Managing Common Psychiatric Conditions in Patients with Substance Use Disorders

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John A. Renner, Jr., M.D. has no financial relationships to disclose.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
Target Audience

- The overarching goal of PCSS is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
Educational Objectives

• At the conclusion of this activity participants should be able to:
  ▪ Identify the most common psychiatric disorders seen in individuals with substance use disorders
  ▪ Discuss the impact of co-occurring psychiatric conditions on the course of substance use disorders
  ▪ Describe procedures for screening individuals with substance use disorders for common psychiatric disorders
  ▪ Explain the management of substance use disorders and co-occurring psychiatric disorders in the primary care setting
Outline

• **Case presentation**
• The epidemiology of alcohol/drug disorders and other common psychiatric disorders
• Screening for suicidal and homicidal risk
• Substance-induced vs. independent psychiatric disorders
• Screening for common psychiatric disorders
• Management of common co-occurring conditions:
  - Depression
  - Anxiety Disorders including PTSD
  - Bipolar Disorder
  - ADHD
• Treatment recommendations and the importance of integrated care
Case: Anna is a 25 yo Army veteran who overdosed on heroin

- Anna returned from Iraq 20 months ago.
- Her boyfriend brought her to the emergency room after she overdosed on heroin. She was breathing but unconscious.

- How should she be managed?
- What are your questions?
Case: Anna 25 yo Veteran

- Anna was successfully revived after multiple doses of naloxone (narcan). History reveals opioid treatment for combat injuries. She now snorts heroin on a daily basis; her boyfriend thinks she may have gotten some heroin laced with fentanyl.

- How likely is this a suicide attempt? Or an accident?
- What diagnoses should be considered?
- What is your initial treatment plan?
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   Depression
   Anxiety Disorders including PTSD
   Bipolar Disorder
   ADHD
• Treatment recommendations and the importance of integrated care
Risk of Completed Suicide Higher Among Patients with Substance Use Disorder

- Heavy alcohol use: 4x
- Alcohol use disorder: 10x
- Opioid use disorder: 14x

Harris and Barraclough 1997; Wilcox 2004
Prescription Opioid Deaths and Suicide

- Sixty-five percent of 184,136 calls to Poison Control Centers (2006-2013) for any prescription opioid misuse documented suicide intent
  - 75% of prescription opioid deaths were suicide
  - 86% of prescription opioid deaths age 60+ were suicides
Case: Anna 25 yo Veteran

Treatment issues:

• Suicide assessment
• Motivation for treatment
• Prior substance use history; medical history, psychiatric history
• Pain – requirements for ongoing care?
• Depression?
• PTSD?
**Odds Ratios for Alcohol Use Disorders and other Psychiatric Disorders**

<table>
<thead>
<tr>
<th>DSM-IV DISORDER</th>
<th>12 MONTH O.R.</th>
<th>LIFETIME O.R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Use Disorder</td>
<td>9.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>6.4</td>
<td>7.5</td>
</tr>
<tr>
<td>Drug Dependence</td>
<td>15.0</td>
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</tr>
<tr>
<td>Nicotine Dependence</td>
<td>3.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Any Mood Disorder</td>
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<td>2.4</td>
</tr>
<tr>
<td>Bipolar I</td>
<td>2.7</td>
<td>3.5</td>
</tr>
<tr>
<td>Bipolar II</td>
<td>2.1</td>
<td>2.6</td>
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<tr>
<td>Any Anxiety Disorder</td>
<td>1.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Panic with Agoraphobia</td>
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<td>2.5</td>
</tr>
<tr>
<td>Panic without Agoraphobia</td>
<td>2.1</td>
<td>2.3</td>
</tr>
<tr>
<td>GAD</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>2.9</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Disorders. D.S. Hasin, 2007
## Odds Ratios for Drug Use Disorders and other Psychiatric Disorders

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<thead>
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<td>Alcohol Abuse</td>
<td>2.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>9.7</td>
<td>7.6</td>
</tr>
<tr>
<td>Nicotine Dependence</td>
<td>5.8</td>
<td>5.5</td>
</tr>
<tr>
<td>Any Mood Disorder</td>
<td>3.5</td>
<td>3.2</td>
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<tr>
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</tbody>
</table>
Lifetime Prevalence in Bipolar I Patients

- Any alcohol use disorder: 58.0%
- Any drug use disorder: 37.5%
- Nicotine use disorder: 44.4%

No differences noted between men and women

NESARC / NIAAA 2001-2002; B. Grant, 2005
The most common co-occurring psychiatric disorders in substance use disorder patients

- Alcohol use disorder or another drug disorder
- Nicotine use disorder
- Bipolar I disorder
- Mood disorders
- Panic with agoraphobia
- Antisocial personality disorder
What about PTSD and SUD?

