Virginia Opioid Addiction ECHO* Clinic

January 31, 2020

*ECHO: Extension of Community Healthcare Outcomes
Helpful Reminders

• Rename your Zoom screen, with your name and organization
• You are all on mute please unmute to talk

• If joining by telephone audio only, *6 to mute and unmute
  ❖ Do NOT put on hold
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

- 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](http://www.vcuhealth.org/echo)
## Hub and Participant Introductions

<table>
<thead>
<tr>
<th>VCU Team</th>
<th>Name</th>
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<tr>
<td>Clinical Director</td>
<td>Gerard Moeller, MD</td>
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<td>Administrative Medical Director</td>
<td>Vimal Mishra, MD, MMCi</td>
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<td>ECHO Hub</td>
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<td>Clinical Experts</td>
<td>Lori Keyser-Marcus, PhD</td>
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<td>Courtney Holmes, PhD</td>
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<td>Albert Arias, MD</td>
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<td>Didactic Presentation</td>
<td>Gerry Moeller, MD</td>
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<td>Program Manager</td>
<td>Bhakti Dave, MPH</td>
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<td>Practice Administrator</td>
<td>David Collins, MHA</td>
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<td>IT Support</td>
<td>Vladimir Lavrentyev, MBA</td>
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Reminder: **Mute** and **Unmute** screen to talk

*6 for phone audio
Use chat function for Introduction
I. Didactic Presentation
   I. Lori Keyser-Marcus, PhD
      Courtney Holmes, PhD
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

Let's get started!
Didactic Presentation
Disclosures

Courtney Holmes, PhD and Lori Keyser-Marcus, PhD have no financial conflicts of interest to disclose.

There is no commercial or in-kind support for this activity.
Integrating Group Counseling into Substance Use Treatment

Courtney Holmes, Ph.D.
Lori Keyser-Marcus, Ph.D.

January 31, 2020
Impact of Addiction

- Addiction/Substance use is complex
- Addiction is not only a physical dependence on a substance
- Addiction and recovery are intricately related to a person’s mental health, mental illness, and history (family relationships, trauma, etc.)

- What do people receive? Judgment and stigma
- What do people need? Support
Risks in early treatment

- Overdose/death
- Relapse
- Criminal justice problems
- Underemployment/unemployment
- Family challenges
- Suicidal ideation
- Mental health symptoms- depression, anxiety, PTSD, trauma
Federal Guide for Opioid Treatment Programs


**REQUIRED SERVICES**

42 CFR 8.12(f) Required services. (1) General. OTPs shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to patients.
Background of Group Work

• Alcoholics Anonymous founded in 1930 – depends on group work
• Time and resource effective
• People are more likely to stay in recovery when treatment is provided in groups (Reading & Weegman, 2004).
• Counseling is more effective than no counseling
• No specific type of group is more effective than other types
• Behavioral and mental health support outcomes consistently show immediate and sustained improvement when compared with medication management only or no treatment (Dugos et al., 2016; Shareh et al., 2018; Weiss et al., 2004)
SAHMSA – Tip 41

• Group therapy has advantages over other modalities. These include:
  • positive peer support
  • a reduction in clients’ sense of isolation
  • real life examples of people in recovery
  • help from peers in coping with substance abuse and other life problems
  • information and feedback from peers
  • a substitute family that may be healthier than a client’s family of origin
  • social skills training and practice
  • peer confrontation
  • a way to help many clients at one time
  • structure and discipline often absent in the lives of people abusing substances
  • the hope, support, and encouragement necessary to break free from substance abuse.
What makes groups therapeutic?

