

Opioid Review and MAT Clinic Anxiety and Mood Disorders *Augsburg*

2/19/2020

Objectives

- Describe primary care approaches to identifying patients with anxiety and/or mood disorders (anxiety, MDD, bipolar affective disorder)
- Describe a primary care approach and structure for treatment of anxiety/depression
- Outline common medication strategies for the management of acute and chronic anxiety disorder and MDD
- Describe follow up intervals and guidance for psychotherapy referral

Anxiety

- Post-traumatic stress
- Generalized anxiety disorder
- Panic disorders
- Social anxiety disorder
- Obsessive-compulsive

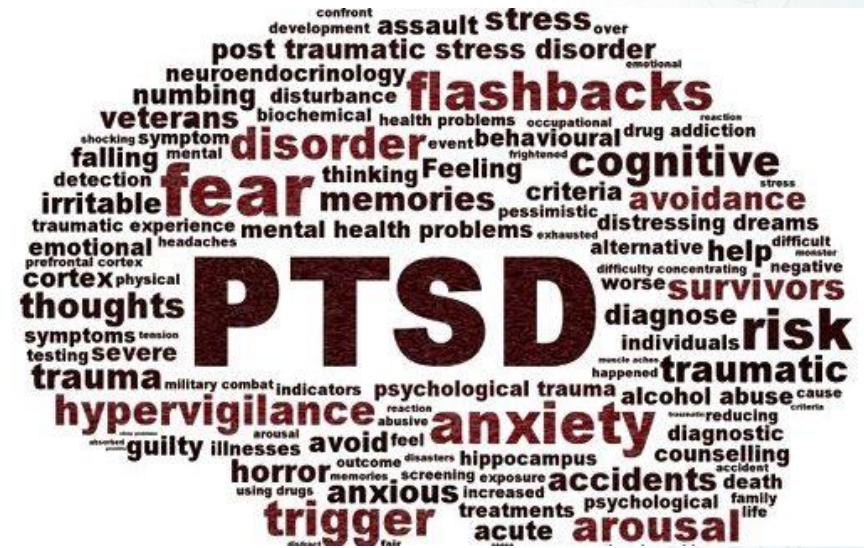
Anxiety All Types

- Lifetime prevalence approximately 1.6% general population
- Lifetime prevalence in patients with opioid use disorders: 3.2%



PTSD

- Characterized by:
 - Intrusive thoughts
 - Nightmares and flashbacks of traumatic events
 - Avoidance of reminders of trauma
 - Hypervigilance
 - Sleep disturbance
- All lead to considerable social, occupational and interpersonal dysfunction



Trauma resulting in PTSD

29 types of events have been characterized to provoke PTSD

WHAT CAUSES PTSD?

TOP 4 REASONS MEN AND WOMEN SUFFER PTSD:

1 Rape

2 Combat exposure

3 Childhood neglect

4 Childhood physical abuse



1 Rape

2 Sexual molestation

3 Physical attack

4 Being threatened with a weapon

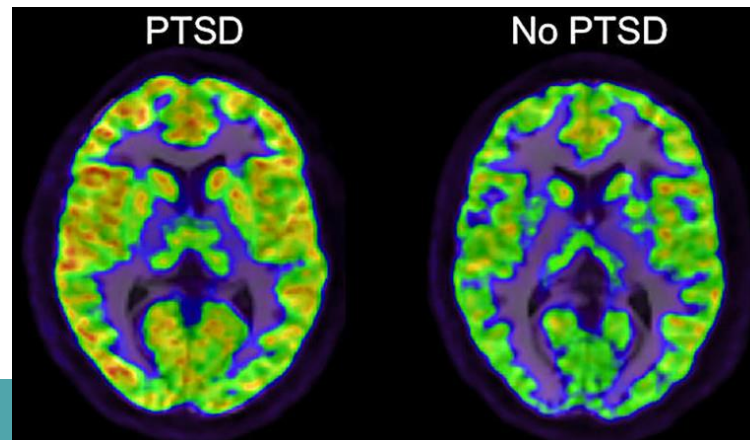




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PTSD

- Prevalence:
 - Lifetime US: 6.1-9.2%
 - Some groups are higher-> Native American population: 14-16%
- Pathophysiology
 - Unclear
 - Likely genetic susceptibility AND environmental interactions