- 34% of PTSD co-occurs with SUD
- 5-12 x more PTSD in women who misuse drugs
- Suicide attempts in 20% of patients with PTSD; risk is double in PTSD + SUD
- US Iraq veterans – 50% binge alcohol & tobacco use
Outline

- Case presentation
- The epidemiology of alcohol/drug disorders and other common psychiatric disorders
- **Screening for suicidal and homicidal risk**
- Substance-induced vs. independent psychiatric disorders
- Screening for common psychiatric disorders
- Management of common co-occurring conditions:
  - Depression
  - Anxiety Disorders including PTSD
  - Bipolar Disorder
  - ADHD
- Treatment recommendations and the importance of integrated care
Principles of Assessment: Initial Screening

• SCREEN FOR SUICIDALITY
  ▪ Current suicidal ideation and specific plan
  ▪ Previous suicide attempts or plans
  ▪ Access to weapons or other means
  ▪ Family history

• SCREEN FOR HOMICIDALITY
  ▪ Identified victim and specific plan/intent
  ▪ History of violence
  ▪ Access to weapons or other means

• OBTAIN IMMEDIATE ASSISTANCE IF SCREENS ARE POSITIVE

• DO NOT LEAVE PATIENTS ALONE WHO ARE AT RISK
Principles of Assessment: Caring for Intoxicated Patients

- Screen for suicidality and homicidality
- Inquire about interest in inpatient medication withdrawal treatment
- Review vital signs / attend to acute medical needs and hospitalize if required
- **DO NOT CONTINUE A PROBING PSYCHIATRIC EVALUATION OF ANY INTOXICATED PATIENT, EVEN IF ONLY MILDLY INTOXICATED**
  - Reschedule for an appointment when sober
  - Explain need for sobriety for a psychiatric assessment
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  - ADHD
• Treatment recommendations and the importance of integrated care
Establish the Diagnosis of an Independent Psychiatric Disorder

- Do not attempt to confirm the psychiatric diagnosis while patient is intoxicated or within 3-4 weeks of substance use or withdrawal management
- Verify drug-free state with laboratory tests and assess psychiatric status when sober
- Obtain a careful longitudinal history tracking both substance use and psychiatric symptoms – track parallel symptom courses
- Confirm history with relatives
- Review family history for psychiatric disorders
Clarify the Diagnosis: Substance-Induced Psychiatric Disorder

- Occur during or within **30 DAYS** of intoxication or withdrawal
- Symptoms are associated with substance use
- Can mimic:
  - PSYCHOTIC DISORDERS
  - MOOD DISORDERS
  - ANXIETY DISORDERS
  - PERSONALITY DISORDERS
Case: Anna 25 yo Veteran

Initial Diagnoses:
• Opioid Use Disorder

• Posttraumatic Stress Disorder
  ▪ Independent or Substance-Induced?
  ▪ Combat related; single incident or complex?

• Major Depressive Disorder
  ▪ Independent or Substance-Induced?
  ▪ Need to reassess after sobriety
Substance-induced Psychiatric Disorders

- Substance intoxication and withdrawal can mimic almost any psychiatric disorder
  - Stimulants / cannabinoids / hallucinogens: can mimic mania and schizophrenia
  - Alcohol / opioid / sedative-hypnotic withdrawal: can mimic depression and anxiety disorders
Clarify the Diagnosis: Independent Psychiatric Disorder

- Symptoms may antedate drug use
- Symptoms don’t diminish post withdrawal
- Symptoms continue during extended periods of sobriety: > 3 months
- Positive family history
Case: Anna 25 yo Veteran

Follow-up Interview reveals:

- No suicidal ideation
- Sad, increased social isolation for the last 3 months
- Does not want to leave her apartment unless she takes extra opioids
- Insomnia, frequent nightmares
- Jumpy; panic with loud noises
- Diagnosis?
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Screening for Depressive Disorders