• Yalom (1995) identified 11 therapeutic factors:
  • Installation of hope
  • Universality
  • Imparting information
  • Altruism
  • Corrective recapitulation of the primary family group
  • Development of socializing techniques
  • Imitative behaviors
  • Interpersonal learning
  • Group cohesiveness
  • Catharsis
  • Existential factors
Programs or Groups for Specific Client Types

*Table 3.3b.* Facilities were asked about the provision of treatment programs or groups specifically tailored for the client types listed below. Overall, 83 percent of facilities offered at least one specifically tailored program or group. The percentages of facilities providing specifically tailored programs or groups were:

- Clients with co-occurring mental and substance abuse disorders: 50 percent
- Adult women: 49 percent
- Adult men: 47 percent
- Clients who have experienced trauma: 40 percent
- Criminal justice clients (other than DUI/DWI): 35 percent
- Young adults: 30 percent
- Clients who have experienced intimate partner violence, domestic violence: 26 percent
- Clients who have experienced sexual abuse: 26 percent
- Adolescents: 25 percent
- Clients arrested for DUI or DWI: 25 percent
- Pregnant or postpartum women: 23 percent
- Seniors or older adults: 21 percent
- Lesbian, gay, bisexual, or transgender (LGBT) clients: 20 percent
- Veterans: 19 percent
- Clients with HIV or AIDS: 18 percent
- Members of military families: 12 percent
- Active duty military: 11 percent

Current State of Affairs

Clinical/Therapeutic Approaches

*Table 3.4a.* Facilities were asked to indicate if they used any of 15 specific clinical/therapeutic approaches.

Two approaches were each used “always or often” by nearly all facilities:

- Substance abuse counseling was used “always or often” by 94 percent of facilities.
- Relapse prevention was used “always or often” by 87 percent of facilities.

By treatment approach, the percentages of facilities that used the approaches at least sometimes (“always or often” or “sometimes”) were:

- Substance abuse counseling: 99 percent
- Relapse prevention: 96 percent
- Cognitive-behavioral therapy: 94 percent
- Motivational interviewing: 93 percent
- Anger management: 83 percent
- Brief intervention: 83 percent
- Trauma-related counseling: 82 percent
- 12-step facilitation: 72 percent
- Dialectical behavior therapy: 58 percent
- Contingency management/motivational incentives: 56 percent
- Rational emotive behavioral therapy: 45 percent

National Survey of Substance Abuse Treatment Services (N-SSATS) - 2018
Types of Groups

• Five group models are common in substance abuse treatment:
  • Psychoeducational groups, which educate clients about substance abuse
  • Skills development groups, which cultivate the skills needed to attain and sustain abstinence, such as those needed to manage anger or cope with urges to use substances
  • Cognitive–behavioral groups, which alter thoughts and actions that lead to substance abuse
  • Support groups, which buoy members and provide a forum to share pragmatic information about maintaining abstinence and managing day-to-day, chemical-free life
  • Interpersonal process groups, which delve into major developmental issues that contribute to addiction or interfere with recovery
Group Leadership (SAHMSA)

• Leaders should be able to
  • Adjust their professional styles to the particular needs of different groups
  • Model group appropriate behaviors
  • Resolve issues within ethical dimensions
  • Manage emotional contagion
  • Work only within modalities for which they are trained
  • Prevent the development of rigid roles in the group
  • Avoid acting in different roles inside and outside the group
  • Motivate clients in substance abuse treatment
  • Ensure emotional safety in the group
  • Maintain a safe therapeutic setting (which involves deflecting defensive behavior without shaming the offender, recognizing and countering the resumption of substance use, and protecting physical boundaries according to group agreements)
  • Curtail emotion when it becomes too intense for group members to tolerate
  • Stimulate communication among group members
Considerations

• Group work can be more than just giving information or worksheets
• The major benefits of group work come when members are able to feel as if they belong
• What approach will guide you?
  • Cognitive behavioral therapy
  • Motivational interviewing
  • Acceptance and Commitment Therapy
• What will you focus on?
  • Relapse prevention
  • Coping skills
  • Specific aspects of recovery
  • Ancillary topics such as mindfulness, anger management, trauma
Considerations, continued

• Group logistics
  • Open or closed
  • How many times a week
  • How long
  • Will members be screened
  • Who will be able to participate? What stage of recovery? What co-occurring issues are relevant?
  • Who will lead the group? Co-leadership model?
  • Billing and funding

• What is the leader’s role?
  • To give information only
  • To help members process and integrate information, build relationships
Challenges

