Welcome!

Mute

Minimize Interruptions

Please make sure to mute yourself when you aren't speaking.

Chat

Go Ahead, Speak Up!

Use the Zoom chat to ask questions and participate in activities.

Naming

Add Your Organization

Represent your team and add your organization's name to your name.

Tech Issues

Here to Help

Chat Host privately if are having issues and need tech assistance.

While we wait, please rename yourself.

Addiction Treatment Starts Here
Behavioral Health Staff Forum Session #4

“MAT for Persons with Co-morbid Mood Disorders”

March 17, 2022 | 10am–11am (PT)

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DHCS

Reflection:

Are Mood Disorders Usually Adequately Treated in People Receiving MAT? What is Your Observation?

Mood Disorders and SUD Often Coexist

- Complicates Diagnosis
- Can lead to more severe symptoms, functional impairment, greater suicide risk than either alone
- Reciprocal influence between the two conditions
  - The presence of one increases likelihood of the other
    - Use of substances in response to emotional distress
    - Substance use reveals predisposition to depression that was not yet expressed
    - Substance-induced depression
  - Shared risk factors – biological, social, environmental (e.g., ACEs)

Reciprocal Relationship

- Adults with mood disorders receive disproportionate amount of opioids prescriptions – nearly twice as likely to take them long-term
- 2 million adults had a OUD in the past year (2015-2017) – 1 in 4 of those adults have co-occurring SMI
- The presence of MDD is estimated to increase risk of substance use disorder by 4.3 times
- VA study – when depression is in remission, those who are exposed to an opioid appear to have greater risk of depression reoccurrence – event after controlling for pain, hx of misuse, other psych concerns
- Research indicates treating one in isolation does not result in reduction/remission of the other naturally
- Optimizing treatment of mood disorders and SUD simultaneously can improve outcomes for both conditions

Treatment Engagement

- Treatment rates are suboptimal
  - 1/3 of adults with OUD received any SUD treatment in the past year
  - Adults with OUD and MH concerns often do not receive MH treatment – even fewer receive MH *and* SUD treatment
  - For adults with OUD and any mental illness (AMI) – 24.5% received MH and SUD treatment in the past year
- Implications for improving MAT availability + incorporating a continuum of treatment supports to address mood disorders
  - Integrated care
  - Hub and spoke model
  - Paradigm/organizational mission shift vs. grant driven "programs"

MAT and Mood Disorders

- MAT is standard of care for OUD
  - Reducing risk for overdose or death
  - Reducing substance use and improving functioning
  - Varied quality of treatment for mood within MAT services
  - Treatment drop out remains higher than desired
    - Could drop out be impacted by not adequately addressing co-occurring mood disorders?
    - When MH is available, is it incorporated too late?
- Collaboration/comprehensive care for SUD and mood disorders could look many ways depending on resources and preference
  - E.g., psychiatry consultation clinic for persons stabilizing

Implications for Treatment – Working Diagnoses

- Initial and *ongoing* assessment of mood and substance use
  - Assess mood disorders and substance use thoroughly for all regardless of door they enter through
  - Develop *working diagnoses* using understanding of relationship between mood symptoms and substance use
    - Self report of timeline of mood sxs, substance use, family history, mood during previous periods without use
    - Treatment history – what worked, what did not, relationship between mood and relapse
    - Waiting to assess mood disorders until after stabilization could risk safety and treatment drop out
  - Develop unified care plan with other team members – all team members can conceptualize mood and SUD as goals they are assisting with – the tools will differ
  - Refine diagnosis with time

Implications for Treatment – Stages of Care

- Often treatment takes place in stages – can treat both at the same time, intervention varies based on severity and motivation for each
  - Consider relationship between depression/hypomania/mania and healthcare burden – simplify!
  - Fluidly adjust plan – consider starting every follow up re-assessing both, allow this to guide focus of visit, and re-evaluate follow up intervals and team members involved at end of each visit
    - Calibrate phases to needs (individually and over time) – e.g., adults with bipolar disorder and any ongoing use may need to be in a stabilization focused phase longer
    - Provide education about Post Acute Withdrawal Syndrome (PAWs) – monitoring PAWs vs. clinically significant mood symptoms
  - Interventions that target and address mood and SUD/recovery
    - What strategies/interventions "kill two bird with one stone"?

Implications for Treatment – Safety

- Morbid Ideation— common in severe substance use
  - "I don't want to live like this."
  - "If I don't wake up tomorrow, I'd be okay with that."
- Suicidal Ideation— stronger correlation between SI and suicidal behaviors
  - "I wish I were dead."
  - "I want to die."
- Mood symptoms may increase isolation, may lack natural supports or make engaging natural supports difficult in safety planning
- Increases likelihood of needing higher level of care
  - Least restrictive options? Community partners with comfort addressing both?

Case #2

54 yo female who is a longstanding primary care patient at the clinic with history of MDD Recurrent, OUD, Cocaine UD. She is chronically unhoused, currently working day labor jobs when feeling well enough. Describes feeling low energy, irritable, it's hard to push herself to make it to appointments. Very limited healthy supports – she has close friends who are all currently using substances. She feels most down when she is bored and without social support. Loneliness and frustration with chronic lack of resources to meet her basic needs often lead to relapse. She is re-engaging in MAT services today.

- As the BH provider on the team, what information would be helpful in collaboratively planning with her?
- How can we help in this episode of care being more successful?
- How might you organize care to meet her where she is and minimize her healthcare burden?

Case #2

41 year old male referred by local hospital where he was seen with pneumonia and opioid and alcohol withdrawal (UDS+ for THC only today). Seen by the behavioral health consultant at first MAT visit – BH established working diagnoses of MDD Recurrent Moderate, GAD, OUD Severe, Amphetamine UD Severe, and Alcohol UD Severe. History of accidental overdose 4 months ago. He mentions years ago someone mentioned he may have bipolar disorder but he doesn't know if that's accurate. States at intake "I don't want to live like this anymore so I was doing every drug I could get my hands on." He recently moved from FL to TN stating his cousin lives here. He is adamantly opposed to inpatient treatment options.

- What information might help guiding BH treatment options in this first phase of care?
- What might the top priorities be in his BH visit today?
- Are there any interventions you might offer that could help with both SUD and mood stabilization?
- How soon would your team see him for follow up?

Case #2 (Continued!)

One year later this 41 yo male remains in MAT and BH care. He struggled with continued daily alcohol use and occasional meth use while taking buprenorphine – nearly 1 year into care he decided to go to inpatient treatment to withdrawal from alcohol and buprenorphine and initiate vivitrol. He has dramatically reduced use of meth and alcohol, no recent use of opioids. He is working in a warehouse setting where he has strong support from coworkers some of whom are in recovery. Housing has been unstable. He describes feeling lonely, emotionally 'raw', and is not enjoying recovery. No recent SI.

- How might the services and structure of care look differently for this patient in this stage of care?
- Are there interventions you find most useful to address mood given improvement in stabilization that you might not have used in the stabilization phase?

Questions –
Other Common Challenges?

Poll

1. On a scale of 1-5, please select the number that best represents your experience with today's session.

5 – Excellent
4 – Very Good
3 - Good
2 - Fair
1 – Poor

2. Please select the number that best represents your response to the statement: Today's session was a valuable use of my time.

5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree

3. I can apply learnings from today's webinar to my MAT work.

5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree


THE
END