



2024 Lipscomb University - Co-Occurring Mental Health  
and Substance Use Disorder Conference

# Opioid Use Disorder and Co- Occurring Disorders

**David Marcovitz, MD**

Associate Professor of Psychiatry and Behavioral Sciences  
Director, Middle TN Hub for Opioid Use Disorder  
Vanderbilt University Medical Center



## **Presenter Disclosure Statement:**

Dr. Marcovitz has disclosed he has equity in Better Life Partners, LLC and Eos Consulting LLC. Dr. Marcovitz's presentation has been peer-reviewed for clinical validation, balance, and bias.

# Learning objectives

- Describe national trends in prevalence of opioid use disorder
- Discuss the chronic disease approach to opioid use disorder and its corollaries
- Discuss the incidence of co-occurring psychiatric and substance use disorders for alcohol, opioid and stimulant use disorder
- Describe an approach for diagnosing co-occurring non-substance psychiatric conditions in the presence of an SUD

# **What is the state of the opioid crisis nationally and locally?**

# Substance Use Disorder (SUD) Prevalence



**40 Million**  
**or >1 in 7**

**AGES 12 AND OLDER HAVE  
A SUBSTANCE PROBLEM...**

**...THIS IS MORE THAN THE  
NUMBER OF AMERICANS WITH:**



**HEART CONDITIONS**  
(27 Million)

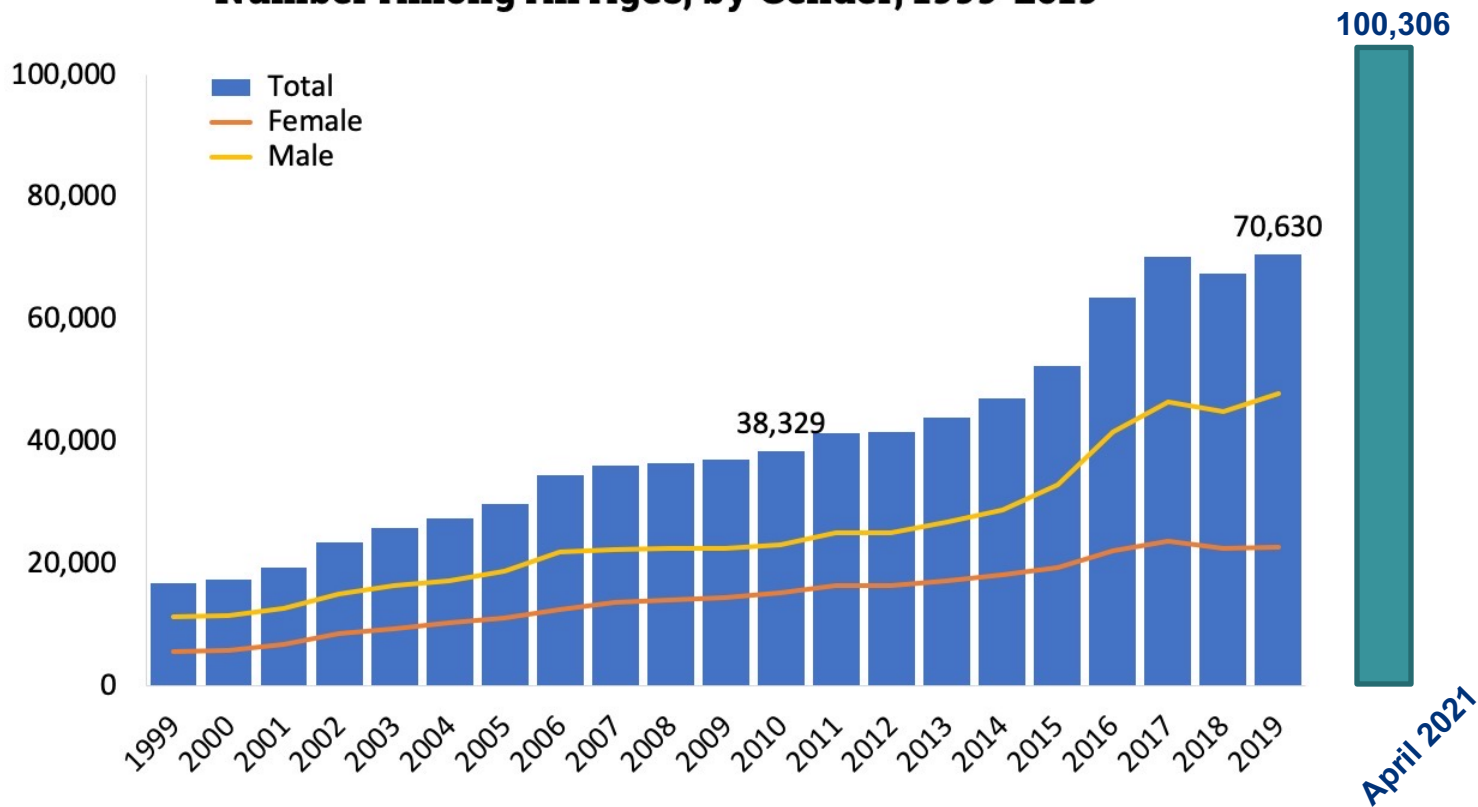


**DIABETES**  
(26 Million)



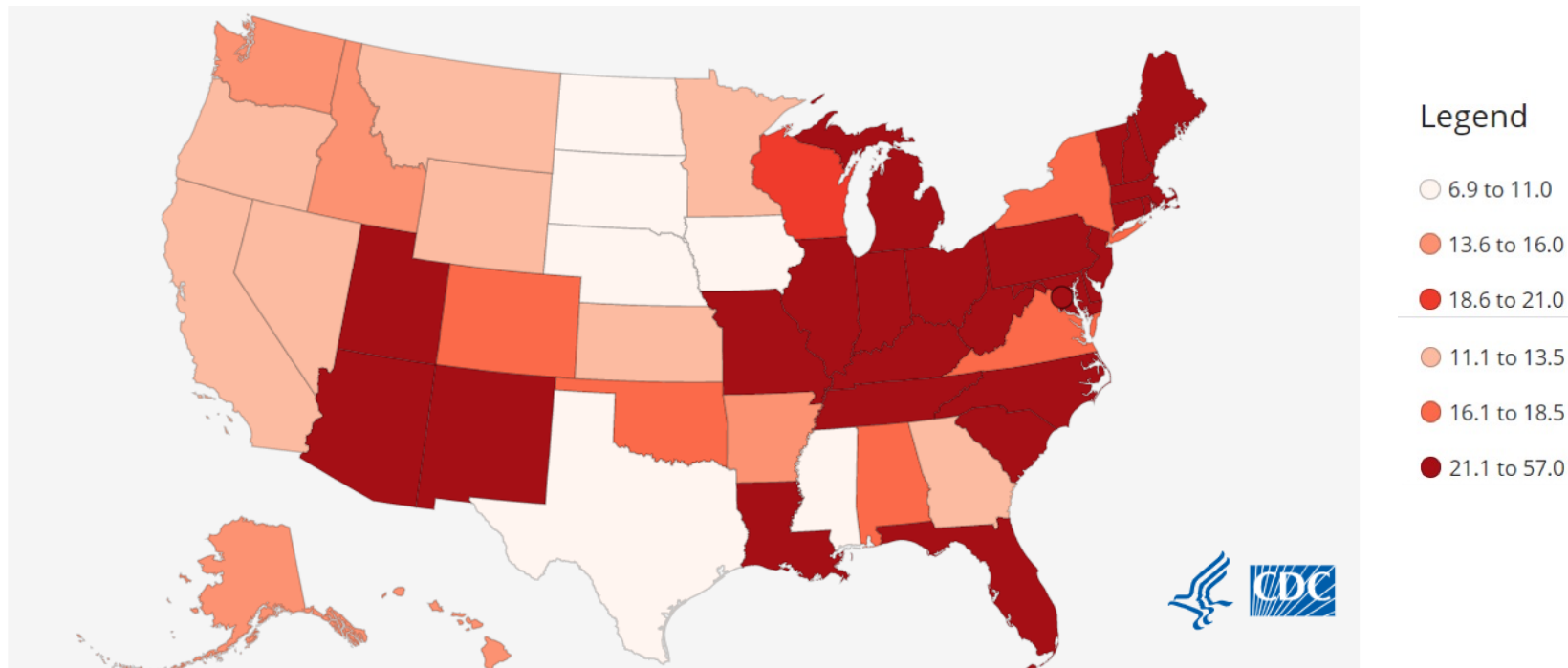
**CANCER**  
(19 Million)

# Figure 1. National Drug-Involved Overdose Deaths\* Number Among All Ages, by Gender, 1999-2019



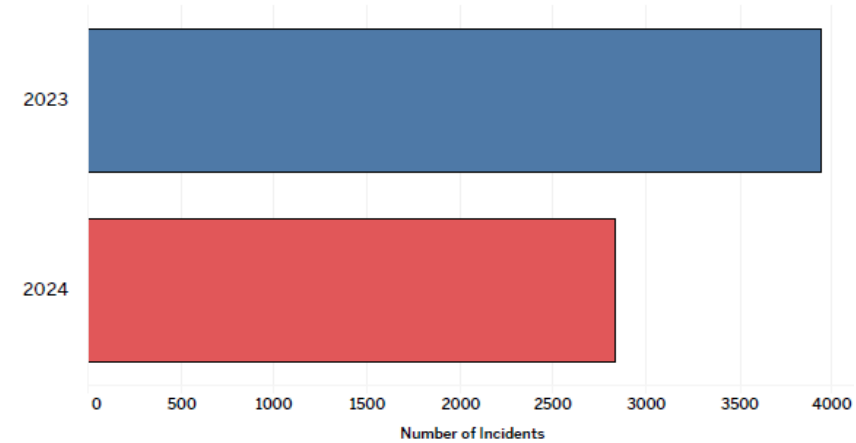
\*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2019 on CDC WONDER Online Database, released 12/2020.

