Psych 101:
Basics of Identifying and Intervening with Mental Health Diagnoses in the setting of SUDs.

Jess McSurdy, MD; Genevieve Verrastro, MD

Disclosures:

- We are going to discuss off-label uses for medications

Objectives

- Outline a time effective approach to evaluation for patients presenting with mental health complaints with emphasis on mood and anxiety disorders.
- Demonstrate an approach to diagnosis that emphasizes symptoms or functional complaints and/or applying DSM criteria.
- Provide an overview of ruling out major psychiatric diagnoses like bipolar and psychotic disorders.
- Recognize the ways that substance use can complicate the diagnostic and therapeutic process.
- Provide an overview of commonly used categories of psychotropic medications with attention to avoidance or use of common side effects..
- Highlight an approach to assessment in the setting of worsening or poorly response symptoms.

Context and disclaimer:

- We are board certified in Family Medicine and Addiction Medicine
- We are going to discuss off-label uses for medications
- ‘Correct’ treatment highly dependent on practice environment and resources available. What works in Wake County probably won’t in Clay County, and vice versa.
- Assign each case has a nonspecific “spiciness score”
  - Bell pepper= bread and butter primary care 
  - Carolina Reaper= attempt only under extreme conditions or consult your friendly addiction psychiatrist! 

Comorbidity goes both ways…

Psychiatric use associated with substance use disorders, SUD associated with worse outcomes of psych disorders

Compton et al NESARC study Arch Gen Psychiatry 2007, McGough et al, Am J Psychiatry 2005

Odds ratio of comorbidity of psychiatric disorder within 12 months of substance use	
Comorbidity	**OR**
Alcohol Use Disorder	15
Mood Disorder	8.5
Anxiety Disorder	6
ADHD	6.2
Personality Disorder	9.6

Substances can mimic behavioral health disorder symptoms

Depression

- ✧Alcohol
- ✧Cannabinoids
- ✧Cocaine Withdrawal
- ✧Opioids

Anxiety

- ✧Alcohol Withdrawal
- ✧Cannabinoids
- ✧Cocaine
- ✧Methamphetamine

American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders: 5th Edn. Washington, DC: (2013)
Image courtesy of NC STAR Network

Format:

Split into 5 groups *(not with your coworkers)* each group will discuss a case for 10 min:

- How does SUD affect psychiatric symptoms?
- What medication options are best? Non-medication management?
- When/why would you refer for higher level of care?
- How many spicy peppers is the case rated? 

Each group will present their answers to the rest of us.

Case #1: Depression in patient presenting for SUD treatment

- A is a 35-year-old male with 10-year history of OUD, currently receiving methadone 100mg daily via local OTP. He has been off and on buprenorphine and/or methadone for several years.
- Although he has been in recovery for 3 months, repaired relationships with his family, and is working, he feels hopeless about his future, is constantly fatigued, and has gained #30.
- His PHQ9 is 15. On question 9 (Thoughts you would be better off dead, or of hurting yourself in some way) he answers 1 for “several days”

Case #1

- Medication considerations: energy, libido, limiting weight gain.
- Drug interactions with methadone.
- Comorbid conditions to rule out.
- Address passive SI

Comparison of antidepressant medications and their possible side effects

Medication (generic and brand names)	OK if patient has high blood pressure	Weight gain	Low sex drive (libido)	Drowsiness	Trouble sleeping or restlessness	Stomach upset
Atypical antidepressants						
Bupropion (Aplenzin, Forfivo, Wellbutrin)	☑				●	●
Mirtazapine (Remeron)	☑	●●●●	●	●●●●		
Selective serotonin reuptake inhibitors (SSRIs)						
Citalopram (Celexa)	☑	●	●●●	●	●	●
Escitalopram (Lexapro)	☑	●	●●●	●	●	●
Fluoxetine (Prozac)	☑		●●●		●●	●
Fluvoxamine (Luvox)	☑	●	●●●	●	●	●
Paroxetine (Paxil)	☑	●●	●●●●	●●	●	●
Sertraline (Zoloft)	☑	●	●●●	●	●●	●●