- Comorbid depressive symptoms are common among substance users
- **PHQ-9** is a free, widely-used screening test, may be completed by patient in the waiting room
- PHQ-9 scores **under 10** → 99% negative predictive value
- PHQ-9 scores **≥10** should prompt further evaluation, but NOT diagnosis

Screening for Anxiety Disorders

- Comorbid anxiety symptoms are common among substance users
- **GAD-7** is a free, widely-used method for *screening* and *following* anxiety symptom severity over time
- GAD-7 score ≥10 suggests moderate-severe anxiety
- **DSM 5** criteria still used for *diagnosis*

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**GAD-7**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Use “✓” to indicate your answer)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*(For office coding: Total Score T___ = ___ + ___ + ___)*

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Screening for Panic Disorder

Additive behaviors may precipitate a panic attack:
• Caffeine, cocaine, amphetamines ingestion
• Alcohol, opiate & sedative withdrawal

May lead to Panic disorder:
• Can’t stop worrying about having another panic attack AND/OR
• Maladaptive behaviors relating to panic attack (e.g. avoidance)
Screening for Obsessive Compulsive Disorders

- **Obsessions** are persistent/repetitive:
  - Thoughts
  - Images
  - Urges (e.g. to wash hands)
- **Compulsions** are repetitive:
  - Behaviors (e.g. washing hands)
  - Mental acts / rituals
- For DSM 5 OCD diagnosis, symptoms must be *either*:
  - Impairing /distressing
  - Time consuming (e.g. >1 hr daily)

Yale-Brown Obsessive Compulsive Scale (**Y-BOCS**) is the standard screening tool for OCD, but may be complicated and time-consuming to use.

Clinical Implications

• SUBSTANCE-INDUCED PSYCHIATRIC DISORDERS
  ▪ Symptoms will clear with sobriety but may require initial hospitalization or psychiatric treatment
  ▪ Additional psychiatric treatment is not required, treatment should be focused on the SUD

• INDEPENDENT PSYCHIATRIC DISORDERS
  ▪ Requires specific psychiatric treatment
  ▪ Should be integrated with the SUD treatment
  ▪ Both SUD and symptoms of the co-occurring disorder will be more severe, there are higher levels of disability and treatment is more complicated
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  ▪ Anxiety Disorders including PTSD
  ▪ Bipolar Disorder
  ▪ ADHD
• Treatment recommendations and the importance of integrated care
General Principles: Managing SUDs and Co-Occurring Disorders

- **Evaluate** when sober
- **Integrate** psychiatric and SUD treatment
- **Sobriety** is the first priority
- **MAT** where appropriate
- **Psychopharmacology** when indicated
  - Avoid habit-forming medications if possible
- **Psychotherapy interventions** if applicable
- Specialized **AA/NA groups**
Managing Co-Occurring Depressive Disorders

First confirm the diagnosis:

- Wait 2 to 3 weeks for withdrawal symptoms to clear
- Positive family history
- +/- Symptoms antedate drug or alcohol use
- Monitor patient for suicidal ideation, changes in mood, affect, appetite or sleep pattern

Consider pharmacotherapy if the patient refuses or has not responded to psychotherapy alone
Initial Stabilization

• Medication withdrawal treatment may be required for alcohol use disorder or benzodiazepine use disorder

• For opioid use disorder: initial stabilization on methadone or buprenorphine; if starting XR- naltrexone, medication withdrawal treatment may be required first

• No other treatment may be possible until the patient is stable
Case: Anna 25 yo Veteran

- After initial stabilization on buprenorphine/naloxone, her depressive symptoms began to clear. This suggests that her depression was substance-induced.

- Her clinician decided to focus treatment on her opioid use disorder and combat-related PTSD.

- Anna agrees to participate in an intensive outpatient “Dual Diagnosis” program for women veterans.
Managing Co-Occurring Disorders

TREATMENT # 1: PSYCHOTHERAPY:

• Once stable, consider psychotherapy options first for patients with a substance use disorder and less severe depressions or anxiety disorders:
  ▪ CBT
  ▪ The “Seeking Safety” Protocol
What is the role of Cognitive-Behavioral Therapy?