# Number and Age Adjusted Rates of Drug Overdose Deaths by State, US 2018

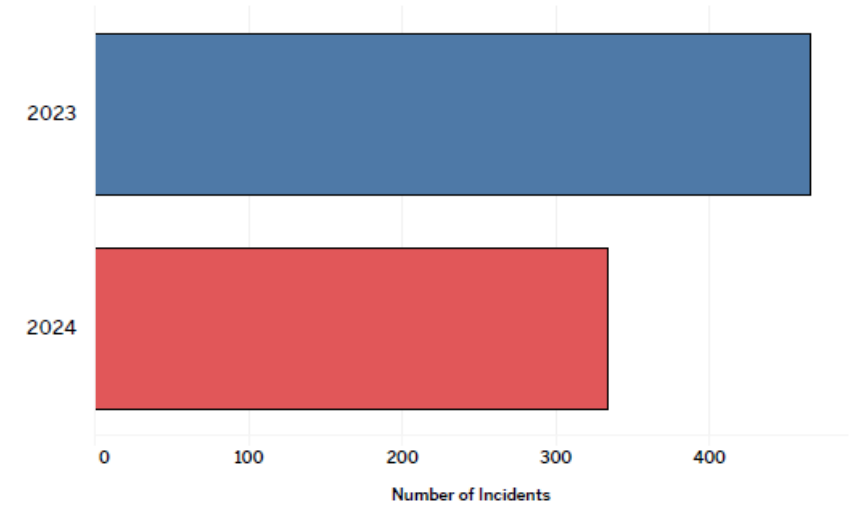


# Metro Public Health Data

Suspected Drug Overdoses Requiring NFD-EMS Response, 2023-2024



Suspected Fatal Drug Overdoses, 2023-2024



Suspected Drug Overdose-Related ED Visits, 2023-2024

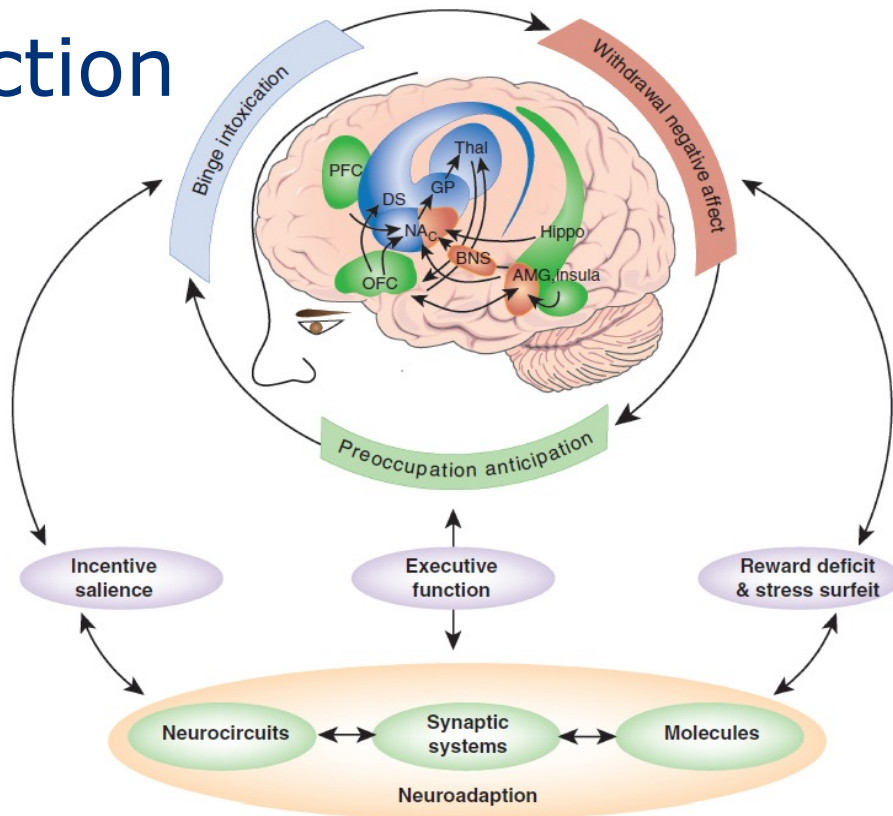




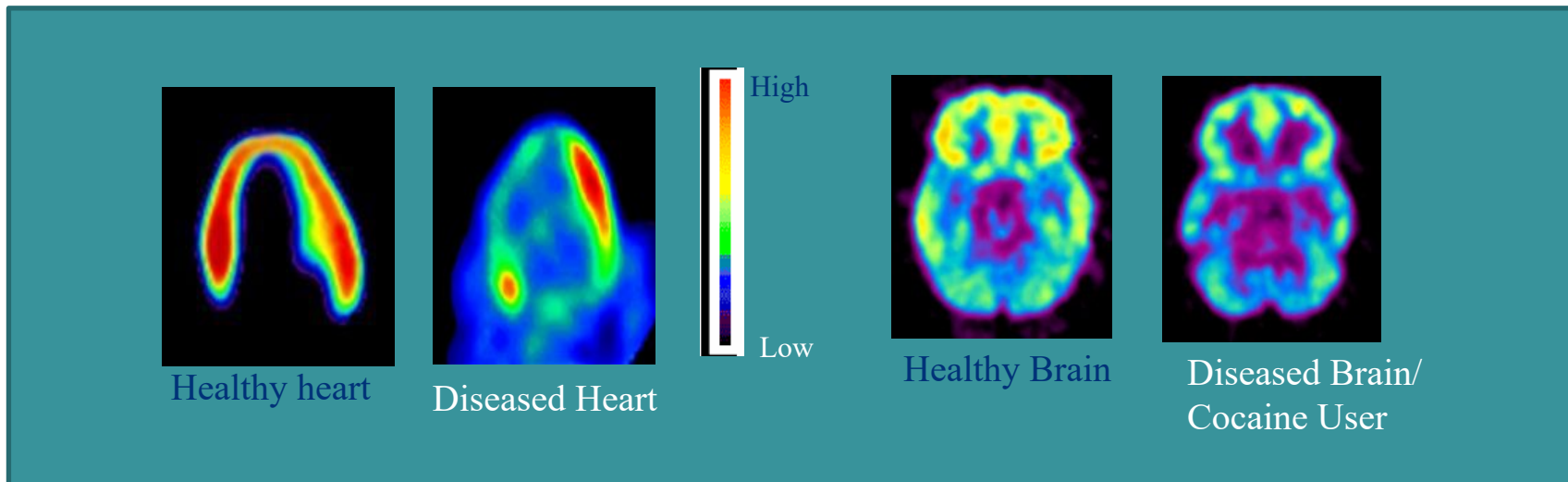
**How are leading  
medical centers  
changing their approach  
to SUD?**

# Neuroscience of Addiction

## Positive and Negative Reinforcement



# Destigmatizing Substance Use Disorders



- **Prevention:** Routine assessment and early intervention when risk factors present
- **Treatment:** Medical therapies, management of co-occurring diseases, lifestyle modification, and social support

# Destigmatizing Substance Use Disorders

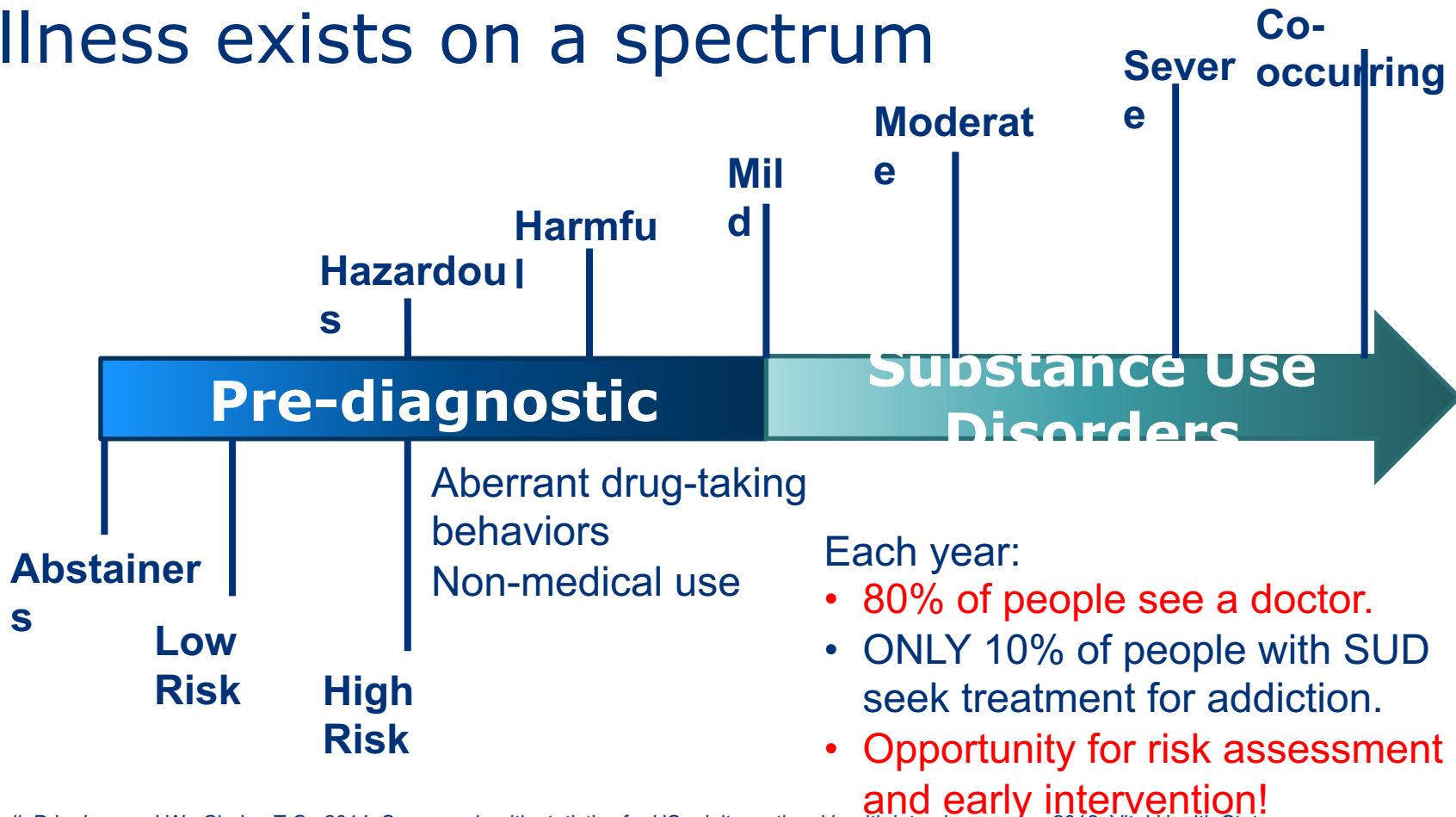
## Language matters

| Commonly Used Term                              | Preferred Term                             | Rationale   |
|---|--|---|
| Addict, abuser, etc.                            | Person with a substance use disorder       | <ul style="list-style-type: none"><li>• Focuses on respect, dignity and primacy of personhood</li></ul>   |
| Substance abuse                                 | Substance use disorder<br>Substance misuse | <ul style="list-style-type: none"><li>• Avoids implication of willful misconduct</li><li>• Shift emphasis to chronic disease model</li></ul>  |
| Opioid substitution therapy/replacement therapy | Opioid agonist therapy                     | <ul style="list-style-type: none"><li>• Avoids implication of “switching addiction”</li><li>• Pharmacologic classification more in line with other medications (i.e., ACEi, SSRI)</li></ul> |
| Clean   | Sober/abstinent                            | <ul style="list-style-type: none"><li>• Avoids value-laden, non-clinical terminology</li></ul>  |

# What are corollaries of the chronic disease model?

- Illness exists on a severity spectrum – treatment individualized
- Medication is “appropriate pharmacotherapy” (part of routine management), not unique “medication assisted treatment”
- Motivation is assessed and not assumed
- “Detox” is not a helpful construct
- Illness co-occurs with other med-psych illnesses (\*\*Gets its own learning objective!)

# Illness exists on a spectrum



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# Medication as appropriate pharmacotherapy...

Stimulant use disorder  
Cannabis use disorder

Opioid use disorder  
Nicotine use disorder

- Psychosocial Treatments
- Medication for Addiction treatment (MAT)



Alcohol use disorder

- Medication for Addiction treatment (MAT)
- Psychosocial Treatments



# Major Features of Buprenorphine

**Partial agonist** at mu receptor – semi-synthetic analog of thebaine

- Comparatively minimal respiratory suppression and no respiratory arrest when used alone

**Long acting**

- Half-life ~ 24-36 Hours

**High affinity** for mu receptor

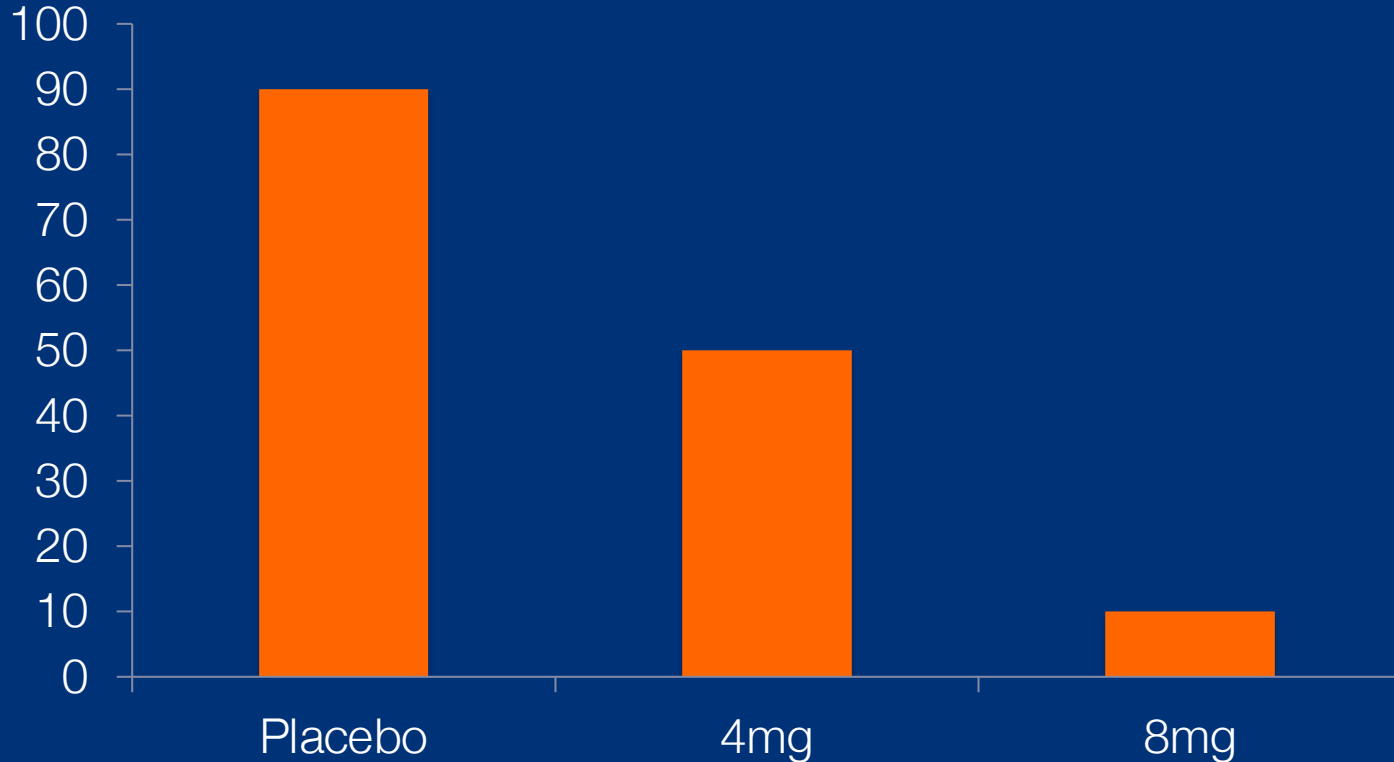
- *Blocks* and displaces other opioids; but can be overcome

**Slow dissociation** from mu receptor

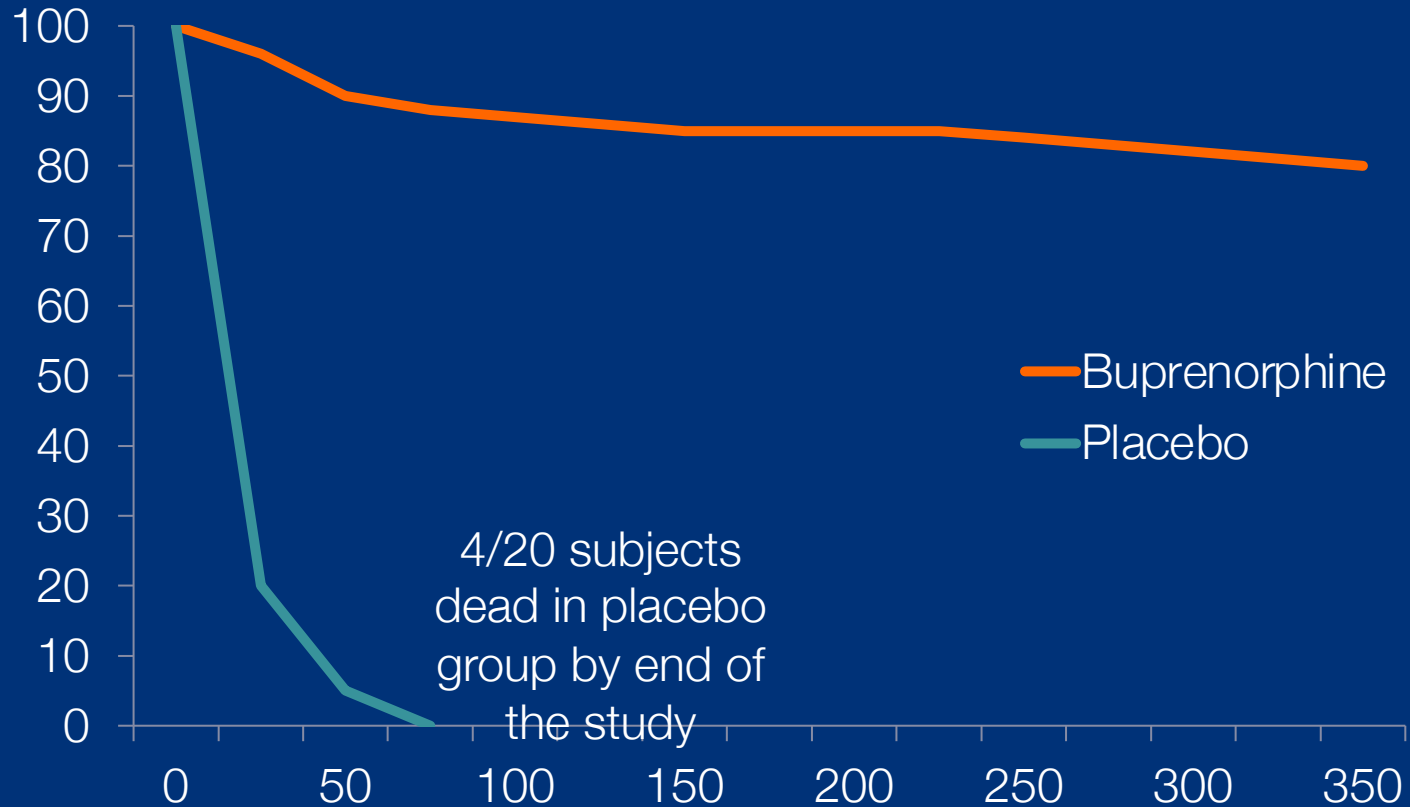
# Medication for Addiction Treatment (MAT)

