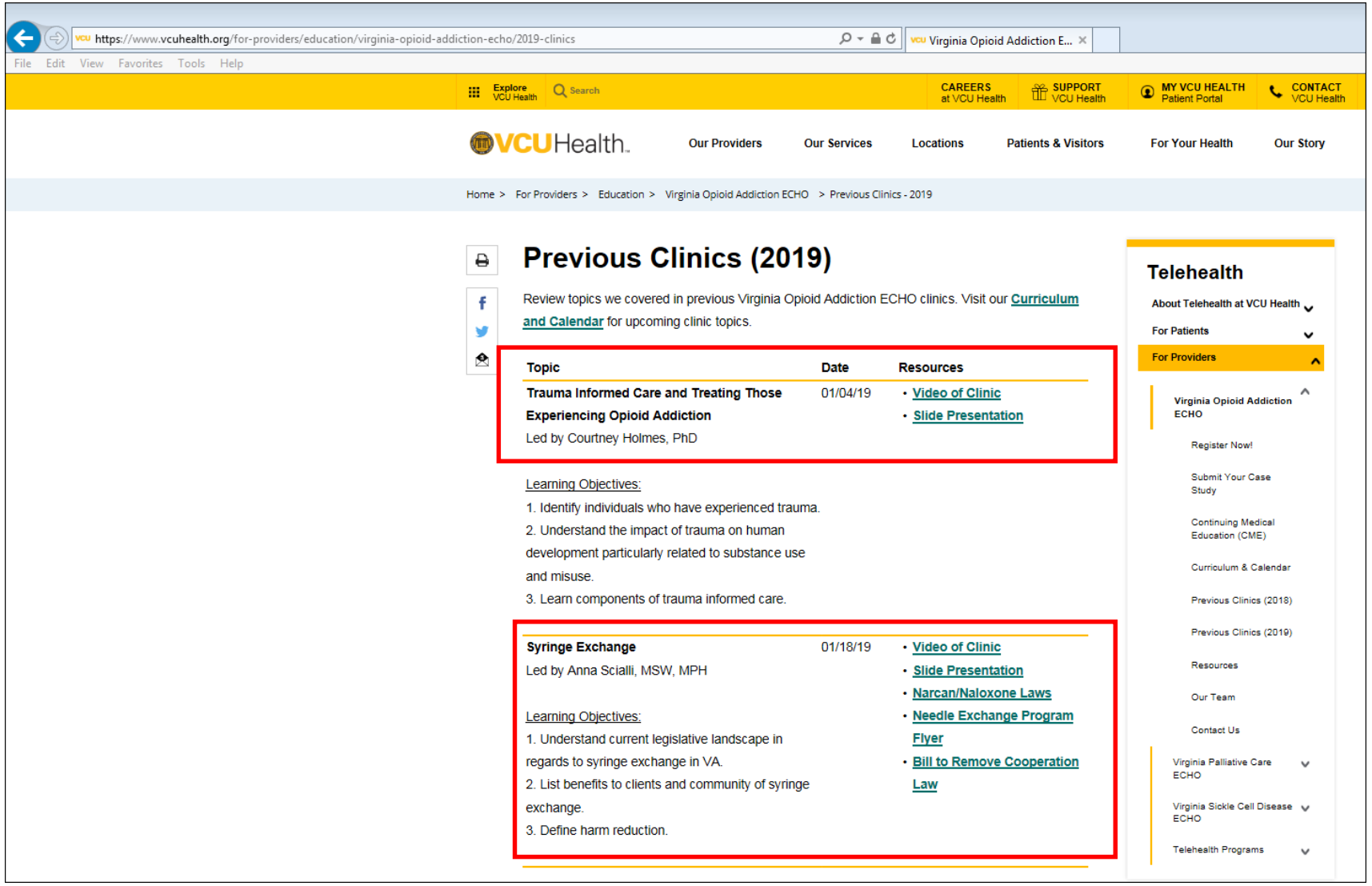
- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to submit your de-identified study for feedback from a team of addiction specialists. We appreciate those who have already provided case studies for our clinics.
- Provide valuable feedback & claim CME credit if you participate in live clinic sessions.

Benefits

- Improved patient outcomes.
- **Continuing Medical Education Credits**: This activity has been approved for ***AMA PRA Category 1***

? Need help

Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

April 9: SUD Virtual Bridge Clinic and PropER Clinic	Brandon Wills, MD Taruna Aurora, MD

Please refer and register at vcuhealth.org/echo

THANK YOU!

Reminder: Mute and Unmute to talk
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