PTSD

- Treatment:
 - Psychotherapy
 - EMDR
 - SSRIs and trauma focused therapy with exposure are the standard at this time
 - Benzodiazepines NOT indicated



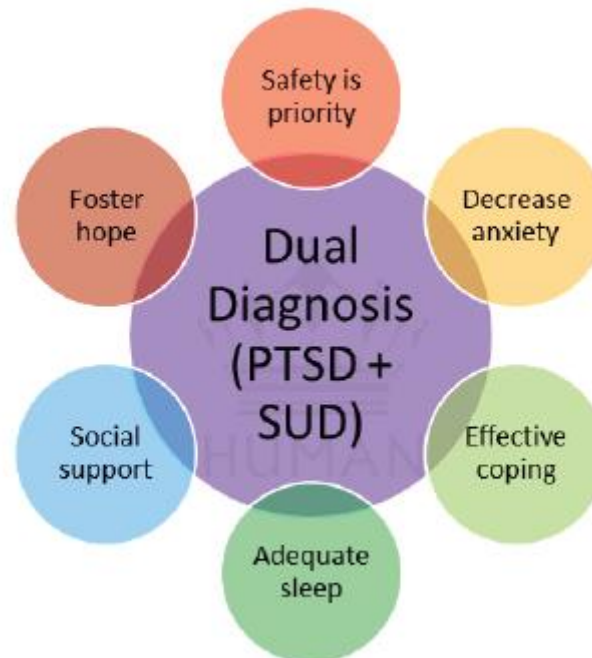
PTSD

- Men:
 - 2x's more likely to have an alcohol use disorder
 - 2.7x's more likely to have another SUD
- Women:
 - 2.5x's more likely to have an AUD
 - 4.5x's more likely to have another SUD

Kessler. Archives of General Psychology 1995, 1048-1060.

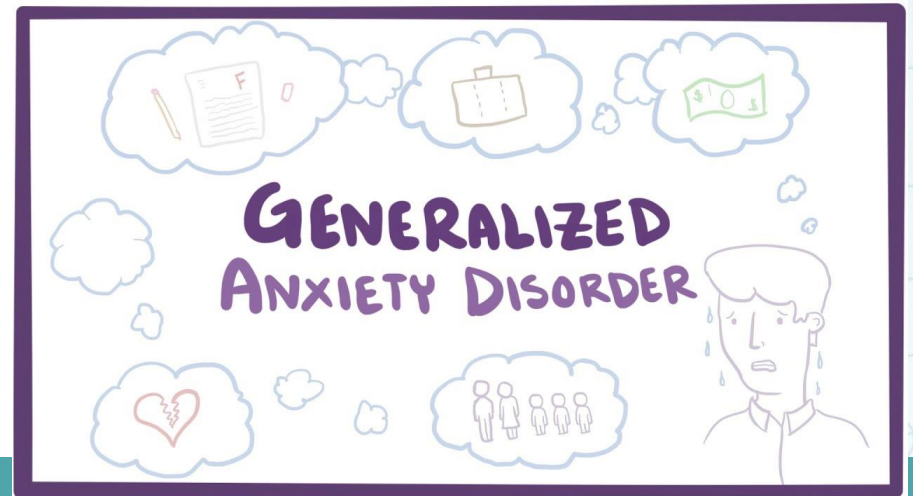
PTSD

- With co-occurring SUD:
 - 50% of patients presenting for treatment [of SUD] have PTSD (5x's the US prevalence rate of PTSD)
 - these patients have worse prognosis and more often relapse early