|                     | Methadone   | Buprenorphine (Oral)   | Naltrexone (IM)   |
|---------------------|---|--|---|
| Mechanism of Action | Full Agonist on Opioid Receptor   | Partial Agonist on Opioid Receptor   | Antagonist on Opioid Receptor   |
| Dosing              | 80mg-100mg (Usual Dose)   | 4-32mg   | 380mg Depot Injection   |
| Advantages          | <ul style="list-style-type: none"><li>▪ Provided in a highly structured supervised setting where additional services can be provided on-site and diversion is unlikely</li><li>▪ Maybe effective for individuals who have not benefited sufficiently from partial agonists or antagonists</li></ul> | <ul style="list-style-type: none"><li>▪ Improved safety due to partial agonism</li><li>▪ Availability in office-based settings</li></ul> | <ul style="list-style-type: none"><li>▪ No addictive potential or diversion risk</li><li>▪ Available in office-based settings</li><li>▪ Option for individuals seeking to avoid any opioids</li></ul> |

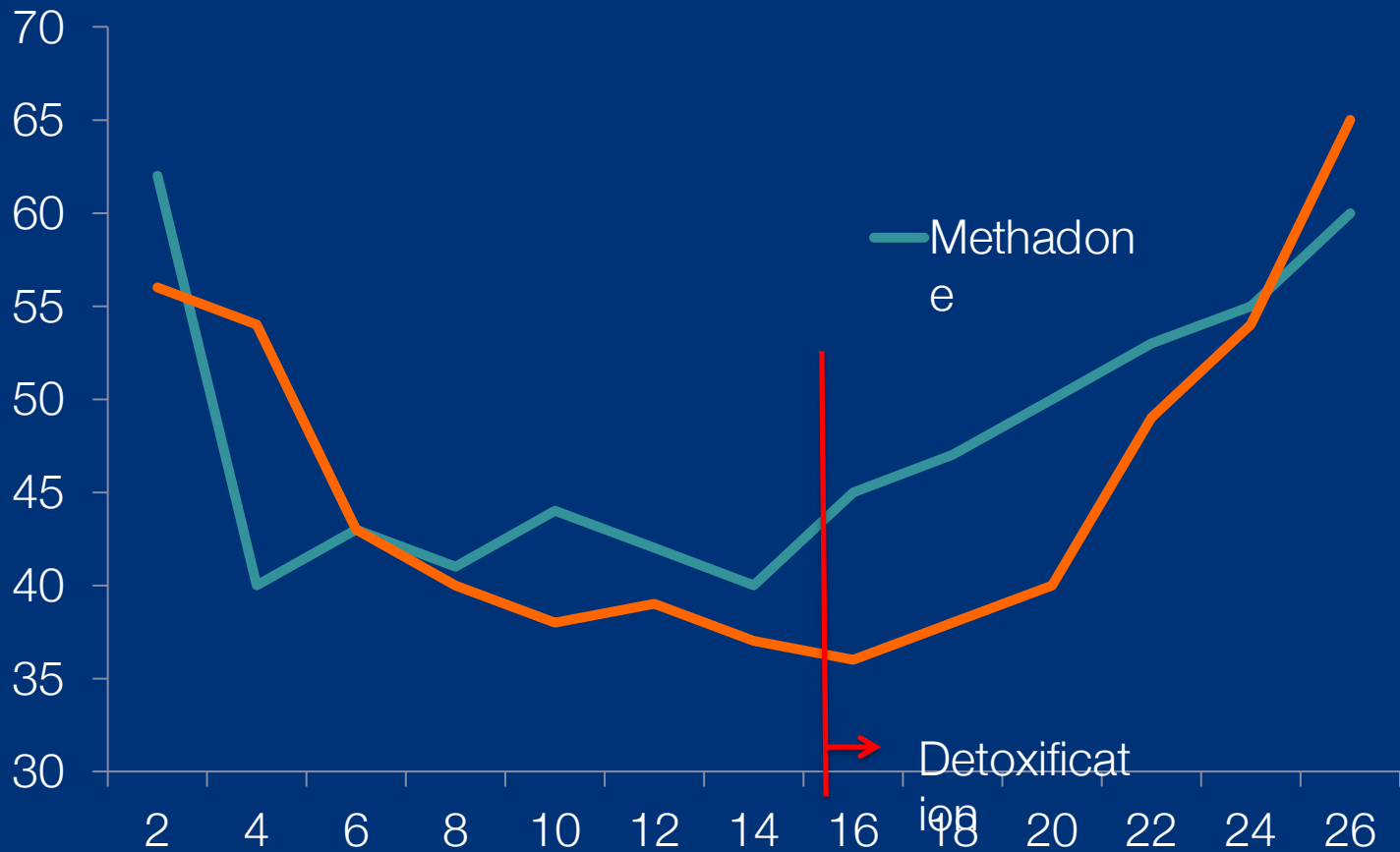
# Percent of doses taken (choice between money or heroin)



# Treatment retention buprenorphine vs. placebo, with intensive psychosocial support



# Percent positive urine tests



# Treatment of opioid use disorder



Cochrane  
Library

Cochrane Database of Systematic Reviews



ELSEVIER

Contents lists available at [ScienceDirect](#)

Drug and Alcohol Dependence

journal homepage: [www.elsevier.com/locate/drugalcdep](http://www.elsevier.com/locate/drugalcdep)

## Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review)

Mattick RP, Breen C, Kimber J, Davoli M

## Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study<sup>☆</sup>

Roger D. Weiss<sup>a,b,\*</sup>, Jennifer Sharpe Potter<sup>a,b,c</sup>, Margaret L. Griffin<sup>a,b</sup>, Scott E. Provost<sup>a</sup>, Garrett M. Fitzmaurice<sup>a,b,d</sup>, Katherine A. McDermott<sup>a</sup>, Emily N. Srisarajivakul<sup>a</sup>, Dorian R. Dodd<sup>a</sup>, Jessica A. Dreifuss<sup>a,b</sup>, R. Kathryn McHugh<sup>a,b</sup>, Kathleen M. Carroll<sup>e</sup>

<sup>a</sup> McLean Hospital, 115 Mill Street, Belmont, MA 02478, USA

<sup>b</sup> Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, USA

<sup>c</sup> University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78229, USA

<sup>d</sup> Department of Biostatistics, Harvard School of Public Health, 677 Huntington Street, Boston, MA 02115, USA

<sup>e</sup> Department of Psychiatry, Yale University School of Medicine, 333 Cedar Street, New Haven, CT 06510, USA

### ARTICLE INFO

Article history:  
Received 22 October 2014

### ABSTRACT

**Background:** Despite the growing prevalence of prescription opioid dependence, long-term treatment response has not been examined. The current study examined outcome

# Medication Saves Lives

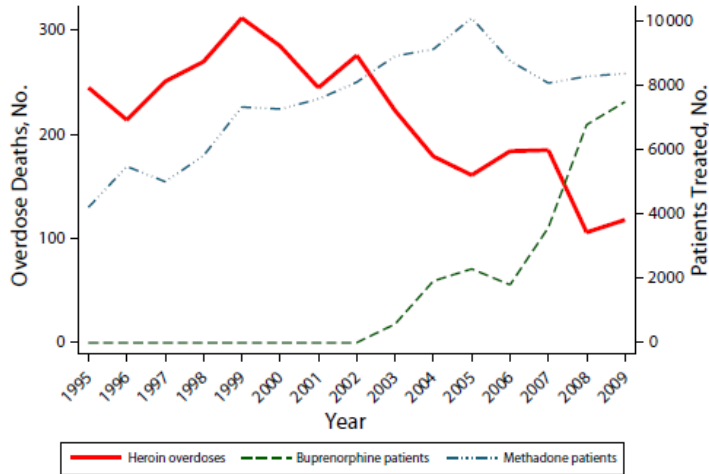
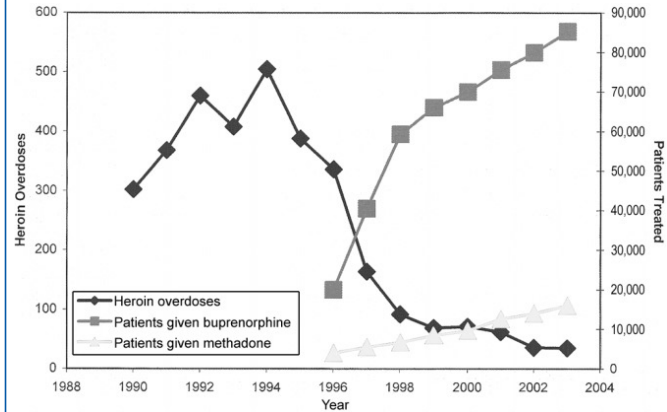


FIGURE 1—Heroin overdose deaths and opioid agonist treatment: Baltimore, MD, 1995-2009.



Maryland: 50% reduction in overdose deaths with opioid agonist treatment

France: 79% reduction in overdose deaths with opioid agonist treatment

**Table 1**

## FDA-approved medications for alcohol use disorders

| Medication               | Dosing                       | Mechanism of action   | Common side effects   | Relative contraindications   |
|--------------------------|------------------------------|---|---|--|
| Naltrexone <sup>4</sup>  | 50 to 100 mg/d               | Mu receptor blockade interrupts reward pathways in the brain  | GI upset, headache, dizziness, nervousness, fatigue                                     | Opioid use or opioid withdrawal, severe liver inflammation or cirrhosis  |
| Acamprosate <sup>5</sup> | 666 to 999 mg, 3 times daily | Modulate overactive glutamatergic brain activity that occurs after stopping chronic heavy alcohol use | Diarrhea; nervousness, fatigue, insomnia, depression have been reported with high doses | Severe renal impairment  |
| Disulfiram <sup>6</sup>  | 125 to 500 mg/d              | Accumulation of acetaldehyde in the blood produces unpleasant symptoms                                | Nausea, vomiting, hypertension if taken with alcohol                                    | Patients who recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations; severe myocardial disease or coronary occlusion, and psychosis |

### Clinical Point

**We consider acamprosate an effective option for patients who do not respond to naltrexone or have a contraindication**





## Medication

- Control cravings (block negative reinforcement)
- Prevent relapse (block positive reinforcement)

## Community supports

- Peer support meetings
- Sober social network
- Family supports

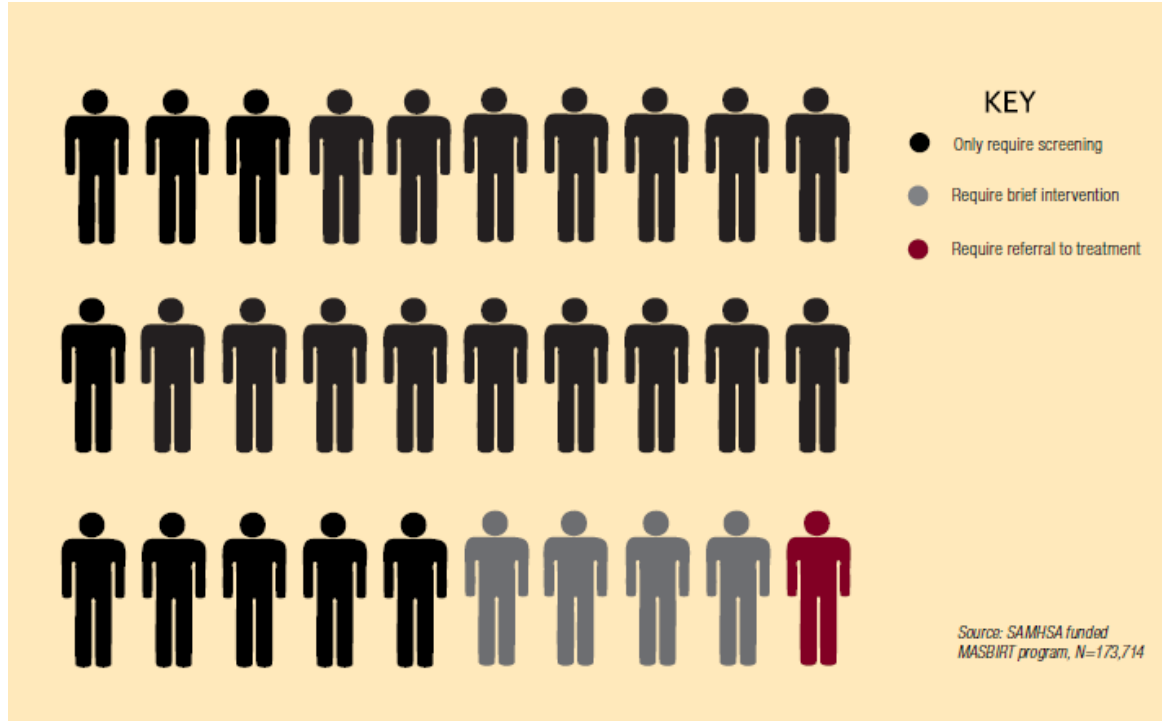
## Counseling

- Learn about addiction and recovery
- Relapse prevention skills
- Treatment of psychiatric co-morbidities

# What are corollaries of the chronic disease model?

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- “Detox” is not a helpful construct
- Illness co-occurs with other med-psych illnesses (\*\*Gets its own learning objective!)