• Open enrollment and member turnover
• Member safety within the group
• Member defensiveness, resistance, disruptive group behavior
• Discouraging unhealthy relationships between members (diversion, etc.)
• Shifting the focus of groups from information giving-only to include processing and inter-relating of members does require more skilled facilitation
• Differing perspectives from those in recovery around continued use of agonist, partial agonist, and antagonist medications
## Closed versus Open Groups

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<tr>
<th>Pros</th>
<th>Cons</th>
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<td>Closed groups</td>
<td>Capitalizes on group cohesion</td>
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<td>Allows for developing and following coherent treatment plan</td>
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<td>Typically requires a waiting period where patients may lose interest or seek treatment elsewhere</td>
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<td>Open groups</td>
<td>Eliminates the need for waitlist</td>
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<td>Group composition may vary considerably from one week to the next</td>
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Weiss, Jaffee, deMenil, & Cogley, 2004
Which modality is more effective?

- Integrated Group Therapy vs Treatment as Usual
  - Integrated
- Group vs No group
  - Group
- Group vs Individual
  - No difference
- Group plus Individual vs Individual
  - No difference
- Group plus Individual vs Group
  - No difference

Weiss, Jaffee, deMenil, & Cogley, 2004
Not always a Field of Dreams

Original Article

No-Show for Treatment in Substance Abuse Patients with Comorbid Symptomatology: Validity Results from a Controlled Trial of the ASAM Patient Placement Criteria

Gustavo A. Angarita, MD, Sharon Reif, PhD, Sandrine Pirard, MD, Sang Lee, BSc, Estee Sharon, PsyD, and David R. Gastfriend, MD
Matching to Level of Care

• Overall, mismatched patients had more no-shows than matched (52.4% versus 43.5%).

• Within the Undermatched group, comorbids had more no-shows (71.2%) than noncomorbids (61.7%);

• The overmatched group, comorbids had significantly more no-shows than noncomorbids (54% versus 28%).

• Patients who no showed compared were more likely to be females (70.4% versus 34.8%), to have anxiety (63% versus 17.4%), or have supportive family/social environments (81.5% versus 34.8%).

Angarita et al, 2007
Barriers (perceived and otherwise)

Survey of 80 patients at VCU Motivate clinic. Focused on behavioral counseling services received. Patients received a $10 gift card for completing the interview. Study was approved by VCU IRB.

• Demographics and substance use (treatment) history
• Satisfaction with behavioral treatment services
• Intake appointment
• **Perceived barriers**
• Items regarding electronic based treatment
Participant characteristics

Sex

- Male 32 (40%)
- Female 48 (60%)

Age

- Mean 45 years (Range 25-71 years)

Time in treatment

- Less than 1 month (n=11) average 2 weeks
- More than 1 month (n=69) average 10 months

Primary drug addressing with treatment services

- Heroin 58 (72.5%)
- Other opioids 11 (13.8%)
- Cocaine 5 (6.3%)
- Cannabis 1 (1.3%)
- Amphetamines 1 (1.3%)
- Alcohol 4 (5.0%)
Study goal

• Low/inconsistent attendance in groups
• Restructuring the program
• Patient feedback
• Identify barriers
Barriers: Practical (e.g., times)

Group times aren’t convenient
  = 30% agree/strongly agree

Childcare unavailable
  = 1.3% strongly agree

Transportation
  = 20% agree/strongly agree
Barriers: Practical (e.g., times)

My schedule is too full to make time for group
  = 13.8% agree/strongly agree

Groups that are offered when I can come are always full
  = 3.8% agree
Barriers: Group context-based

I don’t like talking about my problems in a group
  • 25.1% Agree/Strongly agree

I am very anxious/uncomfortable being in a group
  • 22.5% Agree/Strongly agree

There are too many disruptions in group (people coming in/out)
  • 8.8% Agree

People in the group are always changing
  • 12.5% Agree
Barriers: Counselor-based

I don’t really like my counselor
  • 3.8% Agree/Strongly agree

The group leaders make it a safe place to share
  • 68.7% Agree/Strongly agree

I feel like the counselors have a good understanding of my treatment goals
  • 66.3% Agree/Strongly agree

I feel like the counselors genuinely care about me and my recovery
  • 67.6% Agree/Strongly agree
Barriers: Value of behavioral treatment