Generalized Anxiety Disorder

- Characterized by:
 - Persistent worrying
 - Significant distress/impairment
 - More days than not for 6 months
- Prevalence:
 - US lifetime: 5-12%
 - One of the most common mental disorders
 - 2X higher in women



GAD

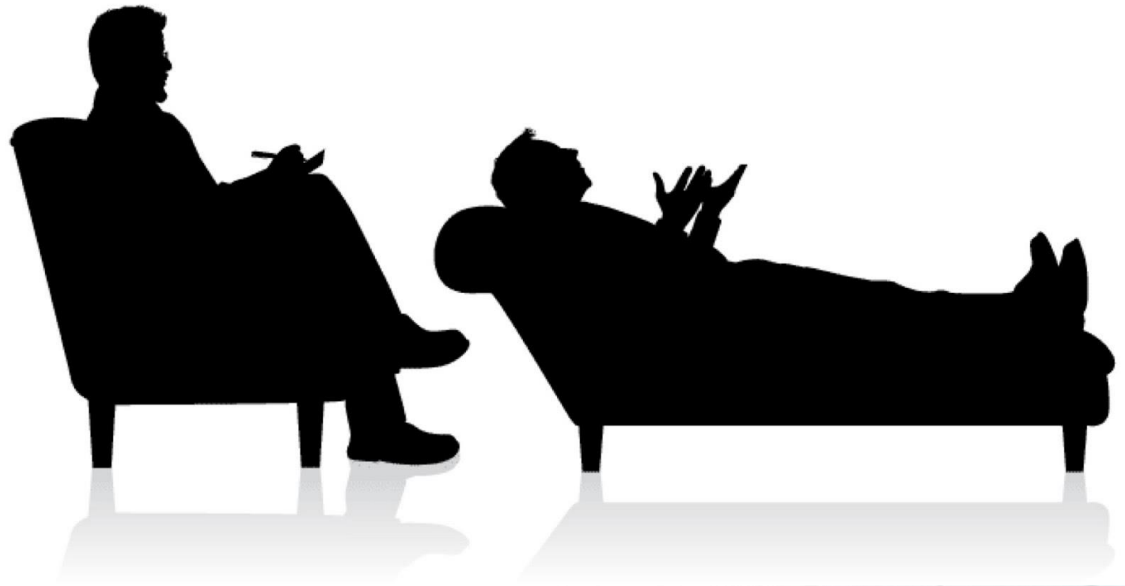
- Screening
 - GAD7

GAD-7				
Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer)</i>	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

(For office coding: Total Score T ___ = ___ + ___ + ___)

GAD

- Treatment:
 - SSRI/SNRI
 - Buspirone- similar efficacy to benzos
 - Benzos:
 - Acute
 - ? Long term



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GAD

- NESARC (National Epidemiological Survey on Alcohol and Related Conditions)
 - 50% of patients with GAD had a co-morbid SUD
 - In patients with GAD + SUD: 90% had AUD
- Other
 - Heavy smokers have 5x's greater risk of GAD
 - Marijuana: unclear association



Panic Disorders

- Prevalence:
 - Lifetime US= 2.7-4.7%
 - 2X more common in women
- Pathogenesis
 - Combination stress and underlying genetic predisposition
- Diagnosis
 - Recurrent panic attacks
 - Attacks followed by change in behavior related to attacks and persistent concern about more attacks
 - Not drug induced or from withdrawal
 - Not explained by other disorders

Panic

- Risk of PD in the presence of AUD is 2-4x's higher than without AUD
- Smoking in PD patients is higher than any other anxiety



ASAM Essentials of Addiction Medicine

SAD (Social Anxiety Disorder)

- Characterized by:
 - Excessive fears of scrutiny, embarrassment
 - Humiliation in performance situations
 - Leads to significant distress or impairment in function
- Epidemiology:
 - Lifetime prevalence 5-12%
- Pathogenesis
 - Heredity and environment implicated
 - Much like other anxiety disorders:
 - Neurohormonal and neurotransmitter systems have been focus of studies