# Motivation is assessed and not assumed...



- SBIRT = Screening, Brief Intervention and Referral to Treatment...
- Brief intervention (BI) = Motivational Interviewing (MI)



Brief Intervention

- → Motivation Interviewing (MI)

  - ASK-TELL-ASK

# Key Skills of Motivational Interviewing

O-A-R-S =

- Open-ended questions
- Affirmations
- Reflections
- Summaries

## Spirit of Motivational Interviewing / SBIRT

P-A-C-E =

- Partnering
- Autonomy (patient autonomy)
- Compassion
- Evocation (of patients own reasons for change)

## What are corollaries of the chronic disease model?

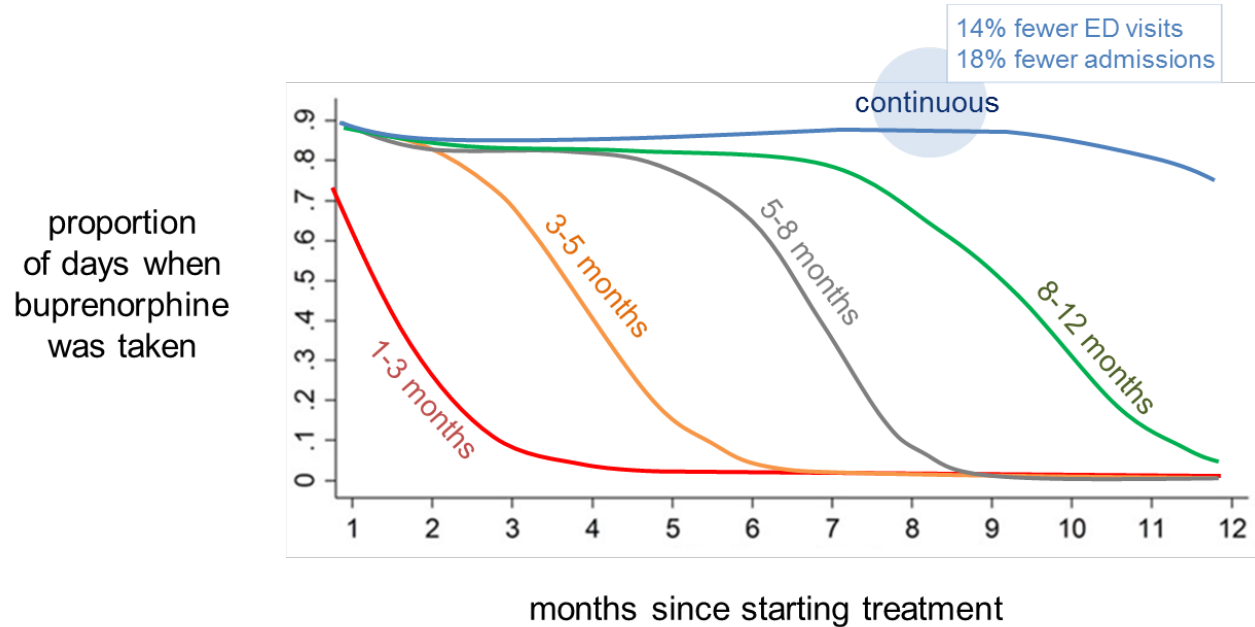
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## **“Detox” is not a useful construct...**

- Chronic disease models demands shift from “one and done – you’re fixed”
- “Withdrawal management” is a more helpful term.
- How long should maintenance medications be used?



# Optimal Duration of MAT



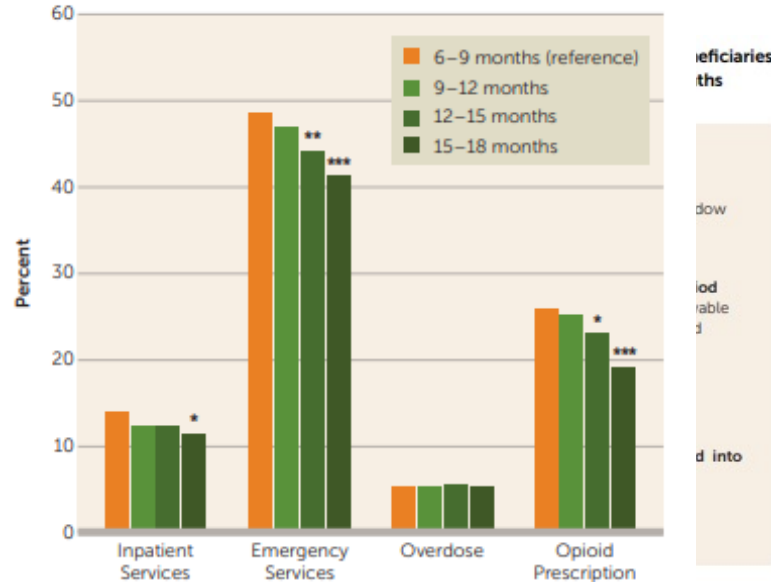
## Acute Care, Prescrip Following Discontin Buprenorphine Tre:

Arthur Robin Williams, M.D., M

**Objective:** Although buprenorphine discontinuation is associated with an increased risk of overdose and death in opioid use disorder, patients who discontinue treatment within 6 months of enrollment in Medicaid were compared among patients who were retained beyond 6 months of enrollment in Medicaid at a minimum treatment duration recommendation at a Quality Forum.

**Methods:** A retrospective cohort study was performed using the MarketScan database (2013–2017), covering 15 states. The sample included Medicaid beneficiaries who received buprenorphine treatment and were retained for 6–9 months (reference) and 9–12, 12–15, and 15–18 months. For the out-of-treatment period, patient visits in Medicaid for 6 months after discontinuation were identified. Primary adverse outcomes included hospital inpatient visits, all-cause inpatient admissions, emergency department visits, and drug overdoses.

FIGURE 3. Unadjusted 6-month outcomes following discontinuation among Medicaid beneficiaries ages 18–64 retained on buprenorphine for ≥180 days, by treatment duration cohort (2013–2017)<sup>a</sup>



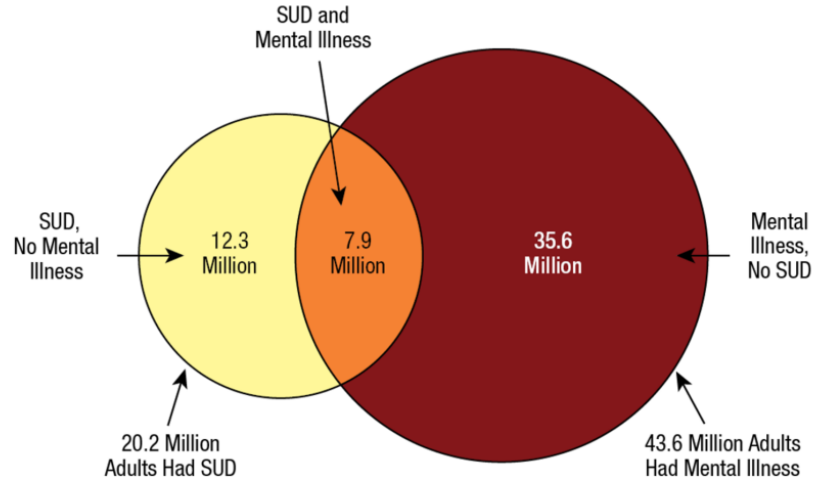
<sup>a</sup> All comparisons are with the reference group (the 6- to 9-month cohort). \*p<0.05. \*\*p<0.01. \*\*\*p<0.001.

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- **Illness co-occurs with other med-psych illnesses (\*\*Gets its own learning objective!)**

# Illness co-occurs with other med-psych illnesses

## Co-occurring Psychiatric Disorders





**Discuss emerging  
approaches to integration  
of BH care and SUD into  
medical settings**

# OUD and Infectious Diseases: Serious Infections

National estimates of hospitalizations related to OUD and associated infections

|   | 2002<br>(N =<br>36,523,831) | 2012<br>(N =<br>36,484,846) |
|---|-----------------------------|-----------------------------|
|   | Number                      | Number                      |
| Opioid abuse/dependence                             | 301,707                     | 520,275 <sup>**</sup>       |
| Opioid abuse/dependence with infection <sup>#</sup> | 3,421                       | 6,535 <sup>**</sup>         |
| Endocarditis  | 2,077                       | 3,035 <sup>*</sup>          |
| Osteomyelitis                                       | 458                         | 985 <sup>**</sup>           |
| Septic arthritis                                    | 729                         | 1,940 <sup>**</sup>         |
| Epidural abscess                                    | 411                         | 1,085 <sup>**</sup>         |

SOURCE Authors' analysis of data from the National Inpatient Sample, 2002 and 2012.

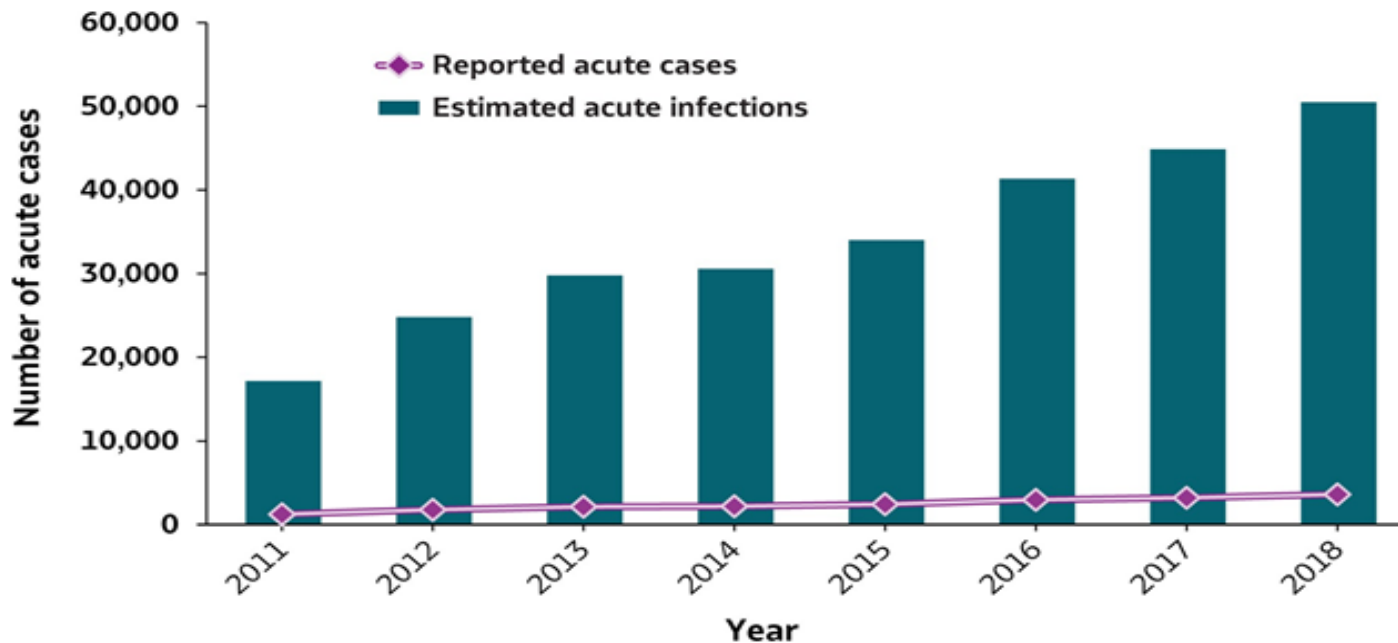
<sup>#</sup>Infection type includes osteomyelitis, septic arthritis, or epidural abscess

<sup>\*</sup>p < 0.01

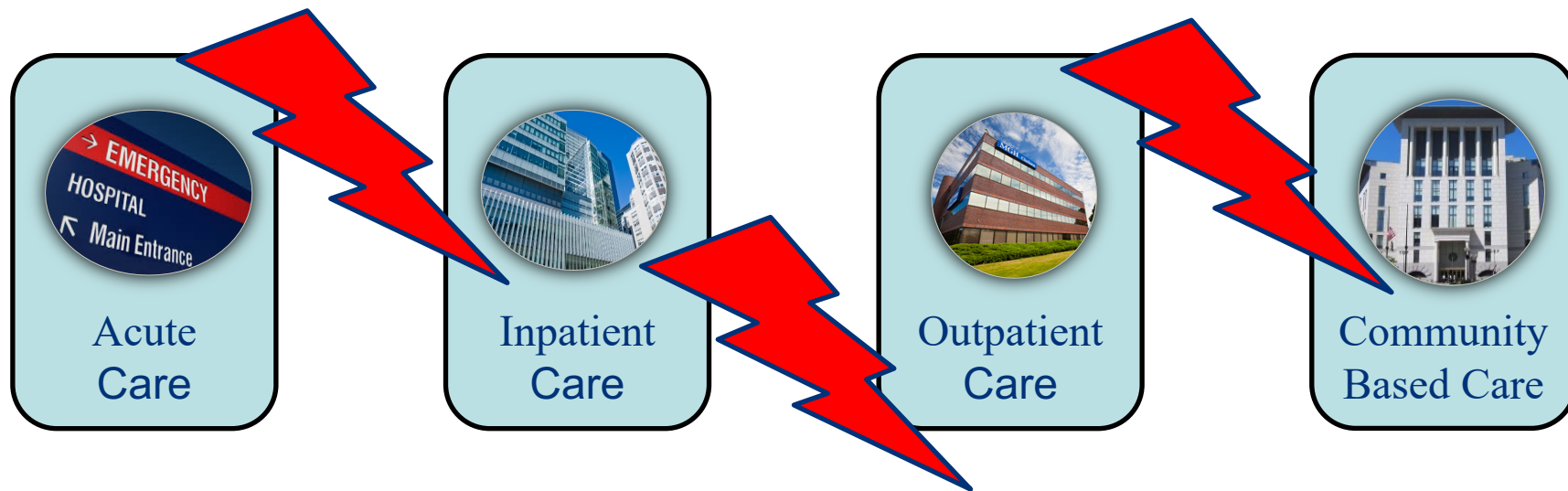
<sup>\*\*</sup>p < 0.001

# OUD and Infectious Diseases: Hepatitis C Virus

Number of reported acute hepatitis C cases and estimated infections in the United States 2011 - 2018