Suicide Risk Elevated with SUD+MDD

Compared to those with no diagnosis of SUD or MDD, those with...		
Alcohol Use Disorder	9 x more likely	to have suicidal thoughts in the last 12 months
Cocaine Use Disorder	11.3 x more likely	
Drug Use Disorder excluding Cannabis	16.2 x more likely	

Onaemo VN, Fawehinmi TO, D'Arcy C. Risk of suicide ideation in comorbid substance use disorder and major depression. PLoS One. 2022;17(12):e0265287. Published 2022 Dec 7. doi:10.1371/journal.pone.0265287

Step 1: Warning signs (thoughts, emotions, behaviors, physical feelings that indicate I may be going into a crisis)	
Step 2: Coping strategies (activities that help me when warning signs are present)	
Step 3: People and social settings that help me feel better and provide comfort or distraction	
Name:	Phone:
Name:	Phone:
Social setting:	Place:
Step 4: People I can ask for help (friend, parent, guardian, sibling, significant other, spiritual leader)	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Step 5: Behavioral health professionals or agencies I can contact during a crisis	
MAHEC (24/7/365	Family Health 828-257-4730 / Psychiatry 828-398-3601 /

Case #2: Worsening anxiety in patient engaged in SUD treatment.

- B is a 52-year-old woman with AUD. She completed inpatient detox a month ago and is on long-acting injectable naltrexone. Her psychiatric history includes a diagnosis of PTSD after leaving an abusive relationship.
- She reports worsening insomnia, worries about her family constantly, and is increasingly nervous when leaving the house for normal activities.
- Her daughter gave her some clonazepam, and it really helped her nerves.

Case #2

- GAD v. sub-acute alcohol withdrawal v. trauma related disorder
- Medications and other therapies
- Role for benzodiazepines?

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) - PTSD: National Center for PTSD

Example

In the past month, have you ...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?	YES	NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	YES	NO
3. been constantly on guard, watchful, or easily startled?	YES	NO
4. felt numb or detached from people, activities, or your surroundings?	YES	NO
5. felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the events may have caused?	YES	NO
Total score is sum of "YES" responses in items 1-5.	**TOTAL SCORE**	

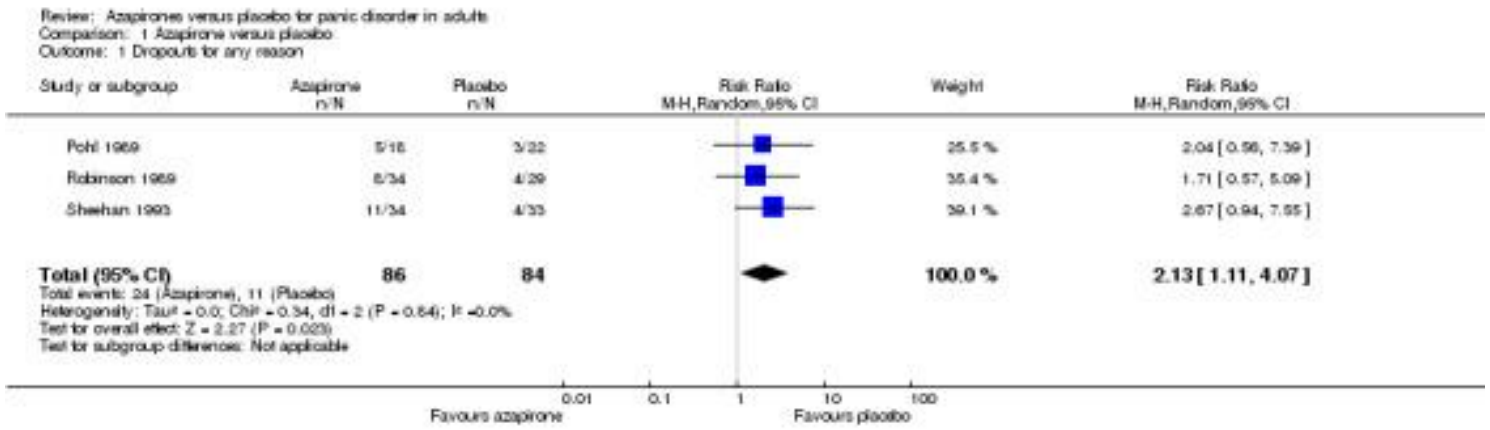
In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
2. Repeated, disturbing dreams of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
4. Feeling very upset when something reminded you of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
8. Trouble remembering important parts of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
12. Loss of interest in activities that you used to enjoy?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
13. Feeling distant or cut off from other people?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
15. Irritable behavior, angry outbursts, or acting aggressively?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
16. Taking too many risks or doing things that could cause you harm?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
17. Being "superalert" or watchful or on guard?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
18. Feeling jumpy or easily startled?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
19. Having difficulty concentrating?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
20. Trouble falling or staying asleep?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯

Quality of evidence for PTSD non-antidepressant pharmacotherapy

Benzodiazepines:					
Alprazolam	1	1	0	2	D
Temazepam	0	1	0	1	D

Berger W, Mendlowicz MV, Marques-Portella C, Kinrys G, Fontenelle LF, Marmar CR, Figueira I. Pharmacologic alternatives to antidepressants in posttraumatic stress disorder: a systematic review. Prog Neuropsychopharmacol Biol Psychiatry. 2009 Mar 17;33(2):169-80. doi: 10.1016/j.pnpbp.2008.12.004. Epub 2008 Dec 24. PMID: 19141307; PMCID: PMC2720612.

What about buspirone for anxiety disorders?



Imai H, Tajika A, Chen P, Pompoli A, Guaiana G, Castellazzi M, Bighelli I, Girlanda F, Barbui C, Koesters M, Cipriani A, Furukawa TA. Azapirones versus placebo for panic disorder in adults. Cochrane Database Syst Rev. 2014 Sep 30;2014(9):CD010828. doi: 10.1002/14651858.CD010828.pub2. PMID: 25268297; PMCID: PMC10590499.

Case #3: Patient presenting for SUD treatment with a history of 'bipolar'

- C is a 24 year old woman with OUD on sublingual buprenorphine 24mg daily. She has struggled with alcohol, stimulant and opiate use since her teen years. She has just left a long term recovery program and is requesting to transfer her MOUD care to her PCP.
- She reports a history of anxiety, her roommate at the Oxford house takes sertraline and has suggested that it could help C too.
- While reviewing her records, you note a diagnosis of bipolar disorder. She has been on fluoxetine and quetiapine in the past

Case #3

- Clarify historical diagnosis of bipolar, what is the differential?
- How would diagnosis affect treatment options for her anxiety?
- What if she was requesting treatment for depression?
- Discuss bipolar II

DIGFAST

Distractibility
Indiscretion
Grandiosity
Flight of ideas
Activities
Sleep deficit
Talkativeness

Manic Episode

- **Duration:** At least **1 week** (or any length if hospitalization is required).
- **Mood/Energy:** Abnormally elevated, expansive, or irritable mood **plus** increased energy or activity.
- **Symptoms: 3+ symptoms** (4 if mood is only irritable), such as:
  - Grandiosity
  - Decreased need for sleep
  - Excessive talking
  - Racing thoughts
  - Distractibility
  - Increased goal-directed activity or agitation
  - Risky or impulsive behaviors
- **Severity:** Causes **marked impairment**, requires hospitalization, or includes **psychotic features**.
- **Exclusions:** Not due to substances or another medical condition.