- CBT is well established as an effective evidence-based therapy for substance use disorders, depression, anxiety, PTSD and chronic pain.
- CBT typically includes skill acquisition:
  - Relaxation therapy
  - Cognitive restructuring
  - Effective communication
  - Stress management
- This is followed by skill consolidation and rehearsal:
  - Training to generalize new skills
  - Maintenance of behavioral change
  - Strategies to avoid relapse
CBT / Relapse Prevention
The “Seeking Safety” Protocol

- Manualized Group Therapy
- 25 sessions
- Integrated PTSD and Subst. Abuse Treatment
- Focuses on “Safety”
  - No Acting Out
  - No Substance Use
- Combines Cognitive Behavioral approaches to both disorders
- Useful for a variety of Dual Diagnosis Patients
Managing Co-Occurring Disorders

• **TREATMENT # 2: PHARMACOTHERAPY:**
  - May be the initial option for most patients; generally medications should not be started until the patient is sober

• **Standard pharmacotherapy for psychiatric disorders**
  - Most options will work, **but**
  - Avoid habit-forming medications
  - Caution with benzodiazepines and gabapentin

• Add medications if symptoms fail to respond to psychotherapy alone
How to Manage the Pharmacotherapy of Psychiatric Disorders in SUD Patients

- Begin with non-dependence producing medications - the selective serotonin reuptake inhibitors (SSRI’s) are a good choice to treat BOTH depression and anxiety
- Adequate doses for an adequate time (6 to 8 weeks)
- If no response consider serotonin-norepinephrine reuptake inhibitors (SNRI’s), or dual action agents
- CBT will improve the response to medications
- Benzodiazepines have no role as a primary treatment for depression, anxiety or PTSD in patients with a substance use disorder
- Benzodiazepines can be used with caution for some anxiety disorders if the patient has not responded to CBT and/or antidepressant medications and has no history of misuse of benzodiazepines
# Antidepressants in the Treatment of Co-Occurring Depression & Alcohol Dependence

<table>
<thead>
<tr>
<th>Double-Blind Studies</th>
<th>Medication</th>
<th>Depression Med vs. Placebo</th>
<th>Drinking Med vs. Placebo</th>
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<tbody>
<tr>
<td>Mason '96</td>
<td>Desipramine</td>
<td>M &gt; P</td>
<td>M &gt; P</td>
</tr>
<tr>
<td>McGrath '96</td>
<td>Imipramine</td>
<td>M &gt; P</td>
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<td>Cornelius '97</td>
<td>Fluoxetine</td>
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<td>M &gt; P</td>
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<td>Roy '98</td>
<td>Sertraline</td>
<td>M &gt; P</td>
<td>M = P</td>
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<tr>
<td>Roy-Byrne '20</td>
<td>Nefazodone</td>
<td>M &gt; P</td>
<td>M = P</td>
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<tr>
<td>Pettinati '01</td>
<td>Sertraline</td>
<td>M = P</td>
<td>M = P</td>
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<tr>
<td>Moak '03</td>
<td>Sertraline</td>
<td>M &gt; P</td>
<td>M = P</td>
</tr>
<tr>
<td>Hernandez '04</td>
<td>Nefazodone</td>
<td>M = P</td>
<td>M &gt; P</td>
</tr>
</tbody>
</table>
Managing Co-Occurring Depressive Disorders

• Most standard pharmacotherapies for depression are effective in patients with substance use disorders

• The majority of well done trials are for SSRIs in individuals with Alcohol Use Disorder
  ▪ Relatively few trials on opioid or stimulant use disorder
  ▪ Few trials with other classes of antidepressants
  ▪ Most trials show improvement in depression; results on SUD symptoms are mixed

• SSRI’s are considered the first line medications

Nunes & Levin, JAMA, 2004
## Comparing Antidepressants

<table>
<thead>
<tr>
<th></th>
<th>Nefazodone</th>
<th>Fluoxetine</th>
<th>Sertraline</th>
<th>Paroxetine</th>
<th>Citalopram</th>
<th>Venlafaxine</th>
<th>Bupropion</th>
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<tbody>
<tr>
<td><strong>Efficacy</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>Sleep</strong></td>
<td>Helps</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Anxiety</strong></td>
<td>Helps</td>
<td>Helps for GAD</td>
<td>Helps for GAD</td>
<td>Helps</td>
<td></td>
<td></td>
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<tr>
<td><strong>Sexual Dysfct</strong></td>
<td>Min. 58%</td>
<td>61%</td>
<td>68%</td>
<td>41%-70%</td>
<td>%69</td>
<td>Min</td>
<td></td>
</tr>
<tr>
<td><strong>Weight Gain</strong></td>
<td>None</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
</tr>
</tbody>
</table>
New Strategy: Combining SSRI and Naltrexone for Alcohol Use Disorder