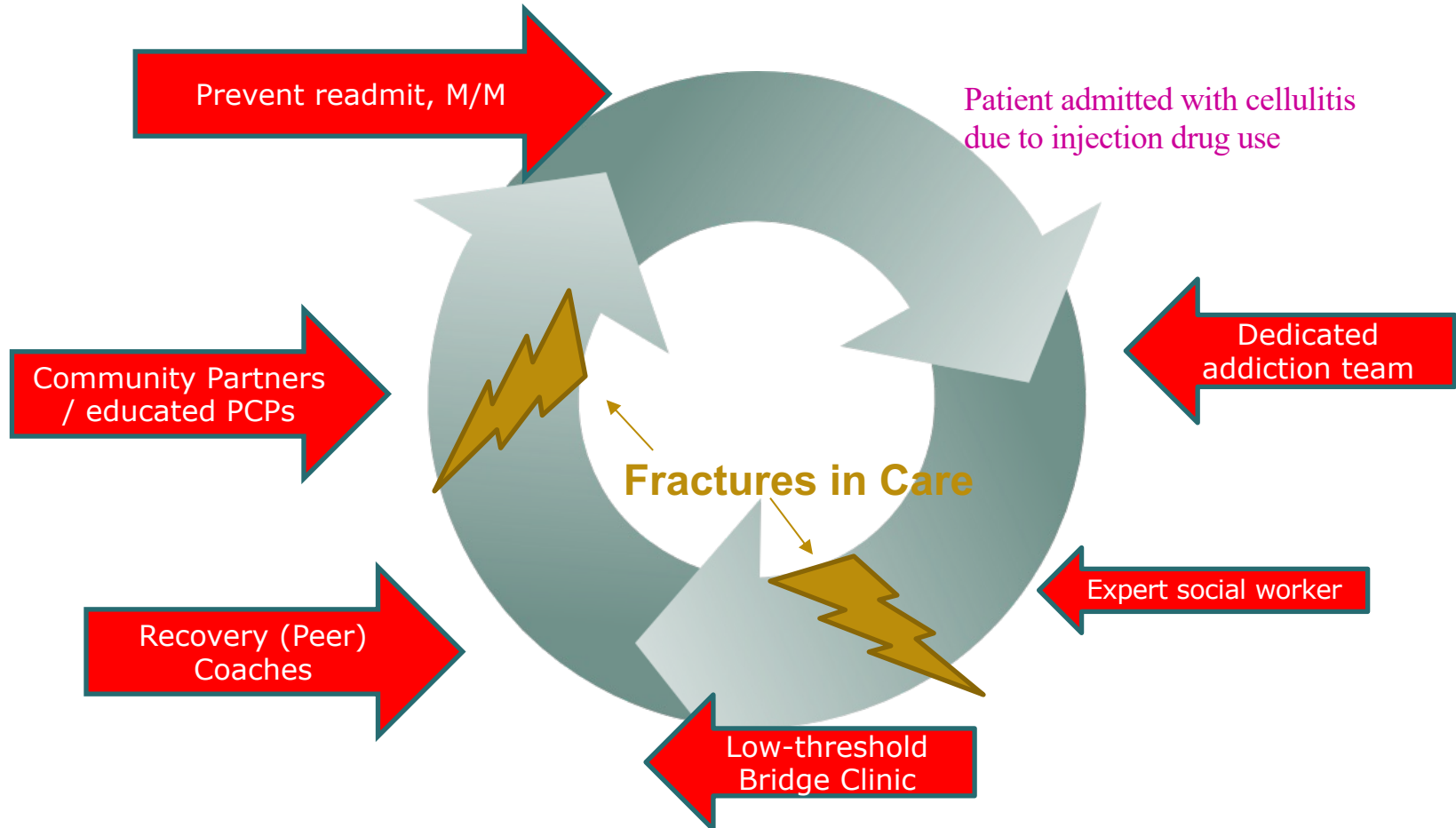
# “Traditional” Model of SUD Care



High risk of fractured care at multiple transition points



# Preventing Fractures in Care



# Integrated care Research: ED, Consults and Bridge

Original Investigation

## Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized

Gail D'Onofrio, MD, MS; Patrick G. O'Connor, MD; Susan H. Busch, PhD; Patricia H. Owe

**IMPORTANCE** Opioid-dependent patients need integrated medical care.

**OBJECTIVE** To test the efficacy of an emergency department referral to treatment (referral to treatment) versus a community-based treatment intervention, ED-initiated treatment versus a community-based care for 10-week follow-up (bridge).

**DESIGN, SETTING, AND PARTICIPANTS** Randomized controlled trial of opioid-dependent patients with a diagnosis of opioid use disorder from 2009, through June 25, 2013.



### Inpatient Addiction Treatment Increases Post-Discharge Opioid Use and Addiction Severity

Sarah E. Wakeman, MD<sup>1,2</sup>, Joshua P. Meisner, MD<sup>1,2</sup>, Grace E. Herman, BA<sup>3</sup>, and Nancy A. Riggs, MD<sup>4,5,6</sup>

<sup>1</sup>Division of General Internal Medicine, Massachusetts General Hospital, Boston, MA, USA; <sup>2</sup>Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA; <sup>3</sup>Harvard Medical School, Boston, MA, USA; <sup>4</sup>Department of Medicine, University of Washington, Seattle, WA, USA; <sup>5</sup>Institute of Psychiatry, Psychology, and Neuroscience, King's College London, London SE5 8AF, UK; <sup>6</sup>Division of General Internal Medicine, University of Kentucky College of Medicine, Lexington, KY 40506, USA

**BACKGROUND:** Alcohol and drug use results in substantial morbidity, mortality, and cost. Individuals with alcohol and drug use disorders are overrepresented in medical settings. Hospital-based interventions provide an opportunity to engage with a vulnerable population that may not otherwise seek treatment.

**OBJECTIVE:** To determine whether inpatient admission and consultation improves substance use outcomes 1 year after discharge.

**DESIGN:** Prospective quasi-experimental evaluation comparing 30-day post-discharge outcomes between participants who were and were not seen by an addiction consult team during hospitalization at an urban academic hospital.

**PARTICIPANTS:** Three hundred ninety-nine hospitalized adults who screened as high risk for having an alcohol



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journal homepage: [www.elsevier.com/locate/jSAT](http://www.elsevier.com/locate/jSAT)



## Patient experiences with a transitional, low-threshold clinic for the treatment of substance use disorder: A qualitative study of a bridge clinic

Rachel L. Snow<sup>a</sup>, Rachel E. Simon<sup>b,c</sup>, Helen E. Jack<sup>d,e</sup>, Devin Oller<sup>f</sup>, Laura Kehoe<sup>b,c</sup>, Sarah E. Wakeman<sup>b,c,\*</sup>

<sup>a</sup> Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114, USA

<sup>b</sup> Division of General Internal Medicine, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114, USA

<sup>c</sup> Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, USA

<sup>d</sup> Department of Medicine, University of Washington, 1959 NE Pacific Street, Seattle, WA 98195, USA

<sup>e</sup> Institute of Psychiatry, Psychology, and Neuroscience, King's College London, 16 De Crespigny Park, London SE5 8AF, UK

<sup>f</sup> Division of General Internal Medicine, University of Kentucky College of Medicine, 800 Rose Street MN 150, Lexington, KY 40506, USA

### ARTICLE INFO

#### Keywords:

Substance use disorders  
Low threshold

### ABSTRACT

**Background:** A minority of patients with substance use disorder (SUD) receives treatment, indicating the need for innovation in care for individuals with SUD. Transitional and low threshold models of care for SUD are utilized to address this treatment gap, but there is limited evidence about their effectiveness or patient perspectives on

# What do these services do?

- Risk stratification and guidance on hospital misuse and DC w/ PICC

- Management of detox and induction to MAT

ED, Hospital Consults, Bridge Clinics

- Assist distinguishing pain and opioid use disorder

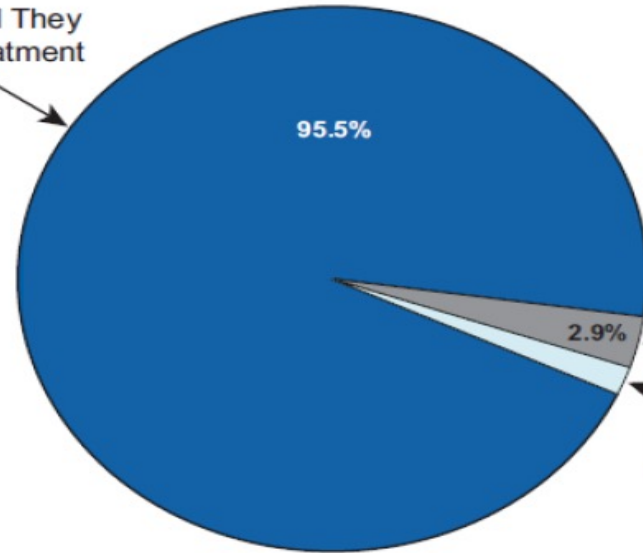
- Motivational interviewing, brief intervention and referral to treatment

- Psychiatric care for co-occurring mental illnesses

# Integrated Hospital and Community Services

- ED Buprenorphine
- General hospital addiction consults
- Bridge Clinic
- **Ambulatory integrated care**

Did Not Feel They Needed Treatment



Felt They Needed Treatment and Did Not Make an Effort

1.6%

Felt They Needed Treatment and Did Make an Effort

20.2 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.- July 2, 2016. Figure 7.10, Page 94

# Why outpatient collaborative care for addiction?

- Patients go to their PCP (82% go once per year)
- CC effective in other behavioral health conditions
- There is evidence for various individual components of addiction treatment being used effectively in primary care setting (Bup-Nx, XR-NTX, MI)

Ober, A. J., Watkins, K. E., Hunter, S. B., Lamp, K., Lind, M., & Setodji, C. M. (2015). An organizational readiness intervention and randomized controlled trial to test strategies for implementing substance use disorder treatment into primary care: SUMMIT study protocol. *Implementation Science*, 10(1), 1.

Research

Original Investigation

# Chronic Care Management for Dependence on Alcohol and Other Drugs

## The AHEAD Randomized Trial

Richard Saitz, MD, MPH; Debbie M. Cheng, ScD; Michael Winter, MPH; Theresa W. Kim, MD; Don Allensworth-Davies, PhD, MSc; Christine A. Lloyd-Travaglini, MPH; Jeffrey H. Samet, MC

**IMPORTANCE** People with substance dependence have health consequences, care utilization, and frequent comorbidity but often receive poor-quality care. management (CCM) has been proposed as an approach to improve care and o

Research

JAMA Internal Medicine | [Original Investigation](#)

# Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care

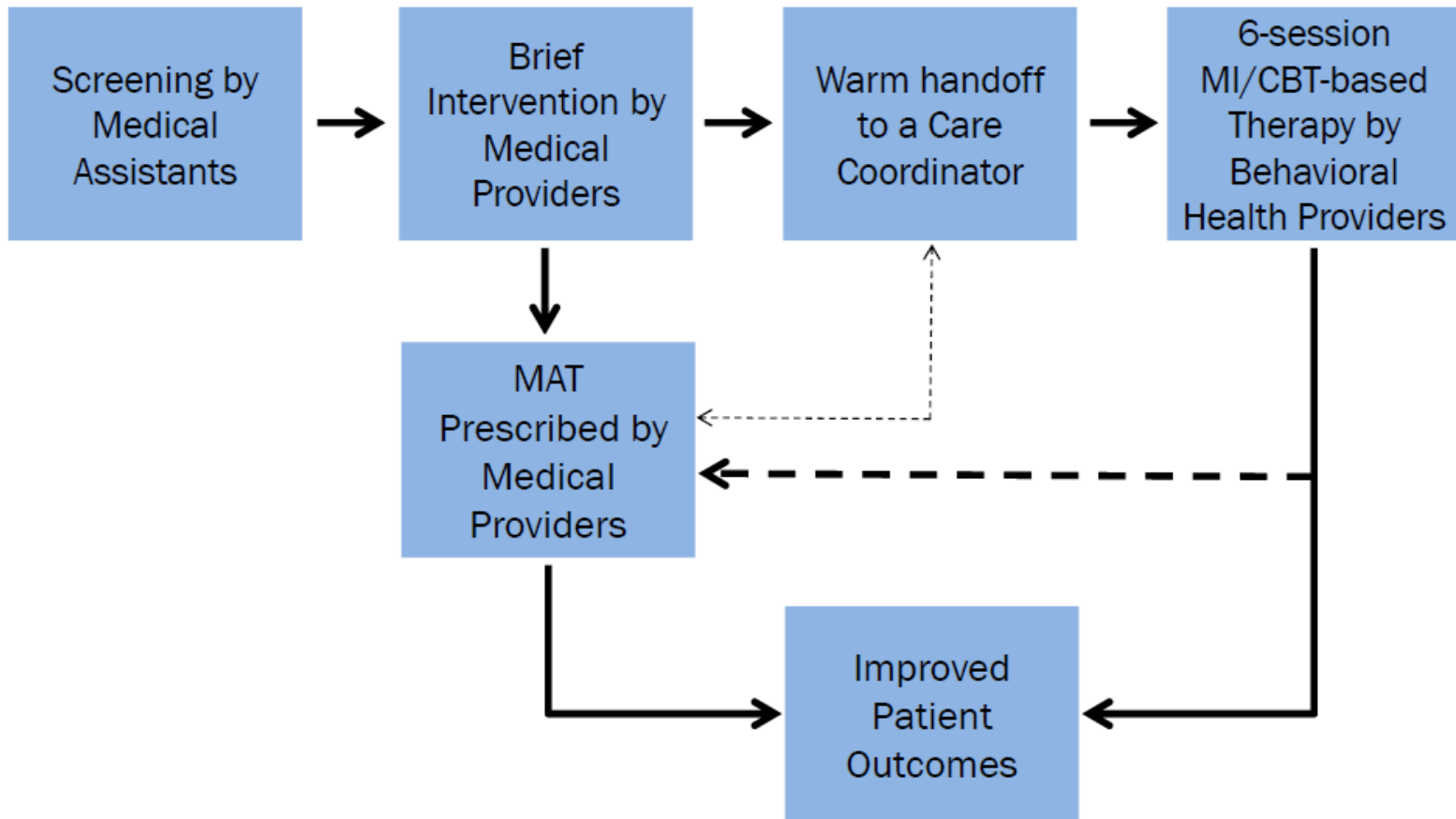
## The SUMMIT Randomized Clinical Trial

Katherine E. Watkins, MD, MSHS; Allison J. Ober, PhD; Karen Lamp, MD; Mimi Lind, LCSW; Claude Setodji, PhD; Karen Chan Osilla, PhD; Sarah B. Hunter, PhD; Colleen M. McCullough, MPA; Kirsten Becker, MS; Praise O. Iyewuare, MPH; Allison Diamant, MD; Keith Heinzerling, MD; Harold Alan Pincus, MD

**IMPORTANCE** Primary care offers an important and underutilized setting to deliver treatment for opioid and/or alcohol use disorders (OAU). Collaborative care (CC) is effective but has not been tested for OAUD.