Major Depressive Episode

- **Duration:** At least **2 weeks**.
- **Symptoms: 5 or more symptoms**, including **depressed mood** or **loss of interest/pleasure**, such as:
  - Depressed or irritable mood
  - Loss of interest or pleasure
  - Significant weight or appetite change
  - Sleep problems
  - Psychomotor agitation or slowing
  - Fatigue
  - Feelings of worthlessness or excessive guilt
  - Poor concentration or indecisiveness
  - Recurrent thoughts of death or suicide
- **Severity:** Causes **clinically significant distress or impairment**.
- **Exclusions:** Not due to substances or another medical condition.

Hypomanic Episode

- **Duration:** At least **4 consecutive days**.
- **Mood/Energy:** Same type of elevated or irritable mood and increased energy as mania.
- **Symptoms: Same symptom list** as mania (3+, or 4 if irritable).
- **Severity:** Noticeable change in functioning and observable by others, **but**
  - **No marked impairment**
  - **No hospitalization**
  - **No psychotic features**
- **Exclusions:** Not due to substances or another medical condition.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.

Diagnosis	Manic/Hypomanic episode	Major Depressive Episode	Psychotic symptoms
Major Depressive Disorder	No	Yes	Yes-if confined to mood episodes only
Bipolar I	At least 1 manic episode	Not necessary	Yes- if confined to mood episodes only
Bipolar II	At least 1 hypomanic episode	At least 1 major depressive episode	No
Schizoaffective disorder	If confined to co-occurring schizophrenia symptoms	Possibly	Yes- at least 2 weeks in the absence of mood symptoms

	Common meds	Depression	Acute Mania/Hypomania	Maintenance for Mania/Hypomania	Considerations
Mood Stabilizer	**Lithium**	Yes	Yes	Yes	Monitoring, narrow therapeutic index, sedation
	Valproic acid	Yes	No	Yes	Monitoring, weight gain, sedation
	Lamotrigine	Yes	No	Yes	Slow titration due to rash (SLE)
Atypical Antipsychotics	**Aripiprazole**	Yes- Adjunct for MDD	No	Yes	Metabolic side effects, EPS, irritability
	Olanzapine Quetiapine Risperidone	Off label	No	Yes	Metabolic side effects, EPS, sedation
	Lurasidone Cariprazine	Yes	No	Yes	Newer agents, take lurasidone with food
	SSRI SNRI Mirtazapine Bupropion	Yes	No	No	Can use for anxiety and depression if on medication preventing mania