- Double-blind placebo controlled trial in 170 depressed patients with AUD:
  - **Sertraline** up to 200mg/day + **Naltrexone** up to 100mg/day
  - All patient received CBT
  - Patients receiving combination achieved more abstinence and had lower likelihood of being depressed compared to those receiving placebo or either drug alone
  - Study needs to be replicated (Pettinatı, 2010)
Managing Co-Occurring Anxiety Disorders

- First confirm the diagnosis:
  - Wait 4 to 6 weeks for withdrawal symptoms to clear (or for the patient to stabilize on MAT)

- Positive family history

- +/- Symptoms antedate alcohol/drug use

- Begin treatment with behavioral therapies
  - If no response after 2-3 weeks, add pharmacotherapy
What are the Evidence-Based Pharmacotherapy for Anxiety Disorders?

- A systematic review of randomized controlled trials, including the Cochran Database, reported on data from trials demonstrating a ≥50% reduction from baseline score on the Hamilton anxiety scale in generalized anxiety disorder:
  - Fluoxetine was ranked first for response and remission
  - Sertraline was ranked first for tolerability

- In a subanalysis for generalized anxiety disorder meds licensed in the UK:
  - Duloxetine was ranked first for response
  - Escitalopram was ranked first for remission
  - Pregabalin was ranked first for tolerability

Evidenced-Based Treatment of Co-Occurring Anxiety and SUD

- There is little research on this topic
- Comprehensive review of studies by McHugh (2015) showed:
  - CBT for SUD generally effective but may be hard to access
  - Medication treatment had some benefits on anxiety but not on SUD
  - Buspirone reduced anxiety and drinking (1 trial). Less clear results in 2 other trials
  - Medication misuse was not seen with benzodiazepines
  - Naltrexone plus exposure therapy had better outcomes for PTSD
  - Integrated treatment for SUD and exposure therapy for anxiety had best outcomes
Managing Co-Occurring Anxiety Disorders

- **Pharmacotherapy recommendations:**
  - Generalized anxiety disorder: SSRIs, DULOXETINE (first line) BUSPIRONE
  - Panic disorder: ANTIDEPRESSANTS BEHAVIORAL THERAPY
  - Agoraphobia: ANTIDEPRESSANTS BEHAVIORAL THERAPY
  - Social phobia: PROPRANOLOL or CLONIDINE
  - OCD: SSRIs

  Benzodiazepines are only recommended if the patient has failed to respond to less dependence producing medications.
Managing Co-Occurring Anxiety Disorders
The Role of Benzodiazepines

- Meta-Analysis including Cochrane Library review showed no advantage for antidepressants over benzodiazepines (BDZ) in treating a range of anxiety disorders.
- Comprehensive literature review demonstrated efficacy for BDZ for GAD, panic disorder and agoraphobia, and probable efficacy for social phobia & alcohol induced anxiety disorders in patients with a history of SUDs, and little evidence of added risk for BDZ misuse or increased relapse.
- Avoid use in individuals with a primary sedative-hypnotic use disorder. Deaths have also been reported with the combination of buprenorphine and BDZ, caution should be used when prescribing. Also see NEJM: Lembke 2/2/18.

Offidani. Psychother Psychosom.9/20/ 2013
Managing Co-Occurring Anxiety Disorders

- Treating Posttraumatic Stress Disorder:
  - SSRIs, Venlafaxine ER
  - Specialized psychotherapy:
    - CBT: Cognitive Behavioral Therapy
    - Exposure therapy: a type of CBT, teaches patient to gradually focus on traumatic memories, feelings or situations
    - CPT: Cognitive Processing Therapy
    - EMDR: Eye Movement Desensitization and Reprocessing
  - Prazosin for nightmares
  - Avoid benzodiazepines, marijuana
Bipolar Disorder and Alcohol Use Disorder

- Drinking typically follows onset of mania
- Mixed or dysphoric mania
- Rapid cycling
- Greater severity - suicidality
- Rarely relapse when depressed or euthymic
- Suboptimal response to lithium
- AUD may remit after mood is stabilized
Pharmacotherapy of Bipolar Disorder and Co-Occurring Substance Disorders