Group is a waste of my time
  • 5.1% Agree/Strongly agree

The medication is all I need for my recovery
  • 17.6% Agree/Strongly agree
Rules of Engagement

• Mismatched placement, according to the ASAM Patient Placement Criteria (PPC), promotes no-shows to treatment
• Treatment-matching seeks to engage patients in the optimal setting and modalities for a good outcome.
• Consider ways to reduce/eliminate practical barriers that may influence treatment engagement (e.g., transportation vouchers, evening groups)
• Consider trying a few group formats to see what your patients respond to (as training/staffing may allow)
• Consistency is key
• Make sure message of importance of behavioral therapy is being conveyed by all clinic staff (support from medical providers is critical)
Resources

- SAHMSA group therapy for substance use treatment:


- Estee Sharon, PsyD, and David R. Gastfriend, MD

- Ingersoll, Wagner, & Gharib. (2002). Motivational Groups for Community Substance Abuse Programs. Mid-Atlantic Addiction Technology Transfer Center


Questions?
Case Presentation #1
Faisal Mohsin, MD

• 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
Please state your main question(s) or what feedback/suggestions you would like from the group today?

How can we get the patient's Primary Care Provider engaged in his treatment?

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

46 yr. single, unemployed white male, residing with his mother. Patient's mother and brother are also being prescribed benzodiazepines from the same PCP.
Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

The patient is currently being treated for an OUD and has been stable on Suboxone 8mg-2mg 1/2 strip twice daily. Previously was on a total of Suboxone 12mg-3mg daily until end of last year.

Patient is being prescribed multiple benzodiazepines by his primary care physician. Prior to the start of the Suboxone treatment, he had agreed to being weaned off the benzodiazepines. In fact it was a condition for the initiation of Suboxone.

<table>
<thead>
<tr>
<th>Date</th>
<th>Alphahydroxylprazolam</th>
<th>7-Aminoclonazepam</th>
<th>Temazepam</th>
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<td>same prescriptions as above.</td>
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What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

He is currently engaged in group therapy at Partners in Recovery. Attends weekly sessions.

He is being prescribed Seroquel and Paxil 2 doses by his PCP.

We fax over a copy of his labs to his PCP. Also I have attempted to call his PCP several times to update him and remind him of the plan to taper off the benzodiazepines. PCP believes he is exercising harm reduction; he believes if he will not prescribe the benzos, the patient will attempt to procure them illegally. However labs suggest the patient is likely getting additional benzos beyond what is being prescribed. PCP makes no acknowledgment of receiving the labs. It's always a one way communication.

What is your plan for future treatment? What are the patient's goals for treatment?

The goal for this patient is to be off all benzodiazepines!! Maybe an unrealistic goal?

Considering writing a formal letter to the PCP, strongly recommending he begin a scheduled taper of the clonazepam to reduce the risk of harm to the patient. This could also help reducing liability for the PCP.

If no response, consider notifying the Dept. of Health Professions?
Other relevant information

There have been occasional "slip ups". He obtained Percocets from a friend recently to treat pain from his hemorrhoids. He stopped Suboxone for 3-4 days while taking the Percocets.

Restate Main Question

Please state your main question(s) or what feedback/suggestions you would like from the group today?

How can we get the patient's Primary Care Provider engaged in his treatment?

End of Case Study
Case Presentation #2
Maureen Murphy-Ryan, MD

- 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

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Use chat function for questions
Please state your main question(s) or what feedback/suggestions you would like from the group today?

Managing insomnia in a patient with opioid dependence on MAT and stimulant use disorder in early remission who has developed tolerance to diphenhydramine and has comorbid bipolar affective disorder partially treated with mood stabilizer

