VIRGINIA MEDICAID: 37—
MEDICAL PROBLEMS VS. MENTAL
HEALTH ISSUES VS. SUD
PAUL BRASLER, LCSW, CAIP

JUNE 21 & 23, 2022

Department of Medical Assistance Services
WELCOME & MEETING INFORMATION

- WebEx participants are muted
- Please use the Q & A feature or the Chat feature if you have a question

- The focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

- We do not offer CEUs for this webinar series
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The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
    - [https://thecaf.acemInb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemInb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
    - Available only to Virginia residents, intramuscular administration
SUPPORT ACT GRANT WEBSITE

HTTPS://WWW.DMAS.VIRGINIA.GOV/#/ARTSSUPPORT
HAMILTON RELAY TRANSCRIPTOR (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven’t already, before the start of today’s webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. https://redcap.vcu.edu/surveys/?s=C8HERT9N3P

• Your name and contact information will not be linked to your survey responses.
• Your decision to complete the survey is completely voluntary.
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• Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Medical vs. Mental Health Issues in Clients with OUD [NEW]
  - Tuesday, June 21, 2022: 10 – 11 AM & Thursday, June 23, 2022: 1 – 2 PM

SUD Treatment for Adolescents
  - Tuesday, July 12, 2022: 10 – 11 AM & Thursday, July 14, 2022: 1 – 2 PM

From Burnout to Resiliency [NEW]
  - Tuesday, July 26, 2022: 10 – 11 AM & Thursday, July 28, 2022: 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Paul also works in a ketamine-infusion practice where he provides psychedelic-assisted psychotherapy. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. He has also worked in community mental health, emergency departments, and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
WHAT IS GOING ON? MARY'S STORY
“WHAT WILL KILL THE PATIENT FIRST?”

RULE OUT ORGANICITY
Signs and symptoms are often used interchangeably in clinical terminology; however, they have specific meanings:

- **Signs** can be detected by someone other than the patient (e.g., elevated heart rate or blood pressure)
- **Symptoms** are experienced and reported by the patient (e.g., depression, anxiety or pain)

**Distinguishing between medical and mental health problems, or specifically, ruling out a medical problem, requires medical testing and attention to the symptom profile—obtain a medical assessment**
MEDICAL ASSESSMENT

- **Vital signs:**
  - Body temperature
  - Blood oxygen level
  - Heart rate
  - Respirations
  - Blood pressure

- **Blood work:**
  - Complete blood count
  - Blood chemistry
  - Metabolic panel
  - Blood alcohol level
  - Therapeutic medication blood levels

- **Urine Testing:**
  - Urinalysis
  - Urine drug screen

- **Pregnancy Test**

- **Electrocardiogram (EKG/ECG)**

- **Medical imaging:**
  - X-ray
  - C-T scans
  - And occasionally an MRI

- **Physical exam by a medical provider**
Many medical illnesses/problems can present with symptoms identical to psychiatric problems, including:

- Brain bleeds/Stroke
- Blood sugar levels too high or too low
- Medication reactions/Allergies
- Thyroid activity levels too high or too low
- Traumatic Brain Injury
- Hypoxia
- Environmental poisonings
- Chronic illnesses (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, H.I.V./A.I.D.S.)

AND...
CASE STUDY: STEPHEN

Stephen was a 56-year-old male who was brought to the hospital after he started a fire that consumed half of his home. He admitted to starting the fire and then calling his family doctor who called the fire department. The doctor told the emergency department physician that he thinks Stephen is psychotic.

No one was injured in the fire. Stephen calmly states that he started the fire because he was trying to get rid of the seven zombies who had been bothering him for the past five days. Stephen does not have a psychiatric history. His urine drug screen was negative for illicit chemicals. He denies any attempt to harm himself or others (with the exception of the zombies).
Neuroleptic Malignant Syndrome (NMS) is a rare, but potentially fatal, medical reaction that is often caused by too high a level of antipsychotic medications (neuroleptics).

Symptoms include: Muscular rigidity, involuntary muscular movements, hyperpyrexia (high body temperature), autonomic instability, delirium, pulmonary/renal failure, stupor/coma, and seizures.
Akathisia is a sense of inner restlessness.

Symptoms include an inability to relax or stay still.

Patients will often rock back and forth while sitting, and pace while standing.