Case #3 PEARLS

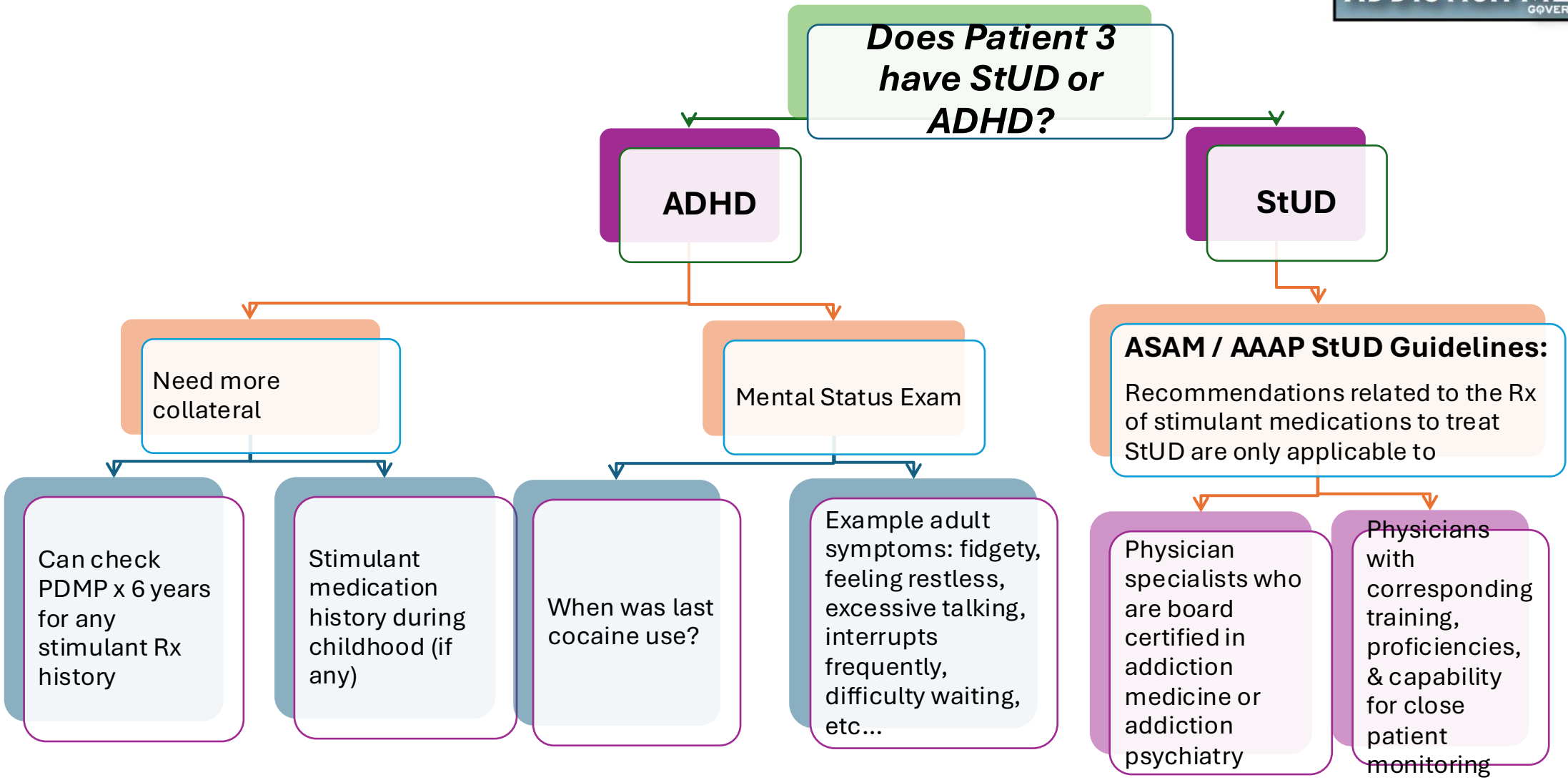
- Incidence of SUD in patients with Bipolar disorder 30-50% (SAMSHA)
- About 30% of patients with SUD have been diagnosed with bipolar disorder
- Emphasis on doing adequate screening -
  - Mood Disorder Questionnaire, Hypomania checklist
- Shared decision making of treatment and appropriate counseling on risks/benefits

Case #4: ADHD treatment with history of stimulant use disorder

- D is a 29-year-old male with stimulant use disorder. He is currently on parole.
- He reports difficulty concentrating at his job, which is short staffed and chaotic. He will violate his parole if he is fired. He reports using methamphetamine intermittently to help him stay focused on work tasks
- He was diagnosed with ADHD as a child and was briefly on lisdexamphetamine which he recalls as being effective. He is requesting to restart it.

Case #4

- Pharmacotherapy for stimulant use disorder v. treatment of ADHD in patient with history of stimulant use disorder
- Stimulant v. non-stimulant options
- If he had not been diagnosed with ADHD as a child, would management differ? How?



American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.
The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder. Journal of Addiction Medicine 18(1S):p 1-56, May/June 2024. | DOI:

STUDY	STUDY TYPE	STUDY DETAILS	SELECT RESULTS / HIGHLIGHTS
Tardelli et al. 2020	Meta-analysis	38 RCTs included: 26 in patients with cocaine use disorder, 12 in patients with amphetamine-type use disorder	Stimulant Rx to treat StUD was associated with 2-3 weeks of sustained abstinence
			NNT 16
Barbuti et al. 2023	Review	Includes overview of pharmacologic treatments for ADHD in setting of comorbid SUD	Prescribed stimulant misuse may be less common with methylphenidate (over amphetamines) & with long-acting formulations.
			Treating ADHD for those with a SUD is endorsed.
			Consider abuse potential when prescribing stimulants to those with ADHD & SUD
Coffin and Suen 2024	Review	Review of methamphetamine toxicities & clinical management of StUD	General Approach: Nonjudgemental, explore administration route & use patterns, understand perceived benefits / harms, use DSM-5™ for diagnosis, employ motivational interviewing
			All pharmacologic treatments reviewed are off-label
			Multiple studies have found reduced self-reported methamphetamine use with medications like dextroamphetamine, methyphenidate, & modafinil. However, none have shown reduction in use by an objective measure, with exception of one small trial.

Tardelli VS, Bisaga A, Arcadepani FB, Gerra G, Levin FR, Fidalgo TM. Prescription psychostimulants for the treatment of stimulant use disorder: a systematic review and meta-analysis. *Psychopharmacology (Berl)*. 2020;237(8):2233-2255. doi:10.1007/s00213-020-05563-3
Barbuti M, Maiello M, Spera V, et al. Challenges of Treating ADHD with Comorbid Substance Use Disorder: Considerations for the Clinician. *J Clin Med*. 2023;12(9):3096. Published 2023 Apr 24. doi:10.3390/jcm12093096
Coffin PO, Suen LW. Methamphetamine Toxicities and Clinical Management. NEJM Evid. 2023;2(12):EVIDra2300160. doi:10.1056/EVIDra2300160

Case #5: Cannabis use in young adults

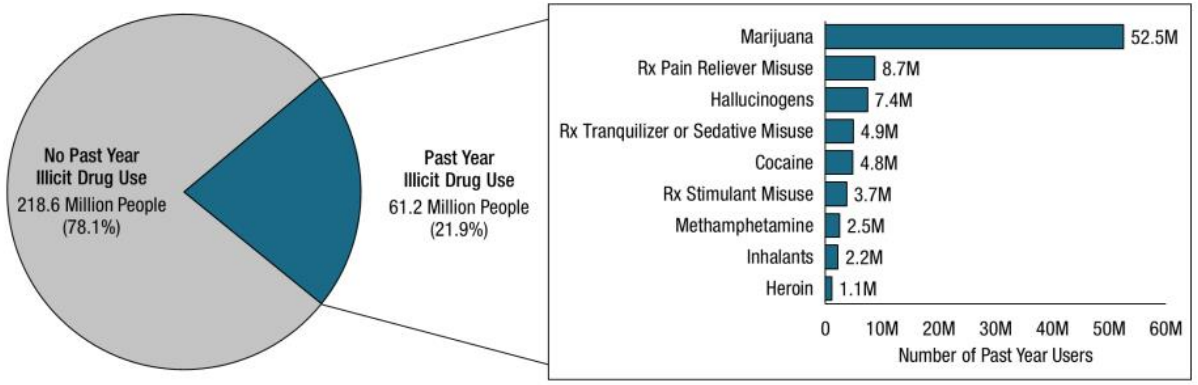
- E is a 19-year-old male who was found by his parents over the weekend agitated, apparently intoxicated, and seeming to be responding to internal stimuli. He is now withdrawn- although answering some questions
- He admits to vaping delta 9 and getting other substances from the gas station and smoke shop. UDS is positive for THC and mitragynine.
- His parents are concerned about him getting involved in 'the system' if he goes to the ER and would prefer to closely supervise him at home.