SAD

- Diagnosis
 - Fear or anxiety associated with scrutiny
 - Fear of humiliation
 - Social situations almost always provoke fear
 - Avoidance
 - Not drug induced
- Treatment:
 - SSRIs, SNRIs, MAOs, Benzos (rare), Gabapentin
 - Treatment also depends on subtype
 - le: B blockers in performance type

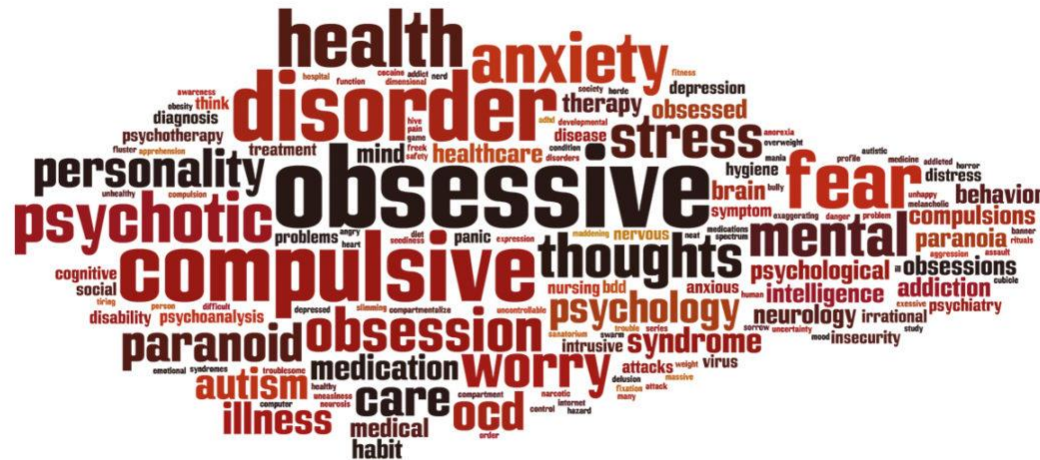
SAD

- Lifetime prevalence of SAD in patients with OUD is 3-39%
- Lifetime prevalence in SAD in AUD is >20% (NESARC)
- Prevalence of AUD in patients with SAD is 48% (ASAM)
- SAD precedes AUD 80% of the time (ASAM)



Obsessive/Compulsive

- Unlike other anxiety disorders there is mixed results as to whether OCD has a higher rate of co-occurrence of SUD than general population
- Has overlapping symptoms with SUDs (rituals)



Other Mood Disorders

- Depression
- Bipolar:
 - Bipolar 1:
 - Manic episodes
 - Usually hypomania/depressive episodes
 - Bipolar 2:
 - Hypomanic episode
 - Major depressive episode
 - Absence of manic episodes

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Depression (unipolar)

- Lifetime prevalence ~12%
- Developed countries higher: 18%
- 2X higher in women
- Caucasians higher



Depression

- Major depression occurs more often in patients with specific risk factors:
 - Internalizing factors:
 - Low self-esteem
 - History of depression
 - Neuroticism
 - Genetics
 - Early onset anxiety
 - Externalizing factors:
 - Genetics
 - Substance misuse
 - Conduct disorder
 - Adversity

Depression

- Neurobiology:
 - Associated with neurobiological change
 - Associated with changes in:
 - HPA axis
 - Neural networks
 - Frontal cortex
 - Subcortical structures
 - Etc.....