Associated with a wide variety of drugs, and usually resolves once the level of the drug is lowered.
TARDIVE DYSKINESIA

- Involuntary **Athetoid** (uncontrolled rhythmic movements, usually of the fingers, hands, head or tongue) or **Choreiform** (rapid, jerky) movements, developed in association with the use of a **Neuroleptic** (antipsychotic) medication for a lengthy time

- Usually has a delayed effect (rarely occurs within the first six months of treatment) but may not take as long to develop in the elderly

- Movements may continue after a change or reduction in the dosage; often disappears in sleep

- **Withdrawal Dyskinesia** is time-limited, and what persists beyond this is called tardive dyskinesia
A rare, but very serious, skin and mucous membrane disorder that can sometimes be caused by certain medications, including Lamictal® (Lamotrigine)

Typically starts with upper respiratory infections, headache, fever, and GI problems

Can then progress to a rash which could indicate that the outer layer of skin (epidermis) is separating from the inner layer of skin (dermis)
SEROTONIN SYNDROME

- Caused by too much serotonin
- Symptoms include—Diarrhea, restlessness, elevated body temperature, tremors, cognitive changes, rigidity, delirium, and autonomic nervous system instability
- Mortality rate is 10% to 15% among untreated patients
- Can occur through the regular use of SSRIs and SNRIs in some individuals and in cases of overdosing on these medications
- Any medication, not just SSRIs and SNRIs, can cause Serotonin Syndrome
- Can also occur with substances of abuse
Abrupt cessation, or major decrease in dosage, from an antidepressant medication that has been taken for at least one month.

Symptoms include—Flashes of lights, a sensation of electric shock, nausea and hypersensitivity to noises or lights, anxiety or feelings of dread.

To qualify for this diagnosis, the symptoms must never have been present prior to the start of the antidepressant medication.
ANTICHOLINERGIC DRUGS

- Used to address medication-induced movement disorders, which are some of the most significant Extra Pyramidal Symptoms (EPS) of Anti-psychotic drugs

- Neuroleptic-induced Parkinsonism is more common in the elderly and in people being treated with high doses of potent neuroleptics

- Also used to treat **Neuroleptic dystonia** (involuntary muscle contractions), and akathisia

- Cogentin® (Benzotropine) is the most common anticholinergic drug used for this:
  - **Anticholinergics can be abused for their mood elevating and sedating properties**
ANTICHOLINERGICS

- Also includes antihistamines, tricyclic medications, and medications to prevent incontinence

- Intoxication symptoms:
  - “Red as a beet” (face is flushed)
  - “Dry as a bone” (dry skin and mucous membranes)
  - “Hot as a hare” (febrile)
  - “Mad as a hatter” (delirium and hallucinations)
  - “Full as a flask” (cannot void)
  - “Can’t spit” (dry)
  - “Can’t S&%t” (constipated)
CORTICOSTEROIDS

- Even normal doses of Decadron® and Prednisone® can cause a severe reaction in some individuals
- The reactions mimic a manic or hypomanic episode
Cognitive disorders which include disruption of one or more of the following:

- Memory
- Language
- Orientation (person, place, time, situation)
- Judgment
- Conducting interpersonal relationships
- Performing actions
- Problem solving
Delirium, or suspected delirium, is a medical emergency—send them to the Emergency Department.

- **Outcomes** are the following:
  1. The patient improves
  2. The patient suffers brain damage
  3. The patient dies
CAUSES OF DELIRIUM

- A general medical problem (e.g., a disease or infection)
- Postoperative delirium
- Seizures
- Substance intoxication (e.g., stimulants or entactogens)
- Substance withdrawal syndrome
- Head trauma
- Pain
- Shock
- Hypoxia
- Emotional stress
- Medication reactions (e.g., too many medications with anticholinergic reactions)
- Sleep deprivation
Delirium: Diagnostic Features

- Disturbance in attention or awareness plus a change in baseline cognition is a key symptom
- **Short development time**
- Often gets worse at the end of the day: “sundowners”
- **Disorientation** (time and place in particular)
- Misinterpretations, delusions and hallucinations (often visual) are common
- Disturbance in sleep-wake cycle
- Emotional disturbance
“Stimulant toxicity resulting in excited delirium syndrome has been described with MDMA, cocaine, amphetamine, cathinones and cannabimimetics” (Rose, 2016, 29)

Delirium, rhabdomyolysis (muscle tissue breakdown which releases a protein into the bloodstream which can damage kidneys), agitated or violent behaviors along with hyperthermia

Like other forms of delirium, this is a medical emergency, requiring immediate care
# Delirium vs. Dementia

<table>
<thead>
<tr>
<th>Feature</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Fast</td>
<td>Slow</td>
</tr>
<tr>
<td>Duration</td>
<td>Hours to days</td>
<td>Years</td>
</tr>
<tr>
<td>Reversible?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hallucinations?</td>
<td>Often</td>
<td>No</td>
</tr>
<tr>
<td>Memory</td>
<td>Globally impaired</td>
<td>Impaired recently, gradually expanding to include long-term memories</td>
</tr>
<tr>
<td>Speech</td>
<td>Incoherent</td>
<td>Problems remembering words, gradually gets worse</td>
</tr>
</tbody>
</table>
Detectible through a urinalysis measuring bacterial levels and blood-work revealing elevated white blood cell counts. Physically, the person often reports a sensation of burning when urinating. In the elderly, a UTI can cause behaviors that are often mis-diagnosed as psychotic disorders. These symptoms often rapidly flare up and occur in people without any previous history of psychosis. Once the UTI is treated, the symptoms will often remit.
MEDICAL VS. MENTAL HEALTH: HALLUCINATIONS