Case#5

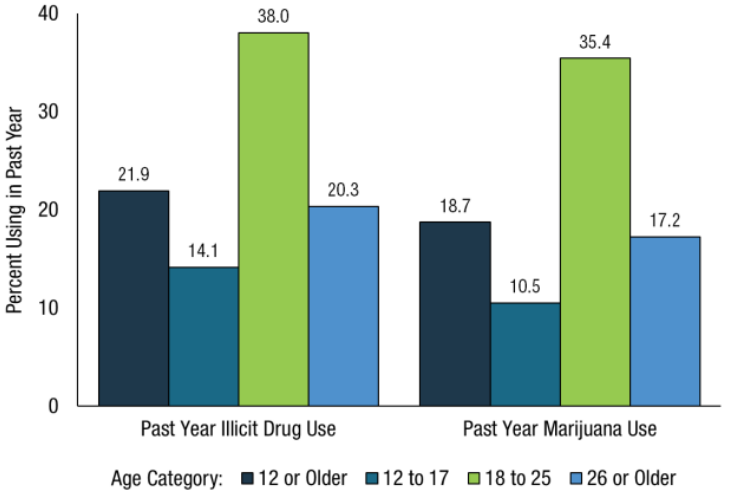
- What's his diagnosis? Stimulant induced psychosis v. psychotic disorder?
- What if he was just using cannabis and nothing else? Would that change his differential?
- How important is the level of care he gets now, if he is closely supervised at home and parents are supportive?

Past Year Illicit Drug Use: Among People Aged 12 or Older; 2021

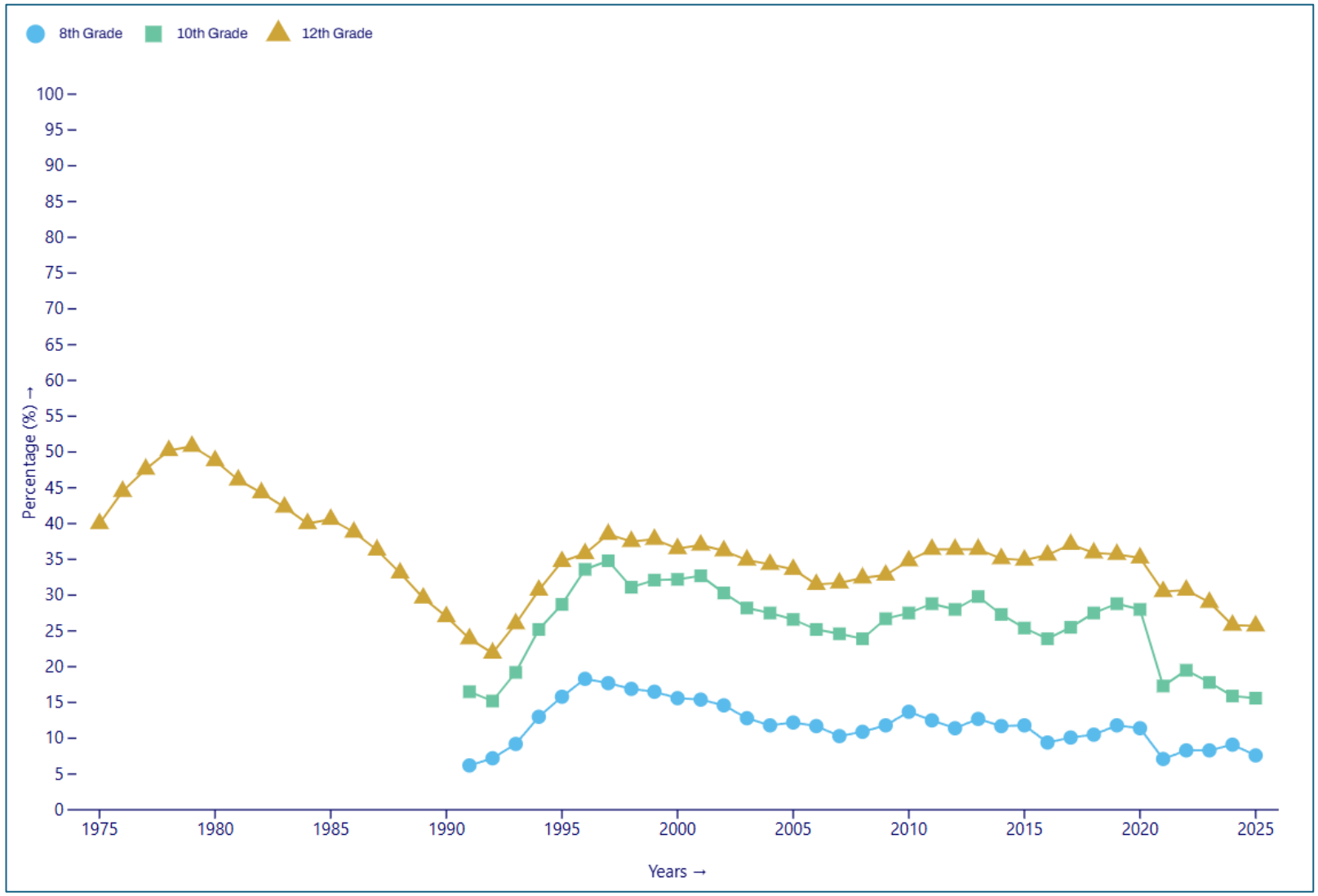
SAMHSA
Substance Abuse and Mental Health Services Administration