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

29 yo single Caucasian male high school education mother is major social support is trying to disentangle from ex-boyfriend who is still using drugs works full time as a cook and lives alone in a trailer, formerly on disability for bipolar affective disorder
Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Short, thin young-appearing man.
Dx: Opioid use disorder, severe, on buprenorphine maintenance, recent UDS + buprenorphine only. Most recent other substance use alcohol to blackout around January 1, uses alcohol for social anxiety.
Stimulant use disorder in early remission
Marijuana use intermittently.
More stable on lithium and lamictal in the past but had been off all psychiatric meds for 6 months prior to intake except gabapentin for neuropathic pain 2/2 injuries sustained in a motor vehicle collision during an episode of mania with psychosis several years ago. Got addicted to opioids after surgical intervention for broken femoral and lumbar spine in car accident.
Buprenorphine to manage opioid dependence more safely, very effective for cravings, no opioid seeking. Still using alcohol and MJ in social stress situations. Started lithium 2 months ago. Brief period of non adherence during last relapse, lithium level several days after was 0.43 on 450mg ER, now on 450mg AM/ 300mg PM

What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

Trazodone between 25mg to 150mg ineffective, does not notice it. Has been taking "1 bottle" of liquid diphenhydramine (no alcohol) weekly. Often goes 2 days without sleep. Paranoid thoughts and feelings related to current mixed episode of bipolar worsen significantly when awake all night, good insight during the day. No SI or HI. Has been offered antipsychotic medication options but declined due to hx of dystonia include laryngeal, high risk for recurrence of this due to body habitus and gender. Offered short term voluntary mental health hospitalization for more rapid medication titration to manage sleep and has declined. Has been close to threshold of safe outpatient management given history of injury to self and others during manic episode involving vehicle collision and current paranoia, protective factors are high cooperation, intellectual insight, future planning, strong will to live, attending SMART recovery groups at local peer center, employment. Has small hatchet but no guns at home.
What is your plan for future treatment? What are the patient's goals for treatment?

Patient wants to be able to work more effectively and make fewer mistakes and support himself financially and not feel so anxious. He doesn't want to lose his ability to feel "highs" in life and is afraid the treatment to become stable will take away his ability to feel good.

I would like to see his lithium level approach 1.0 and see him able to sleep reliably and his paranoia decrease significantly. Plan to titrate his lamotrigine once the lithium is stable. Plan to titrate down diphenhydramine gradually once stable with patients cooperation.

Restate Main Question

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End of Case Study
Case Studies

• Case studies
  • Submit: [www.vcuhealth.org/echo](www.vcuhealth.org/echo)
  • Receive feedback from participants and content experts
  • Earn $100 for presenting
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:

- Michael Bohan, MD from Meridian Psychotherapy
- Diane Boyer, DNP from Region Ten CSB
- Melissa Bradner, MD from VCU Health
- 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
- Faisal Mohnes, 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
- Jenny Sear-Cockram, NP from Chesterfield County Mental Health Support Services
- Daniel Spencer, MD from Children’s Hospital of the King’s Daughters
- Cynthia Stroud, FNP-C, ACHPN from Memorial Regional Medical Center
- Barbara Tranel, MD from Colonial Behavioral Health
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Sarah Woodhouse, MD from Chesterfield Mental Health
Claim Your CME and Provide Feedback

- [www.vcuhealth.org/echo](http://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?
Access Your Evaluation and Claim Your CME

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 Credit™.
Access Your Evaluation and Claim Your CME
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- www.vcuhealth.org/echo

- To view previously recorded clinics and claim credit
Access Your Evaluation and Claim Your CME

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Previous Clinics (2019)

- Trauma Informed Care and Treating Those Experiencing Opioid Addiction
  - Date: 01/04/19
  - Resources:
    - Video of Clinic
    - Slide Presentation
  - Led by Courtney Holmes, PhD

- Syringe Exchange
  - Date: 01/19/19
  - Resources:
    - Video of Clinic
    - Slide Presentation
    - Needle Exchange Laws
    - Needle Exchange Program
    - Bill to Remove Cooperation Law
  - Led by Anna Skalit, MSW, MPH

Learning Objectives:
1. Identify individuals who have experienced trauma.
2. Understand the impact of trauma on human development particularly related to substance use and misuse.
3. Learn components of trauma informed care.
VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

Feb 21: Pharmacotherapy for Methamphetamines  Gerry Moeller, MD

March 6: Enhanced Recovery After Surgery: Opioid Reduction Program  Nirav Patel, MD

Please refer and register at vcuhealth.org/echo
THANK YOU!

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