MEDICAL
- Delirium
- Substance intoxication or withdrawal syndromes
- Medication reactions
- UTI
- Hypoxia
- Neurological disease or injury

MENTAL HEALTH
- Schizophrenia and other psychotic disorders
- Severe mood disorders (Bipolar I Disorder and Major Depressive Disorder)
- Severe Borderline Personality Disorder
- Severe Posttraumatic Stress Disorder
# MEDICAL VS. MENTAL HEALTH: DISORIENTATION

## MEDICAL
- Delirium
- Hypoxia
- Postictal
- Traumatic brain injury
- Stroke
- Substance intoxication syndrome
- Medication reactions

## MENTAL HEALTH
- Schizophrenia and other psychotic disorders
- Dissociative disorders, including severe Posttraumatic Stress Disorder
- Dementia
MEDICAL

- Thyroid imbalance
- Blood-sugar issues
- Substance intoxication or withdrawal syndromes
- Medication reactions
- Multiple sclerosis and other chronic illnesses
- Chronic pain

MENTAL HEALTH

- Depressive disorders, including Persistent depressive disorder
- Psychotic disorders, including schizophrenia
- Bipolar disorders
- Adjustment disorders
- Bereavement, grief and loss
- Posttraumatic Stress Disorder
MEDICAL VS. MENTAL HEALTH: MANIA/HYPOMANIA

MEDICAL

- Stimulant intoxication syndrome
- Cannabinimimetic reactions
- Corticosteroid reactions
- Inappropriate dosages of medications

MENTAL HEALTH

- Bipolar Disorders
- Major Depressive Disorder (short “flares” of mania can occur)
- Borderline Personality Disorder
- Some anxiety symptoms can mimic mania
MEDICAL

▪ Medication reactions
▪ Asthma and other respiratory syndromes
▪ Substance intoxication or withdrawal syndromes

MENTAL HEALTH

▪ Anxiety disorders, including Panic Attacks
▪ Posttraumatic Stress Disorder and related disorders
▪ Adjustment disorders
▪ Obsessive-Compulsive Disorder and related disorders
▪ Depressive Disorders
▪ Personality Disorders
DIFFERENTIATING SUBSTANCE-INDUCED MENTAL DISORDERS & NON-SUBSTANCE RELATED DISORDERS
- Over half the people (a low estimate in my opinion) with a serious mental illness also have a serious substance use problem

- **Co-occurring disorders** (which used to be called Dual Diagnosis) are defined as the existence of at least one independent major mental disorder and one independent SUD

- Since most mental illnesses and SUD symptoms are identical, it is often difficult to determine if the symptoms are because of a mental illness or the effects of a drug
<table>
<thead>
<tr>
<th><strong>Substance-Induced</strong></th>
<th><strong>Non-Substance Related</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted use of a substance</td>
<td>▪ No evidence of recent substance use (UDS results are unreliable)</td>
</tr>
<tr>
<td>No history of mental illness symptoms</td>
<td>▪ Documented history of mental illness symptoms</td>
</tr>
<tr>
<td>Short duration of symptoms</td>
<td>▪ Long duration of symptoms</td>
</tr>
<tr>
<td>Manifestation of symptoms occur at any time</td>
<td>▪ Manifestation of symptoms started in late-adolescence/early adulthood</td>
</tr>
<tr>
<td>Variation in symptoms severity over several hours</td>
<td>▪ Little variation in symptoms over time</td>
</tr>
<tr>
<td>Cessation of symptoms when the substance is metabolized and excreted</td>
<td>▪ Symptoms continue without treatment</td>
</tr>
</tbody>
</table>
SUBSTANCE-INDUCED MENTAL DISORDERS

- Alcohol-induced Depressive Disorder:
  - Alcohol-Induced Anxiety Disorder
  - Alcohol-Induced Bipolar Disorder
  - Alcohol-Induced Psychotic Disorder
  - Alcohol-Induced Neurocognitive Disorder (Dementia)
  - Alcohol-Induced Delirium
  - Alcohol-Induced Sleep Disorder
  - Alcohol-Induced Sexual Dysfunction

- Cannabis-Induced...

- Opioid-Induced...

- Stimulant-Induced...

- Hallucinogenic-Induced...

- Inhalant-Induced...
“Individuals should be engaged in treatment that addresses their co-occurring psychiatric symptoms, even if the origin of the co-occurring mental disorder is unclear”

(SAMHSA, 2020, p. 126)
Here is the link to the Post-Webinar Survey. It should take you less than 5 minutes to complete:

https://redcap.vcu.edu/surveys/?s=W4P4ANWYK7

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REFERENCES