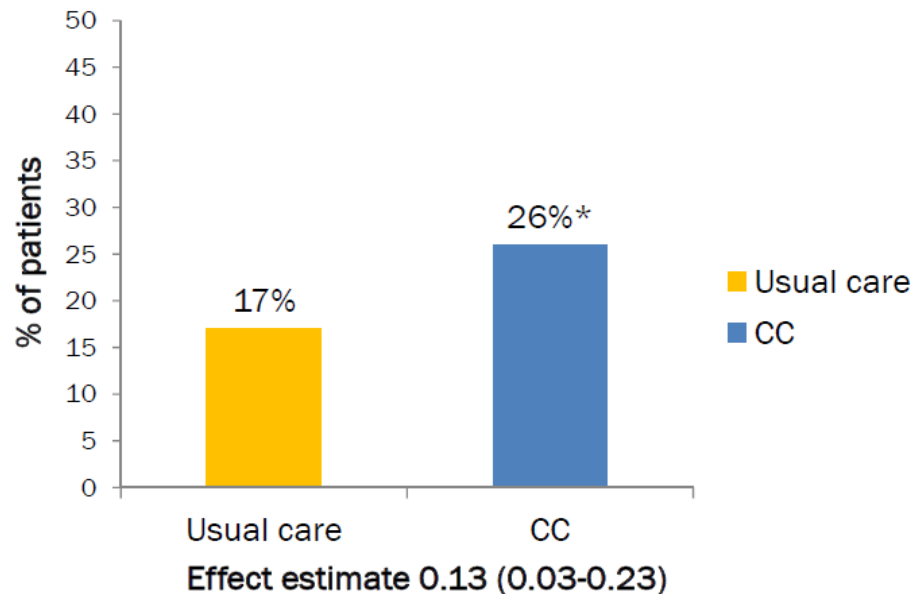
**OBJECTIVE** To determine whether CC for OAUD improves delivery of evidence-based treatments for OAUD and increases self-reported abstinence compared with usual primary care.

[+ Supplemental content](#)





## As well as abstinent from alcohol and all drugs at 6 months



\*p = 0.01

# What are the basic ingredients?

- Staff familiarity with anti-stigma measures (language slide above to start)
- Basic screening with AUDIT-C and NIDA 1-Question Screen
- X-waivered providers
- Treatment can be delivered in primary care
- A social worker / care coordinator / recovery coach helpful but not required
- Key resources:
  - National: PCSS ([pcssnow.org](http://pcssnow.org)); Opioid Response Network ([ORN-opioidresponsenetwork.org](http://ORN-opioidresponsenetwork.org))
  - Local: Project ECHO (next slide); local Hub-Spoke networks through TDMHSAS

# Opioid Response Network and PCSS



Opioid  
Response  
Network

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PCSS

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We H  
HELP

Discover the rewards of treating  
patients with Opioid Use Disorders

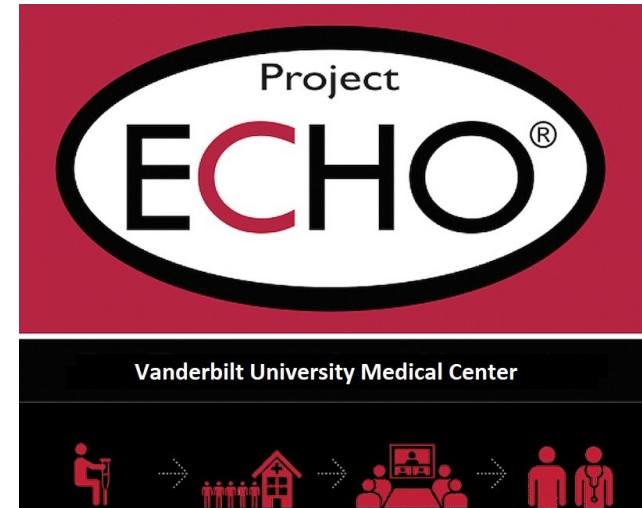
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- [Opioidresponsenetwork.org](https://opioidresponsenetwork.org) and [pcssnow.org](https://pcssnow.org)

# Project ECHO

- In February 2020, TDMHSAS designated VUMC as a Project ECHO Tele-Education Hub. TennCare supported Hub at ETSU pre-dates.
- Project ECHO is a model for technology-enabled education and mentoring meant to expand capacity for community providers to deliver best-practice care for complex health conditions.
- Two-tier model of participation; twice monthly sessions



[kristopher.a.kast@vumc.org](mailto:kristopher.a.kast@vumc.org)

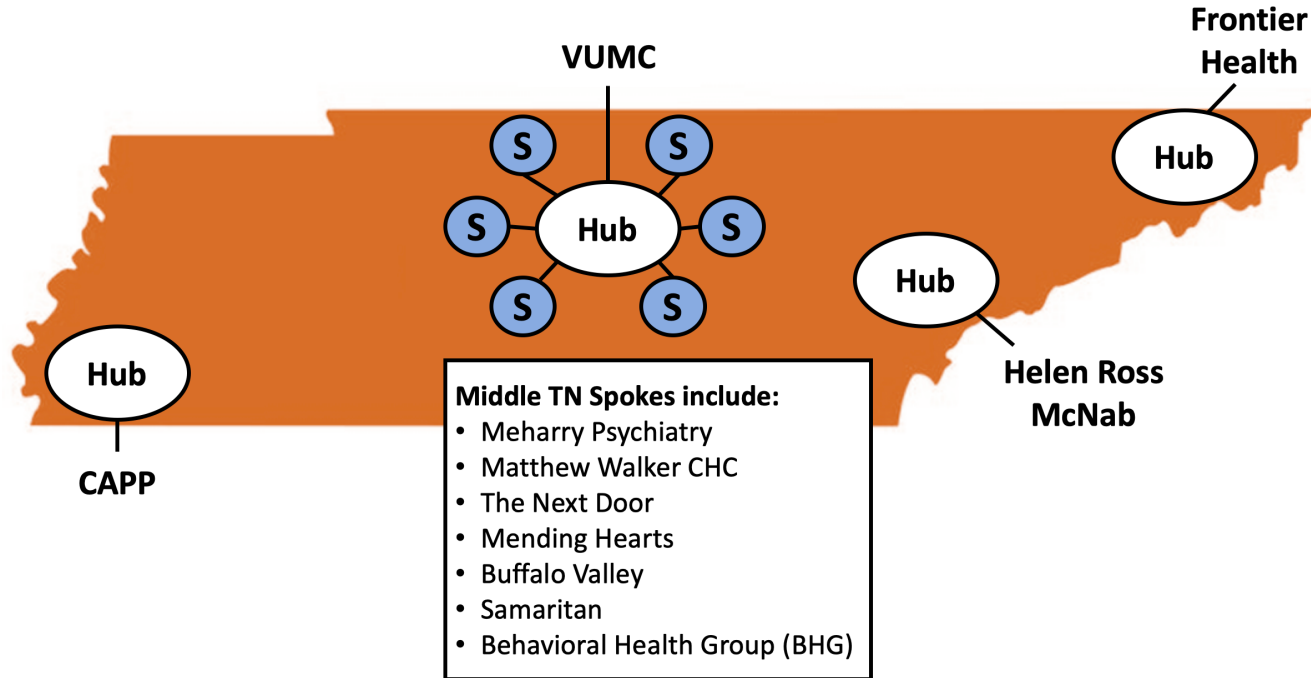


**Describe basic features  
of a Hub-and-Spoke  
model of OUD care**

# Hub and Spoke - Background

- Hub - an anchor site that provides comprehensive and specialized care for a condition
  - Application to OUD – extend the reach of MOUD especially buprenorphine
  - Originated for OUD in Vermont – used opioid treatment programs (methadone clinics)
  - Other states have defined more broadly
- Spoke - satellite sites offering more limited services
  - Could be any site offering a form of MOUD
  - Could also include broad psychosocial services
- Hub-and-Spoke Network
  - A way to better expand access and integrate care continuum
  - ECHO Tele-education platform can support education and alignment

# Regional Hub-and-Spoke Network



SORII: Added Spokes include Cedar Recovery and Meharry Family

## A case...

- Jeff is a 42-year-old married man with a history of alcohol and opioid use disorder. You see him in your primary clinic following a recent medical admission. He tells you the psychiatric provider in the hospital visited him and diagnosed him as bipolar depressive, starting him on fluoxetine 20mg and lorazepam 2mg at night. He is also taking Suboxone 8mg BID and acamprosate 666mg TID.

### Questions to consider:

- How often do these three conditions (OUD, AUD, bipolar) co-occur?
- Would you tend to accept the diagnosis?
- What about the treatment plan?



## **A case... (continued)**

Questions to consider:

- How often do these three conditions (OUD, AUD, bipolar) co-occur?
- Would you tend to accept the diagnosis?
- What about the treatment plan?

# Poll Everywhere

- Please text PCTEAM in the message line to phone number 22333 to join session
- Confirmation text will appear
- Respond with A,B,C,D or E when prompted by question or text answer if question is open ended

Your audience texts **PCTEAM** once to **22333** to join your session.

Then they respond with **A, B, C, or D** when the activity is active.



In a patient with OUD, the prevalence of serious mental illness and alcohol use disorder, respectively, are:

✔ 0

41% and 22%

26% and 26%

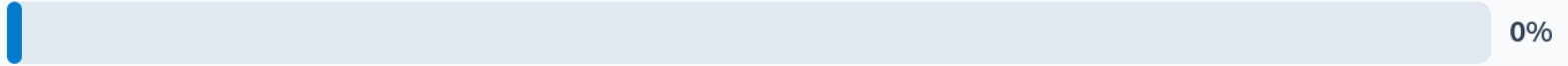
16% and 21%

9% and 14%

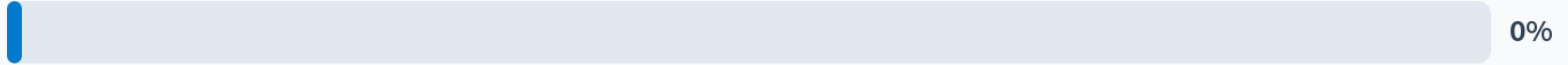
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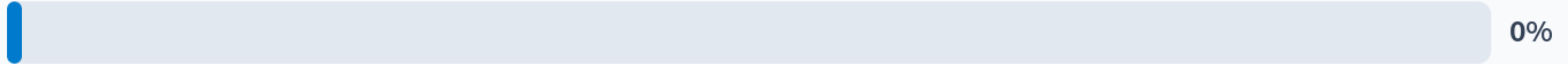
41% and 22%



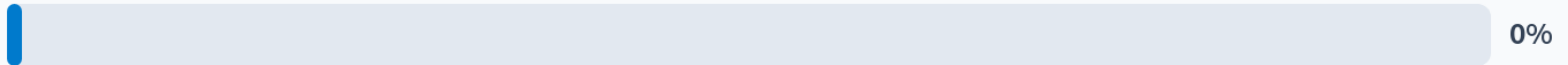
26% and 26%



16% and 21%



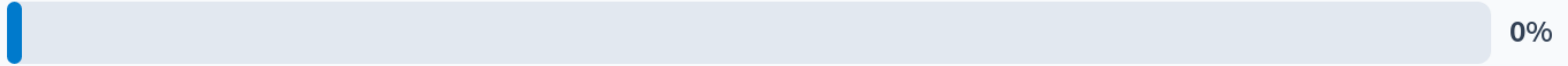
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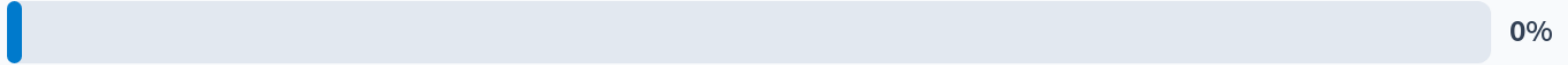
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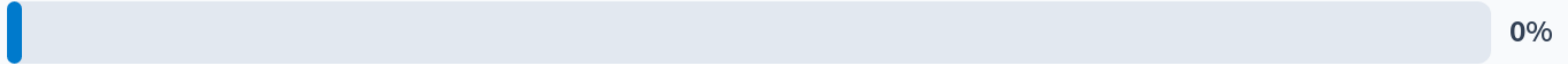
41% and 22%



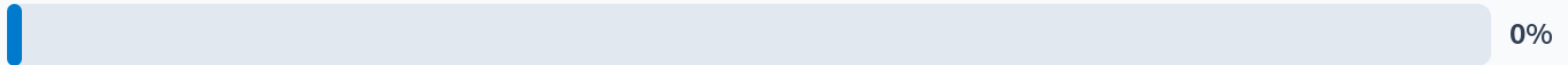
26% and 26%



16% and 21%



9% and 14%



## Learning objectives

At the end of this session, participant will be able to:

- Discuss the incidence of co-occurring psychiatric and substance use disorders for common SUD
- Describe an approach for diagnosing co-occurring non-substance psychiatric conditions in the presence of an SUD
- Discuss treatment considerations for common co-occurring non-substance psychiatric conditions in the presence of an SUD