Depression

- **Diagnosis:**

- **History the most important part:**

- Depressed more days than not
 - Loss of pleasure (anhedonia)
 - Insomnia/hypersomnia
 - Weight change
 - Decreased energy
 - Poor concentration
 - Worthlessness
 - Suicidal thoughts

- **PHQ-9: best screen**

- Sensitivity: 88%
 - Specificity: 80%

1. Little interest or pleasure in doing things

2. Feeling down, depressed, or hopeless

3. Trouble falling or staying asleep, or sleeping too much

4. Feeling tired or having little energy

5. Poor appetite or overeating

6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down

7. Trouble concentrating on things, such as reading the newspaper or watching television

8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

9. Thoughts that you would be better off dead, or of hurting yourself

Depression

- Treatment:
 - Major depression:
 - medication + psychotherapy: combination therapy better than either alone
 - Many drug classes are efficacious
 - SSRIs generally first line
- Make sure mood disorder is independent of substance use disorder or withdrawal

Depression

- Lifetime prevalence of depression in alcohol/drug treatment centers is 20-50%
 - 10-20% of the time it is current (ASAM Essentials, 491)
- Co-occurrence of drug or alcohol disorders in MDD
 - Etoh:
 - Females: 4.1x's higher
 - Males: 3x's higher
 - Drug:
 - Female and male: 9x's higher



Bipolar

- I: mania and major depression
- II: hypomania (not full-blown mania)
 - One episode of depression
- General:
 - Lifetime prevalence US:
 - Bipolar I: 1%
 - Bipolar II: 1.1%
 - Mean age of onset:
 - Bipolar I: 18
 - Bipolar II: 20



Bipolar

- Diagnosis:

- Mania:

- Elevated, expansive, irritable mood
 - >1 week, all day, every day, grandiose
 - No sleep
 - Racing thoughts
 - Excessive involvement in pleasure
 - Not drug induced

- Hypomania:

- Same except >4 days
 - Not severe enough to cause social impairment
 - Not caused by a drug

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Bipolar

- Pathogenesis:
 - Not known
 - Certain heritable factors: family and twin studies
 - Lifetime risk monozygotic twin: 40-70%
 - Lifetime risk dizygotic twin: 5%



Bipolar

- Treatment
 - Hypomania and mania treated the same
 - Severe mania:
 - Lithium- first line
 - Valproate and antipsychotics- second line
 - Hypomania (mild to moderate)
 - Risperidol
 - Olanzapine
 - Benzos: SHORT term if needed