Past Year Illicit Drug Use and Past Year Marijuana Use: Among People Aged 12 or Older; 2021



Cannabis: Trends in 12 Month Prevalence of Use in 8th, 10th, and 12th Grade



Miech, R. A., Patrick, M. E., O'Malley, P. M., Jager, J. O. and Jang, J. B. (2026). Monitoring the Future national survey results on drug use, 1975–2025: Overview and detailed results for secondary school students. Monitoring the Future Monograph Series. Ann Arbor, MI: Institute for Social Research, University of Michigan. Available at https://monitoringthefuture.org/results/annual-reports/

Psychosis

- "A collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not."
  - National Institute of Mental Health

- Characterized in the DSM-V as a disconnection with reality/alteration in reality testing, with delusions and/or hallucinations

- Primary psychotic disorder
  - Ex: Schizophrenia, Schizoaffective d/o, Delusional d/o

- Secondary psychosis
  - Medical conditions, medications, mood disorder w/ psychotic symptoms, substance-induced

- Cannabis intoxication
  - During active use, lasting <24 hours
- Cannabis-induced psychosis (CIP)
  - In the setting of recent use, typically lasting <1 month with cessation
- Schizophrenia
  - Symptoms present for a month, with disorganization/affect changes

Prodrome	**Subtle changes in behavior, more social isolation, suspicious behavior, typically minor distress a/b symptoms**
Schizophrenia: Severe disturbance in behavior with at least two of the below during a 1 month period for most of the time. At least one of them must be 1, 2, or 3.	
1. Hallucinations	Perceptions (auditory/visual) that are occurring in the absence of any external stimuli
1. Delusions	Fixed false beliefs despite evidence to the contrary. Can be not- bizarre (possible) or bizarre
1. Disorganized speech	Topic jumping, tangential thinking/speech, word salad
1. Disorganized behavior/Catatonia	Cannot perform goal-directed behavior, or decreased responsiveness to the environment
1. Negative symptoms	Flattened affect, anhedonia, decreased activity, decreased social engagement, decreased speech,

Case #5 PEARLS

- Cannabis use should be strongly discouraged in younger patients!!!
- Low evidence/poorly studied benefit of cannabis for mood disorders
- 2-11x increased risk in psychotic symptoms and up to 50% develop into persistent psychotic disorders. [1]
- Positive correlation with emergence of schizophrenia [2]
- Assess type of use! High frequency and high potency associated with higher risk for psychosis
- Early intervention is key, consider higher level of care more urgently with younger patients to improve outcomes

Cannabis-Related Disorders and Toxic Effects. David A. Gorelick, M.D., Ph.D. December 13, 2023. N Engl J Med 2023;389:2267-2275
Transition to Schizophrenia Spectrum Disorder Following Emergency Department Visits Due to Substance Use With and Without Psychosis. JAMA Psychiatry. October 31, 2023.

Disclosures

Objectives

Presentation