# What disorders commonly co-occur with OUD?

Alcohol – 26.4%

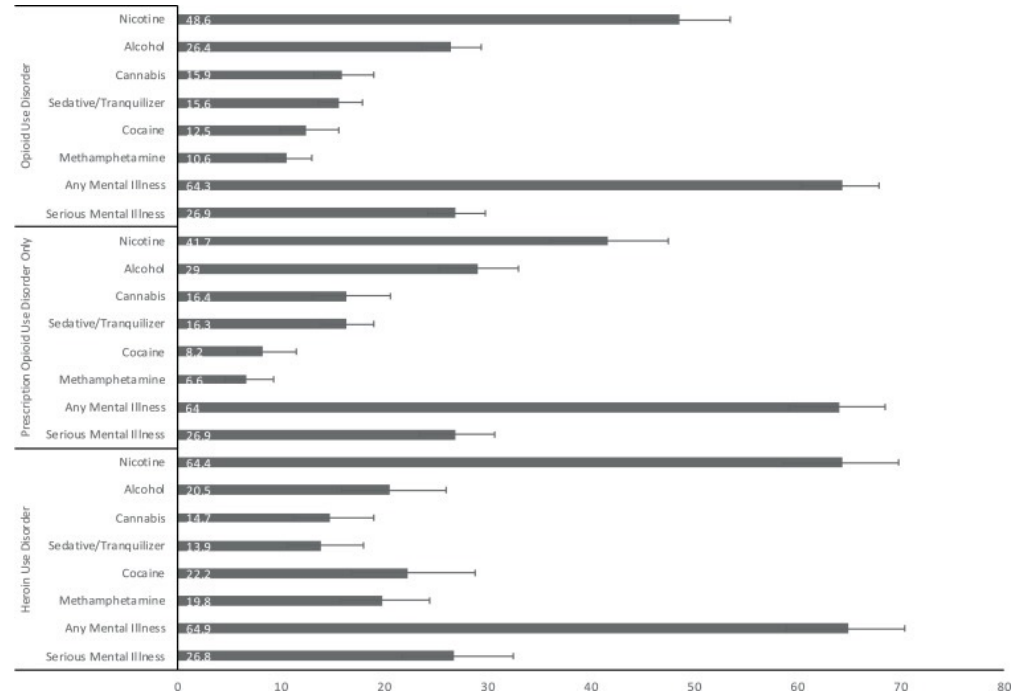
Methamphetamine – 10.6%

Cocaine - 12.5%

Sedative – 15.6%

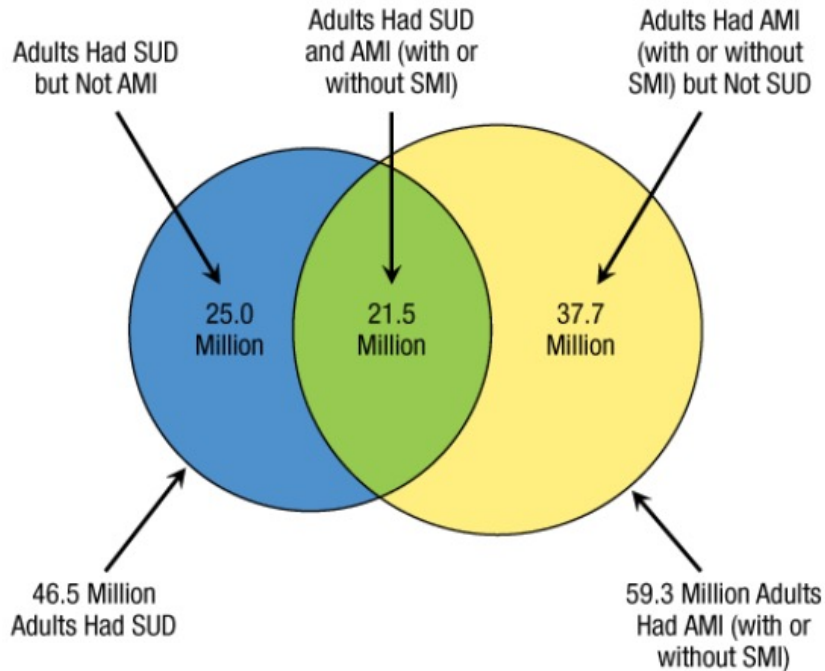
Any mental illness: 64.3%

Serious mental illness: 26.9%

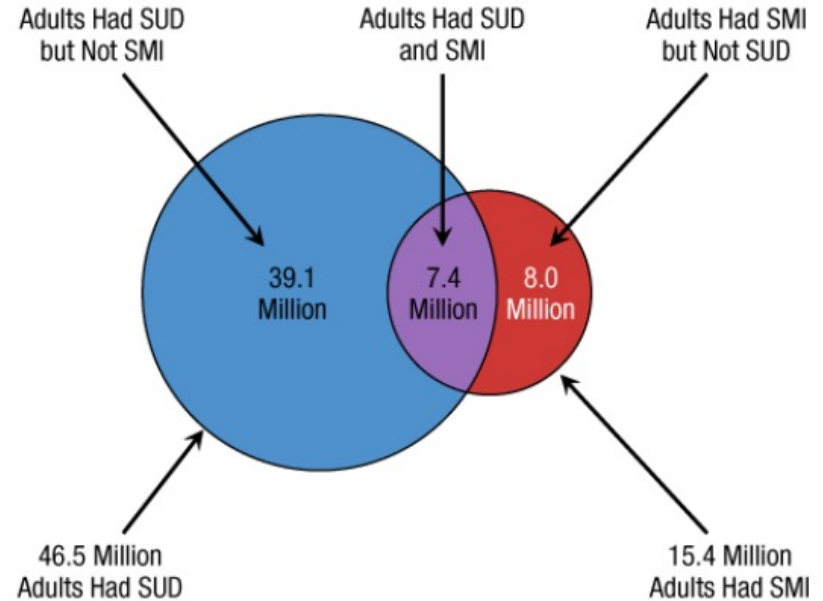


Jones, C. M., & McCance-Katz, E. F. (2019). Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug and alcohol dependence, 197*, 78-82.

## Past Year Substance Use Disorder (SUD), Any Mental Illness (AMI) and Severe Mental Illness (SMI) among Adults Aged 18 or Older: 2022



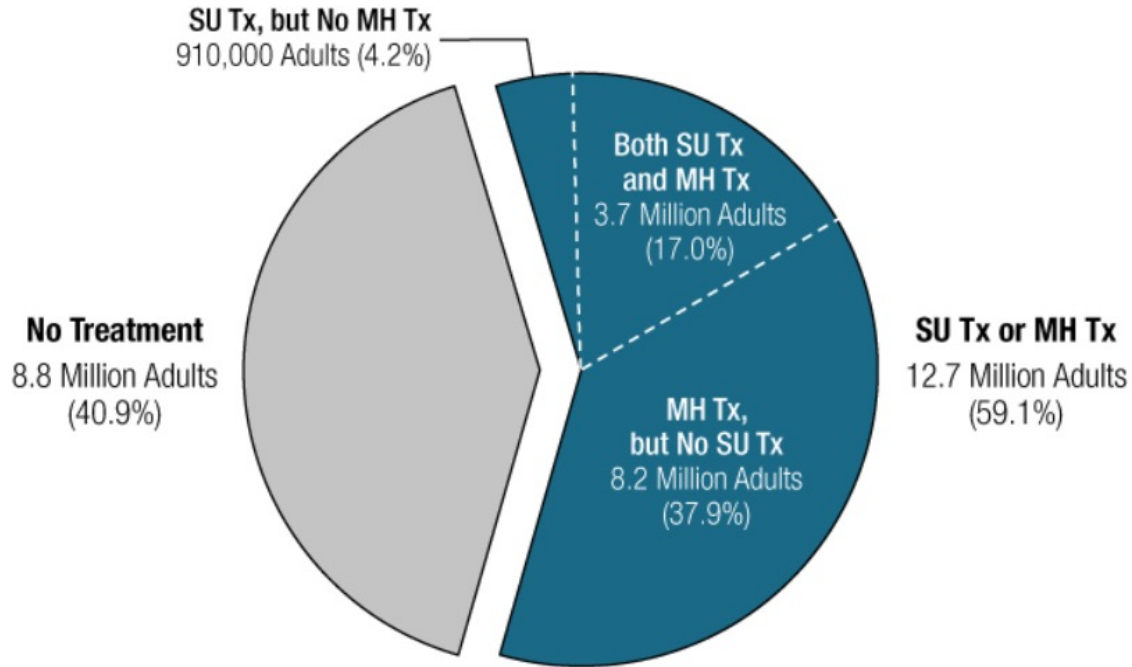
**84.2 Million Adults Had Either SUD or AMI (with or without SMI)**



**54.4 Million Adults Had Either SUD or SMI**



## Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adults Aged 18 or Older with Past Year Substance Use Disorder and Any Mental Illness; 2022



21.5 Million Adults with a Substance Use Disorder and Any Mental Illness

[D](#)

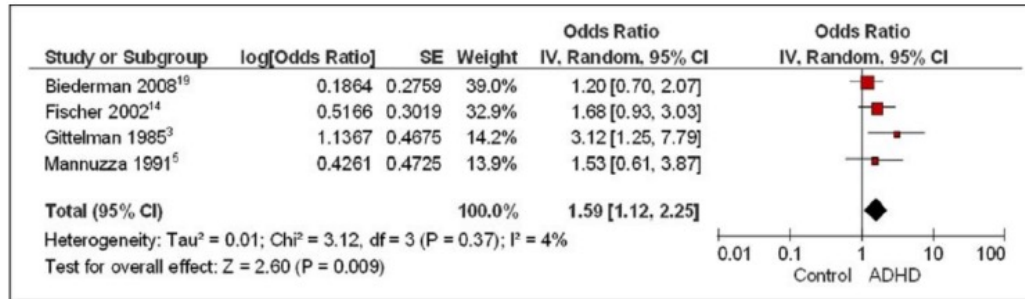
**comorbidity:**  
rule rather than exception.

| diagnosis   | relevant rates                |
|-------------|-------------------------------|
| MDD         | 15-50% across SUD samples     |
| bipolar     | up to 40% have SUD            |
| anxiety     | 20-80% of SUD; 20% in PCP     |
| PTSD        | 30-60% of SUD; 20-40% of PTSD |
| psychosis   | 70-90% NUD; 20-30% other SUD  |
| ADHD        | 25% in SUD                    |
| personality | 65% BPD in SUD                |
| eating      | up to 50% have SUD            |

# linked disorders:

childhood ADHD → SUD.

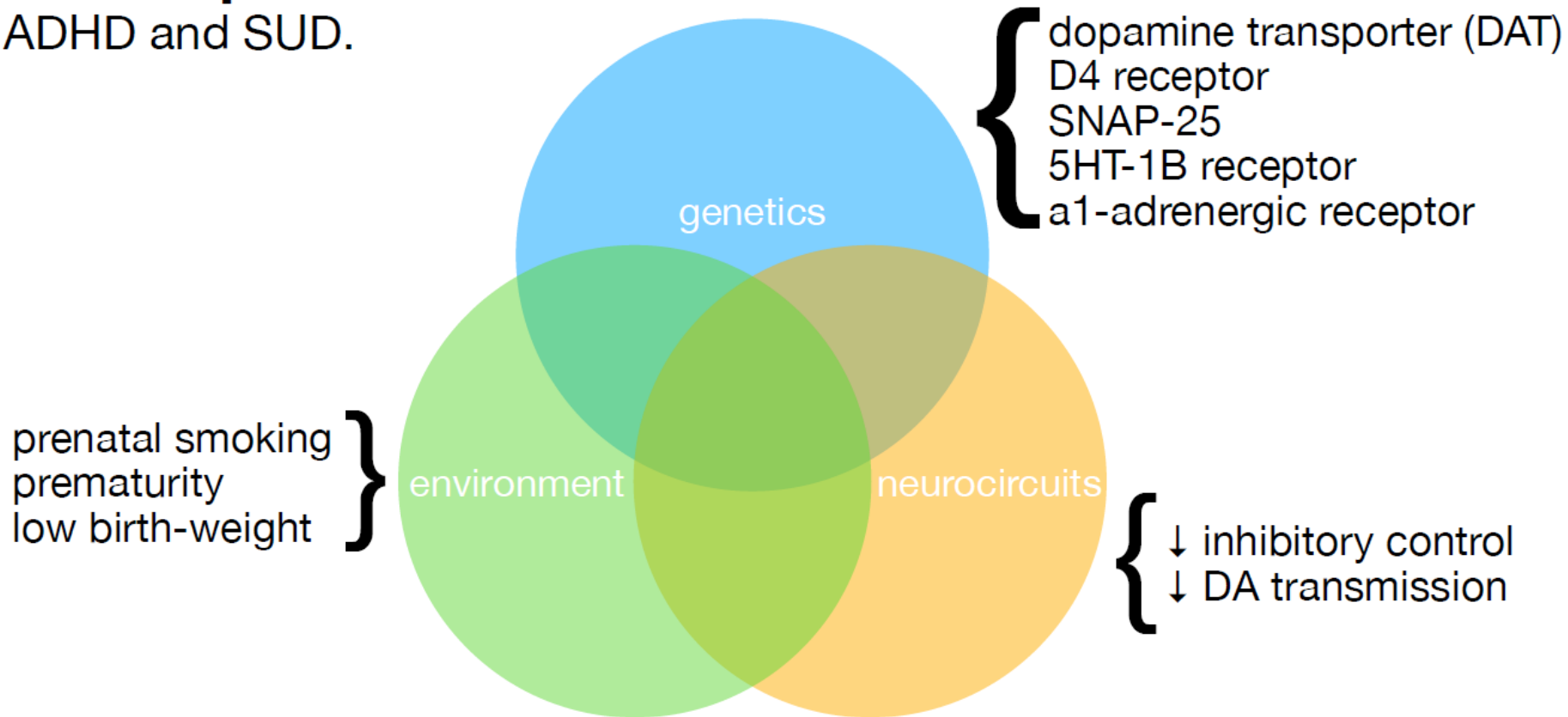
**FIGURE 4** Meta-analysis of attention-deficit/hyperactivity disorder (ADHD) and psychoactive substance use disorder. Note: Results from a meta-analysis comparing ADHD versus control subjects for psychoactive substance use disorder. CI = confidence interval.