- Randomized – double-blind placebo controlled trials
  - 59 Alcohol Dependent Patients – Salloum, 2001
  - 139 Cocaine Dependent Patients – Brady, 2002

- Open Label, Non-Randomized – 6 studies
  - Used Valproate, Lithium, Lamotrigine, Aripiprazole, or Quetiapine
  - Abused drugs included alcohol, cocaine, opiates
  - Number of subjects ranged from 9 to 30
  - Five studies showed improvement in symptoms and drug use
  - One showed improved hypomania, but not in cocaine use

Valproate in Bipolar Alcohol Use Disorder

- Double-blind placebo controlled trial in 59 Bipolar individuals with alcohol use disorder:
  - Valproate + Treatment as usual (TAU) vs. Placebo + TAU
    - TAU = Lithium + psychosocial treatment
  - Results:
    - Valproate group had less heavy drinking days
    - Valproate group had fewer “any” drinking days
    - Both groups had fewer mood swings
Treating ADHD in at Risk Patients

- CBT X 2 weeks without medication
- Then start meds if symptoms persist – medication choices ranked by risk potential
  - Atomoxitine – has no misuse potential
  - Bupropion
  - Methylphenidate ER or amphetamine/dextroamphetamine mixed salts
Managing Insomnia in Patients with Substance Use Disorders

- Substance misuse alters the cycling between NREM and REM sleep
- Insomnia may be prolonged during periods of sobriety and may increase relapse
- Standard medications for insomnia have a high risk for misuse and may cause physiologic dependence
Managing Insomnia in Patients with Substance Use Disorders

- The following medications are not habit forming and have no known misuse potential:
  - Sedating antidepressants: Trazodone (most studied in patients with AUD) & Mirtazapine
  - Melatonin agonists: Melatonin, Ramelteon and Agomelatine
  - Sedating anticonvulsants: Gabapentin* and Topiramate
  - Prazosin (suppresses nightmares in PTSD)

* some patient may misuse gabapentin
Outline

- Case presentation
- The epidemiology of alcohol/drug disorders and other common psychiatric disorders
- Screening for suicidal and homicidal risk
- Substance-induced vs. independent psychiatric disorders
- Screening for common psychiatric disorders
- Management of common co-occurring conditions:
  - Depression
  - Anxiety Disorders including PTSD
  - Bipolar Disorder
  - ADHD
- Treatment recommendations and the importance of integrated care
General Principles: Managing SUDs and Co-Occurring Disorders

- **Evaluate** when sober
- **Integrate** psychiatric and SUD treatment
- **Sobriety** is the first priority
- **MAT** where appropriate
- **Psychopharmacology** when indicated
  - Avoid habit-forming medications if possible
- **Psychotherapy interventions** if applicable
- **Specialized AA/NA groups**
General Principles: Managing Pharmacotherapy for Co-Occurring Disorders

- Check State PDMP
- Standard pharmacotherapy for psychiatric disorders
  - First choose non-habit-forming drugs
  - Adequate doses for adequate times
- Caution with habit-forming medications
  - Start low
  - Go slow
  - Non-refillable prescriptions
  - Monitor carefully
Pharmacotherapy Recommendations for Psychiatric Disorders in Primary Care

- Depression – SSRIs; Venlafaxine, Duloxetine, Bupropion
- Generalized Anxiety Disorder – SSRIs; Duloxetine, Buspirone, Escitalopram
- Panic Disorder – SSRIs
- Social Anxiety – Paroxetine
- PTSD – SSRIs, Venlafaxine ER and Prazosin
- Bipolar Disorder – Valproate
References

- Baldwin D, Stein MB, Hermann R. Generalized anxiety disorder in adults: Epidemiology pathogenesis, clinical manifestations, course, assessment, and diagnosis “UpToDate” Current through July 2018; Last updated April 3, 2018
- Harris EC, Barrraclough B. Suicide as an outcome for mental disorders: a meta-analysis. British J Psychiatry 1997;170(3):205-228
References

• Roy-Byrne PP, Stein MB, Hermann R. Panic disorders in adults: epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis “UpToDate” Current through Jul 2018; last updated Jan 25, 2018
PCSS Mentor Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medication-assisted treatment.

- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.

- No cost.

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Ask a Colleague

A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now
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