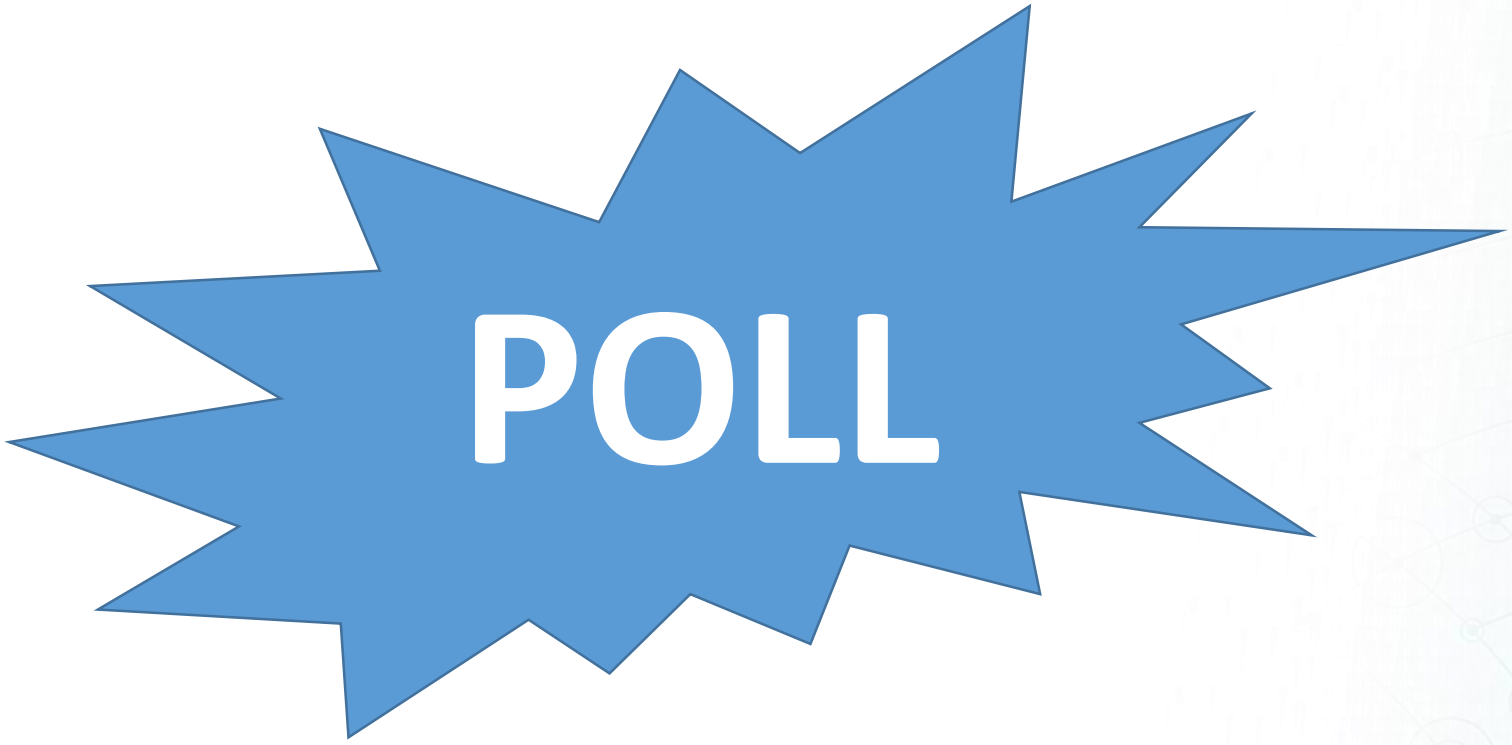
Bipolar

- The association of BPD and SUD is much greater than for depressive disorders by a factor of: 4
- History of bipolar disorder
 - Lifetime ETOH abuse: 48.5%
 - Illicit drug abuse: 43.9%
 - 60% had a history of some lifetime substance abuse
 - M>W
 - No difference in mixed bipolar disease + mania

Cassidy, A etal. Substance Abuse in Bipolar Disease. *Bipolar Disorders*. 2008.

Prevalence

- 12 month prevalence of independent mood and anxiety disorder with SUD who sought treatment in last 12 months:
 - Any mood disorder: 60%
 - Major depression: 44%
 - Mania: 20%
 - Hypomania: 2%
 - Any anxiety disorder: 42%
 - Social anxiety disorder: 12%



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Pearls

- Any mental health disorder predicts:
 - Higher rates of opioid use
 - High daily doses
 - Long duration of therapy
 - Multiple opioids
 - Concurrent benzos
- 16% of Americans with mental health disorders receive over ½ opioid prescribed

Case Presentation

Meet Jim Doe

- 34 yo man who works as a tree trimmer**
- History of polysubstance abuse (heroin, meth, alcohol, marijuana)
- Has been on MAT through St. Cloud methadone clinic
- Daily dose of methadone increased from 50 to 55mg recently
- Your nurse note reads that Jim is interested in switching to Suboxone
- Chart: medical history of anxiety, bipolar disorder

What questions do you need to ask?

- Use your microphones!
- Try put yourself in the shoes of a provider that has to make shared decisions with this patient
- We may call on people in the audience and prompt some questions

Plan

- Taper dose of methadone to 20-30mg
- Abstain from methadone for 36-72 hours
- Come to clinic for induction once you feel withdrawal symptoms

Part 2 – 2 years later

- Successful suboxone induction almost 1 year after initial intake
- Completed inpatient rehab, employed, sober, no longer using alcohol
- However, his anxiety is worsening – what should we ask regarding the intersection of his substance use and his mental health?

Learning points from the case

- Switching from methadone to suboxone involves tapering to a safe level, going through withdrawal, and then starting suboxone
- Methamphetamine intoxication can look like mania, be careful of chart lore in a patient with polysubstance use
- Marijuana at high doses carries a risk of worsening anxiety as well as psychotic breaks – modern marijuana much more potent than historically