▸ OR 1.12-2.25 across prospective cohort studies

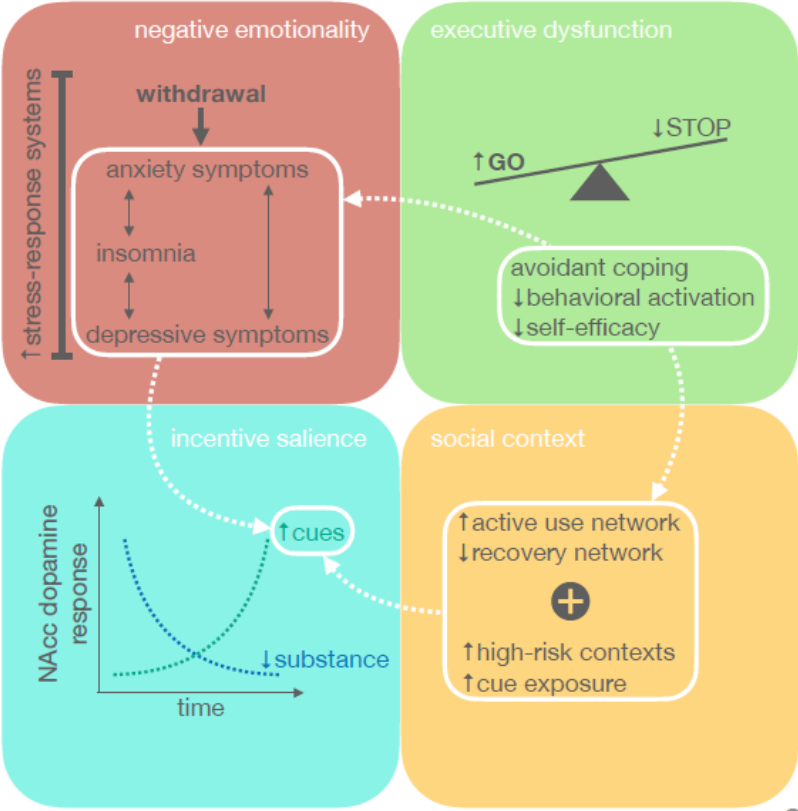
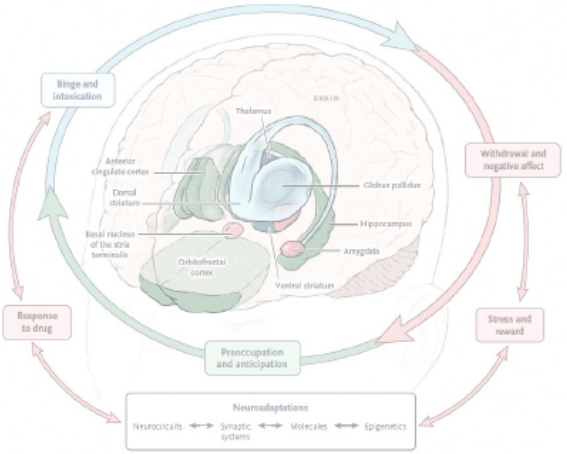
# overlap:

ADHD and SUD.



# neurobiology:

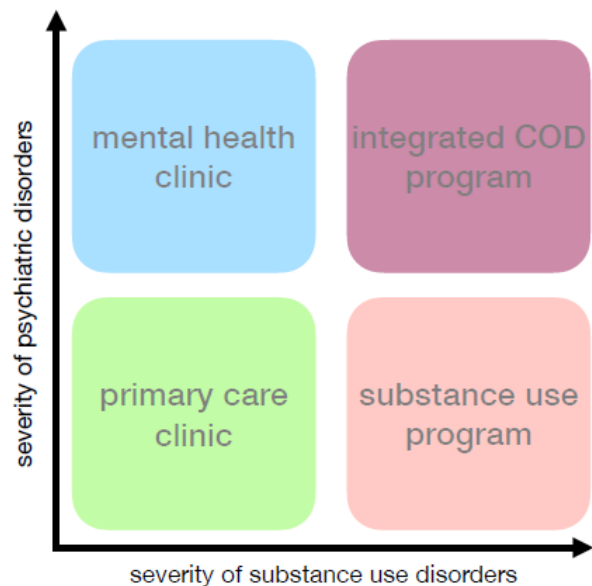
mutually-reinforcing mechanisms.



# comorbidity:

worsened outcomes.

- higher relapse rates
- higher acute care use
- higher SDOH burden
  - challenged by non-integrated care



## Learning objectives

At the end of this session, participant will be able to:

- Discuss the incidence of co-occurring psychiatric and substance use disorders for alcohol, opioid and stimulant use disorder
- Describe an approach for diagnosing co-occurring non-substance psychiatric conditions in the presence of an SUD
- Discuss treatment considerations for common co-occurring non-substance psychiatric conditions in the presence of an SUD

## Case continued

- Jeff is a 42-year-old married man with a history of alcohol and opioid use disorder. You see him in your primary clinic following a recent medical admission. He tells you the psychiatric provider in the hospital visited him and diagnosed him as bipolar depressive, starting him on fluoxetine 20mg and lorazepam 2mg at night. He is also taking Suboxone 8mg BID and acamprosate 666mg TID.

How would you approach clarification of Jeff's diagnosis from the recent admission?



## What is your approach to Jeff's mood diagnosis?

0

Since he has only been sober for 9 months in his 30s following a residential admission, we should defer his diagnosis

Regardless of the underlying diagnosis, we need a period of sobriety to determine if he currently meets mood disorder criteria

It is unwise to question the diagnosis made in a psychiatric hospital, since psychiatrists probably work there

Jeff's symptoms prior to onset of SUD and during sober periods can usually help us make a diagnostic decision

## What is your approach to Jeff's mood diagnosis?

0

Since he has only been sober for 9 months in his 30s following a residential admission, we should defer his diagnosis

0%

Regardless of the underlying diagnosis, we need a period of sobriety to determine if he currently meets mood disorder criteria

0%

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0%

## What is your approach to Jeff's mood diagnosis?

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0%

Jeff's symptoms prior to onset of SUD and during sober periods can usually help us make a diagnostic decision

0%

# Primary or Secondary?

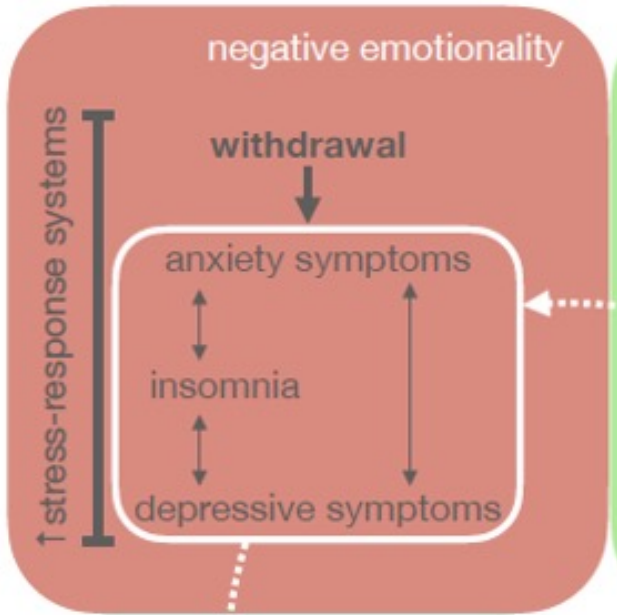
## Substance-induced disorders

- Depressive and anxiety symptoms most common
- In AUD, 40% on presentation
  - 5-10% persist at 4 weeks
  - 5x more likely to persist if prior MDD or low drinking volume
  - Risk of suicidal behavior is not different for SIDD and MDD

| DSM 5 substance-induced mental disorder criteria |  |
|--|--|
| <b>Evidence of both:</b>                         | onset within 1 month of use or intoxication/withdrawal |
|  | substance is capable of causing the symptoms           |
| <b>and, symptoms not better explained by:</b>    | independent disorder present prior to use              |
|  | persistent symptoms for prolonged period (>1 month)    |
| <b>and:</b>                                      | not delirium + causing impairment                      |

# Primary or Secondary?

## Substance-induced disorders



### Questions for the interview:

Were symptoms present during longest period of recovery?

Age of symptom onset relative to substance use?

Developmental history and associated risk factors?

Family history of the psychiatric disorder?

# How to screen quickly for the most common psychiatric conditions

| Mood                      | "Anxiety"                    | Thought                  |
|---------------------------|------------------------------|--------------------------|
| Major Depressive Disorder | Generalized anxiety disorder | Schizophrenia            |
| Bipolar Disorder          | Panic Disorder               | Schizoaffective Disorder |
|                           | OCD                          |                          |
|                           | PTSD                         |                          |
|                           |                              |                          |

# How to screen quickly for specific mood disorders

During X period of sobriety, or before onset of use...

- MDD – 2 weeks of feeling down or depressed or not being able to enjoy anything most of the day every day?
  - During that time did you experience problems with sleep, appetite, energy, guilt or hopelessness?
- BPAD - Did you ever have “the opposite” of depression where you didn’t need much sleep for several days, but you weren’t tired?
  - During that time, did you have too much energy like people thought you were “high” but you didn’t use drugs, talking fast, racing thoughts, feeling more irritable, doing lots of things?

# How to screen quickly for specific anxiety disorders

During X period of sobriety, or before onset of use...

- GAD – Are you a worrier?
  - Do you find you're worrying more than half the time?
  - Does it cause problems like poor sleep, muscle tension, restlessness?
- Panic Disorder – Do you ever get physical symptoms from anxiety like can't breathe, heart racing, feel like you're going to die?
  - How often? Does it cause you problems?
- OCD – do you have to do unusual things to relieve anxiety like wash hands, check locks, count numbers?
  - How much time is spent? Does it cause you problems?



# Consider use of measures like PHQ9 and GAD7

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

|  | Not at all | Several days | More than half the days | Nearly every day |
|--|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things   | 0          | 1            | 2                       | 3                |
| 2. Feeling down, depressed, or hopeless  | 0          | 1            | 2                       | 3                |
| 3. Trouble falling or staying asleep, or sleeping too much                                       | 0          | 1            | 2                       | 3                |
| 4. Feeling tired or having little energy   | 0          | 1            | 2                       | 3                |
| 5. Poor appetite or overeating   | 0          | 1            | 2                       | 3                |
| 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0          | 1            | 2                       | 3                |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television         | 0          | 1            | 2                       | 3                |
| 8. Moving or speaking so slowly that other people could  |            |              |                         |                  |

## GAD-7 Anxiety

| Over the <u>last two weeks</u> , how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|--|------------|--------------|-------------------------|------------------|
| 1. Feeling nervous, anxious, or on edge  | 0          | 1            | 2                       | 3                |
| 2. Not being able to stop or control worrying  | 0          | 1            | 2                       | 3                |
| 3. Worrying too much about different things  | 0          | 1            | 2                       | 3                |
| 4. Trouble relaxing  | 0          | 1            | 2                       | 3                |
| 5. Being so restless that it is hard to sit still  | 0          | 1            | 2                       | 3                |
| 6. Becoming easily annoyed or irritable  | 0          | 1            | 2                       | 3                |
| 7. Feeling afraid, as if something awful might happen  | 0          | 1            | 2                       | 3                |

Column totals \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ =

Total score \_\_\_\_\_

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

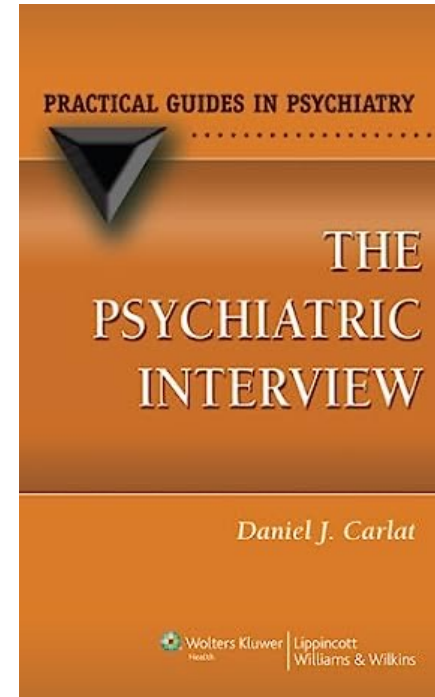
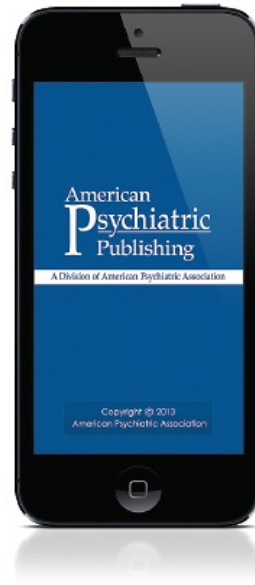
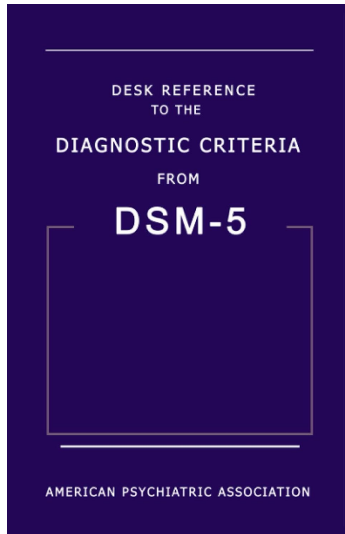
|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Not difficult at all     | Somewhat difficult       | Very difficult           | Extremely difficult      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

# How to screen quickly for specific thought disorders?

During X period of sobriety, or before onset of use...

- Schizophrenia spectrum: Have you had unusual experiences such as:
  - Hearing voices other people weren't hearing?
  - Seeing visions other people weren't seeing?
  - Feeling you were being watched, followed or monitored?
  - Had beliefs that other people thought were unusual?

# How to diagnose psychiatric conditions: Practical Tools



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**Thank you! Questions?**

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